CHART AUDIT FOR PROOF OF MEDICAL NECESSITY

	Yes	No
Pre-Admission Screening		
Are medical conditions requiring ongoing care identified?		
Is current functional status and potential for improvement stated?		
Is justification for admission to inpatient rehabilitation clearly communicated?		
Is physician in agreement with admission?		
Physician Documentation		
Are MD orders for admission present?		
If there is a graduated therapy program are the orders appropriate? (hours and duration of therapies ordered)		
History & Physical:		
Is H&P completed and signed?		
Does H&P indicate why patient needs rehab stay including rehab nursing and intensive therapy?		
Are medical diagnosis, rehab impairment category, etiological dx., and active co-morbidities listed?		
Does H&P have a review of systems, functional limitations identified, and note problems that will interfere with rehab outcomes?		
Are rehab potential and expected outcomes stated?		
Is a plan for medical care, therapy, and rehab nursing noted?		
Is estimated length of stay stated with a discharge destination identified?		
Ongoing Documentation:		
Documentation of weekly staffing? Is goal attainment addressed?		
Does the team conference/weekly staffing note include justification for continued stay?		
If there is a graduated therapy program, is it reviewed/addressed for appropriateness?		
Are new diagnoses and co-morbidities identified?		
Do notes and orders and notes reflect medical management of the identified co-morbidities and diagnoses?		
Do progress notes reflect impact of co-morbidities and diagnoses on functional performance?		
Are changes to discharge plan identified?		
Discharge Summary:		
Is discharge summary present?		
Are primary RIC, rehab diagnosis, and co-morbid conditions?		
Is progress toward attaining functional goals in rehab and nursing noted?		
Is there a review of medical interventions managed during the stay?		
Is on-going medical and rehab plan of care stated?		
Team Assessment		
Do short-term goals address key functional areas?		
Are the team goals multidisciplinary?		
Are goals adjusted throughout the stay if needed to maximize progress?		
Is rehab potential qualified?		

	Yes	No
Nursing Documentation		
Are daily flow sheets completed initialed and signed?		
Are Bowel & Bladder Records completed? Progress in program noted?		
As applicable is diabetic documentation completed?		
Are Medication Administration Records completed properly?		
If used, is Restraint Documentation completed?		
Are skin integrity issues addressed through positioning and weight shifting techniques?		
Is nutritional and hydration status addressed?		
Is pain assessed and managed daily?		
Are safety concerns addressed including both cognitive and physical limitations?		
Is education documented with patient and family training explained?		
Do nursing notes support therapy goals and interventions?		
Is discharge planning evident in daily notes?		
Therapy Documentation		
3-hours of therapy is documented for each day? Acceptable variances are documented?		
Are interventions and time spent specified?		
Are safety concerns addressed including both cognitive and physical limitations?		
Is education documented with patient and family training explained?		
Do therapy notes support goals and interventions of other disciplines (nursing, psychology, ST, SW)?		
Is discharge planning evident in daily notes?		
Weekly Documentation		
Are short-term goals documented?		
Does documented progress relate to the accomplishment of the short-term goals and functional improvement?		
Does documentation show the barriers for discharge and need for continuation of the stay?		
Documentation reflects potential for significant practical improvement and need for continued services?		
Discharge Summary		
Does D/C Summary reflect progress made throughout stay?		
Are discharge recommendations or plan for continued care completed and shared with the patient/family?		
Percentage of Long-Term Goals Met	_ of _	%