

**LARNED STATE HOSPITAL  
MEDICAL STAFF  
EVALUATION REPORT**

<b>MEDICAL STAFF:</b>	<b>UNIT:</b>
<b>SUPERVISOR:</b>	<b>MONITORING PERIOD:</b>

<b>CHART #'S</b>			
------------------	--	--	--

- PERFORMANCE:** Completed at least every six months.
- FOCUSED:** Encircle # of focused topics that are being evaluated for this period when applicable

**SOURCES OF INFORMATION:**

**CR----**Chart Reviews  
**DO----**Direct Observation

#	TOPIC	SOURCE	COMMENTS:
<b>1</b>	<b>ADMISSION INTAKE ASSESSMENT (AIA) EVALUATIONS</b>		
	a. Completed within 24 hours.		
	b. DSM IV TR terms used appropriately.		
	c. Suicide Risk assessed descriptively in Thought Content.		
	d. Other/Comments		
<b>2</b>	<b>SECLUSION/RESTRAINT</b>		
	a. Sign S/R Order in 12 hours.		
	b. Complete Face to Face with patient in 1 hour.		
	c. Release Criteria is measurable and linked to the behavior that precipitated the use of S/R.		
<b>3</b>	<b>PHYSICAL EXAMINATION</b>		
	a. Completed within 24 hours.		
	b. If not, followed up on timely basis until done.		
	c. Topics in form addressed appropriately.		
	d. Other/Comments		

<b>4</b>	<b>MEDICATION USE</b>		
	a. Medications appropriate to diagnosis and patient need ( including dose and strength ).		
	b. Medication Reconciliation process is completed upon admission and upon return from outside healthcare provider where changes to medication regime are recommended.		
<b>5</b>	<b>PROGRESS NOTES</b>		
	a. Information re-patient's response to treatment, significant event, findings or observations.		
	b. Legible.		
	c. Timely.		
	d. No dangerous abbreviations used.		
<b>6</b>	<b>ADVERSE EVENTS OCCURRED/REPORTED</b>		
	a. Malpractice lawsuits ( reported, filed, completed )		
	b. Patient death, serious significant injury/morbidity		
<b>7</b>	<b>OTHER ADMISSION PAPERWORK ( for new physicians )</b>		
	a. Completed on timely basis.		
	b. Paperwork done accurately.		
<b>8</b>	<b>OTHER DISCHARGE PAPER WORK</b>		
	a. ePN's completed within 72 hours.		
	b. Release summary completed in a timely manner.		
<b>9</b>	<b>INTERPERSONAL &amp; COMMUNICATION SKILLS</b>		
	a. Display professional conduct that fosters dignity, trust and respect among colleagues.		
	b. Communicates patient information effectively using SBAR (Situation, Background, Assessment, Recommendation)		

	<b>approach during unit transfers, and EMTALA situations.</b>		
--	---	--	--

ADDITIONAL COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**REVIEWER OR SUPERVISOR SIGNATURE** **DATE**

Reviewed on \_\_\_\_\_ by \_\_\_\_\_  
Date Senior Supervising Physician Signature

with \_\_\_\_\_  
Medical Staff Signature

**MDO: mm 9/08, rev. 12/08**

**6/9/09**

On the Evaluation Report... 5 charts are audited for specific items that have been problematic for our medical staff, i.e.

- Timely completion of the initial Admission Intake Assessment,
- S/R processes being followed,
- Physical exam completed in a timely manner.

On the Evaluation Report other hospital processes are monitored that are high risk and ones that affect patient safety, i.e.

- Medication use / reconciliation,
- Content of electronic progress notes,
- Adverse effects reported,
- Completion of admission/ discharge paper work,
- Interpersonal/ communication skills.

You may share this form and the MS bylaw section with others.  
 Janice Lubeck  
 Accreditation Officer  
 Larned State Hospital