Sample Audit Worksheet: Observation Services

Criterion	Description	Met	Not met	Comments
1	The physician's order for admission to observation status as well as the order for discharge from observation status must be dated, timed, and signed.			
2	The nurses' notes must reflect the date and time the patient was admitted to the observation bed and the date and time the patient was discharged.			
3	The physician must include in the documentation a risk stratification that addresses the assessment results that determined the beneficiary would benefit from observation services.			
4	The nurses' notes must address the reasons for the observation stay.			
5	All diagnostic testing should include the orders for the testing and the results. This includes any preadmission testing.			
6	Procedure notes and/or operative notes must address any complication that would support admission to observation status.			
7	Anesthesia and recovery room/PACU notes from the physician and the nurse must detail orders, progress notes and any complications requiring observation admission.			
8	Social Services, Utilization Review, or Case Management notes should include progress notes that detail reasons for admission to observation care, as well as any potentially custodial care issues. Any use of Condition Code 44 must also be documented.			
9	Any stay beyond 48 hours must be supported by documentation from all disciplines and that documentation must be submitted.			
10	Documentation related to an outpatient clinic visit or critical care service which was provided on the same date of service must be included and should also address any need for observation services, complications, additional follow-up needs, etc.			
11	All patient education provided must be addressed in the documentation.			
12	If a patient was placed in Observation status for a non covered service, an Advance Beneficiary Notice should have been given and a copy of that notice must be submitted, along with the documentation related to it.			

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