

Review a minimum of 5 and a maximum of 10 medical records.

Focus:

For this review, focus on the review of medical records of currently readmitted patients. Review randomly selected charts of inpatients (e.g. the last 5) who had a diagnosis of CDI made while an inpatient. Do not include charts of patients who developed CDI as an outpatient.

Instructions:

When reviewing the medical record, if documentation is found for the process, mark “**Yes**” in the box. If documentation is not found for the process, mark “**No**”. If the process being reviewed is not applicable to the medical record, mark “**N/A**”. After completing the review of all records, note the rows with the highest number of “**No**” responses. This will identify priority focus areas for improvement.

Note: Do not spend more than 20-30 minutes per medical record.

SUBMIT YOUR DISCOVERY TOOL FINDINGS WHEN COMPLETE: Take a 2 minute survey to report your findings. By submitting your findings, you will have taken the time to identify process gaps in which to focus improvement and to guide educational activities.

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Mini RCA CDI Process Improvement Discovery Tool

Medical Records #										
Within 24 hours prior to stool collection:										
The patient had 3 or more unexpected and unexplained stools										
The patient had NOT received a stool softener, laxative or enema										
The patient had NOT received lactulose, tube feedings, a bowel prep, or oral contrast										
The patient had the following:										
Risk factors for CDI: antibiotics in prior 60 days										
Risk factors for CDI: proton pump inhibitors for at least 3 of the prior 7 days										
Symptoms of CDI: abd pain, elevated WBC, T>38C?										
Status:										
The patient did NOT have a history of a previously positive test										
Specimen quality:										
The stool specimen submitted was unformed stool										
Other (specify):										

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