Quality Chart Review Tool

Rationale

This document is designed to use as an audit tool in conjunction with your Documentation Policies and Procedures. We recommend that Documentation Policies and Procedures include a definition of the components of the medical record and chart entry guidelines for each patient encounter.

- The tool will provide a method to proactively identify risks related to documentation practices.
- Chart review is a key element of performance measurement for office practice and involves reviewing a representative sampling of patient charts for each practitioner. This tool can also be used to collect data for quality improvement initiatives.
- The medical record is the official record of the care of the patient; therefore, gaps in documentation should be avoided.
- Quality chart review is a three step process to improve quality and reduce risk exposure. The tool is the first step and is the method to collect the data. The second step is data analysis and the third step is action predicated on the analysis.
- Analysis of the data can be displayed through graphics. For example, a compliance goal can be set at 100% and then each criterion can be measured and related to the goal. The results will assist you in focusing and prioritizing improvement action plans. Quality review information can be used to augment documentation and position the physician for immediate participation in future Pay for Performance initiatives.

SAMPLE QUALITY CHART REVIEW TOOL

Recommended sampling: 10% of patients seen during a one-week period to include a sampling of all practitioners.
Frequency: Twice a year.

Purpose: To provide a proactive measurement tool to identify risks and trends related to documentation practices.

Components of a complete medical record include:	Yes	No	N/A	Comments
Documentation of the informed consent process, when applicable	☐	☐	☐	
Documentation of phone encounters	☐	☐	☐	
Patient allergies (medications, food, latex, etc.) are listed on an allergy sticker or other form easily visible in the chart.	☐	☐	☐	
Completed Medication List	☐	☐	☐	
Prescription refills	☐	☐	☐	
An initial medical/surgery/social history – updated as appropriate.	☐	☐	☐	
Dispensed sample drugs are entered and include dosage, name, and quantity.	☐	☐	☐	
Preventive health screens are documented such as immunizations, pap smears, PSAs, lipid profiles, etc.	☐	☐	☐	
All lab tests and diagnostic imaging results are in the chart, dated and initialed by the practitioner ordering the tests.	☐	☐	☐	
Documentation of communication and failed communication efforts to the patient regarding all labs, diagnostic procedure results & referral results.	☐	☐	☐	
Documentation of referral results.	☐	☐	☐	
Progress note for each encounter.	☐	☐	☐	

Criteria for Each Patient Encounter	Yes	No	Comments
1. Patient's name, date and time	☐	☐	
2. Practitioner's signature and/or initials	☐	☐	
3. Primary complaint or reason for visit	☐	☐	
4. Vital signs as appropriate	☐	☐	
5. Current medications	☐	☐	
6. Current allergies	☐	☐	
7. Positive and pertinent negative findings	☐	☐	
8. Diagnosis/impression	☐	☐	
9. Studies ordered	☐	☐	
10. Therapy administered including new prescriptions	☐	☐	
11. Patient disposition/instructions	☐	☐	
12. Copies of or reference to printed materials, if applicable	☐	☐	
13. Referral information if applicable	☐	☐	
14. Updated problem list	☐	☐	
15. Written notes are legible	☐	☐	