



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.

Rationales and the tools are not legal advice and are not meant to substitute for medical judgment. You may have other tools, systems or protocols in your practice which may make this tool, or a part of it, unnecessary. Further, the tool, or parts of it, may not be applicable to your specialty or practice. You should use or adapt the tools only if appropriate for your practice. You should always consult your own legal counsel for current legal advice as laws and regulations may change.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of phone encounters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patient allergies (medications, food, latex, etc.) are listed on an allergy sticker or other form easily visible in the chart.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Completed Medication List	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prescription refills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
An initial medical/surgery/social history – updated as appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dispensed sample drugs are entered and include dosage, name, and quantity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Preventive health screens are documented such as immunizations, pap smears, PSAs, lipid profiles, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
All lab tests and diagnostic imaging results are in the chart, dated and initialed by the practitioner ordering the tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of communication and failed communication efforts to the patient regarding all labs, diagnostic procedure results & referral results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of referral results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Progress note for each encounter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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