



Medical Record Check-List Assessment

Review the following key areas and items in order to assess and improve your current medical record policies and procedures.

Medical History & Problem List

- Is a past medical, surgical, family, and social history documented for each patient in the medical record?
- Is there a current assessment of tobacco, alcohol, substance abuse, and recreational use in the medical record?
- Is there evidence of annual updates in the medical record for medical, surgical, family, and psychosocial histories?
- Is there a consistent list of active problems documented in the medical record?

Allergy Documentation

- Are patient medication and food allergies easily accessible in the record and updated on a regular basis?
- Is the reaction type documented for each allergy?
- Are the responsibilities for updating and documenting allergies clearly defined for staff/provider?

Patient Assessment

- Are vital signs taken and recorded for patients with an acute illness before and after an office procedure?
- Does each progress note contain a reason/chief complaint for why the patient presented for treatment?
- Does each progress note contain documentation of objective findings, review of systems, and patient assessment?

- Is there a plan of action documented for each patient office visit?
- Do providers document the presence of chaperones for intimate exams?
- Are the names of the persons accompanying the patient to their visit documented?

Medications

- Is there a complete list of medications, including dose, route, and frequency maintained in the medical record?
- Does staff review the medication list at each visit and document reconciliation in the medical record?
- Is there a copy of all medication orders, prescriptions, and refills maintained in the patient's medical record?
- When injections, immunizations, or IVs are given, does the documentation include the name of the drug, dosage, route, site, time and date administered, name or initials of ordering physician, and name or initials of the person administering the drug?
- Are medication refills delegated to clinical staff without a written standing protocol or documented authorization by the provider's electronic signature?
- Does the medication and prescription function alert providers of drug interactions, allergies to prescribed drugs, and dosage errors?

Communications

Telephone Interactions

- Do providers and staff document phone calls when medical information or treatment advice is provided?
- Are after-hours phone calls by practice providers as well as those made by covering providers documented in the medical record?
- Is medical advice provided by clinical staff without a written standing protocol or documented authorization by the provider's electronic signature?

Patient Education

- Are patient educational materials updated routinely by the system vendor or a designated provider in your practice?
- Are educational materials reviewed with the patient and documented in the medical record?
- Do available educational resources meet the language needs of the patient?

Health Information Management

Medical Record Processes

- Is there a process in place to ensure dictated and transcribed documentation is reviewed and approved for accuracy?
- Does your practice have a policy on late entries, addendums, or corrections to the medical record?
- Does your practice have a process that addresses using the copy and paste function in the medical record?
- Is there a process in place to ensure any potential follow-up actions for patients who no-show or cancel their appointment is recorded in the system?
- Is there a recall system in place for the tracking of high-risk and/or non-compliant patients, diagnostic test results, and referrals?
- Is there a process in place to ensure documented provider reviews all laboratory findings, diagnostic reports, and consultation reports that are electronically transmitted or scanned into the medical record?
- Does your practice have medical record retention policy?

Digital Information

- Does your practice have an electronic communication policy in place?
- Are online communications, text messages, and faxed information filed in the medical record?



- Are patient education materials maintained on the electronic medical record system for topics such as preventative health, pre- and post-procedure instructions, disease entities, medications, and treatments?

Consents

Informed Consent

- Are in-office, procedure-specific informed consent forms outlining the risks, benefits, and alternatives of a proposed treatment or procedure discussed with patient, completed, signed, and stored in the system?
- When a signed consent form is not required, is the informed consent discussion documented in the medical record?
- Is consent to treat a minor child obtained from parents/legal guardians?

Informed Refusal

- When a patient refuses recommended treatment, is the informed-refusal process documented in the medical record?
- Are the names of individuals involved in refusal discussions documented?
- Does the patient sign an informed refusal document, and is it stored in the system?

Workforce Privacy & Security

Security

- Are all users assigned individual passwords that are periodically changed and eliminated at termination of employment?
- Are security levels in place for restricting both local and remote users to relevant job category sections?
- Does the system allow for monitoring and auditing access, entries, and changes made to medical records prior to lock-in, and can it prevent erasures in the event of system failure?

- Is there a policy and procedure that addresses reporting and responding to system security incidents?
- Are security and privacy audits performed to ensure that patient information has not been compromised?

Confidentiality

- Do all employees—at beginning of employment and annually—sign a confidentiality agreement?
- Is there an office policy that supports workforce sanctions and training regarding the confidential nature of passwords and other identifiers?
- Are there quality control practices in place related to the release of protected health information?

Quality Performance

Documentation Standards

- Are all provider and clinical staff entries into the medical record electronically signed?
- Are appropriate co-signatures completed?
- When a scribe is used, are the following processes in place: written documentation guidelines, a clear definition of the scribe's role and auditing protocols?
- Are visit notes completed or finalized in a timely manner?
- Are recall system actions documented in the medical record for tracking high-risk and/or non-compliant patients, diagnostic test results, and referrals?
- Are issues related to patient non-adherence documented, including methods used to address compliance issues (e.g., additional education, behavior contracts, etc.)?
- Are referrals to consultants documented in the medical record?

- Are adverse events documented in sufficient detail to demonstrate an objective recording of the event, an appropriate response, and any follow-up care provided?
- Are staff instructed to refrain from placing incident reports or peer review documents in the medical record?

System Integrity

- Are there quality control processes in place to check data entered?
- Can the system search for specifically requested data and compile or develop reports on findings?
- Does the system have the flexibility to integrate additional programs and equipment?

System Support

- Is the system vendor accessible to provide updates in a timely manner, user training, and ongoing support as needed?
- Is there a staff member assigned to troubleshoot system problems?
- Does your organization have downtime procedures in place in the event of a system failure to capture interim data?
- Does your electronic system have an efficient backup plan with regularly scheduled backups (at least every 24 hours)?
- Are system backups stored in a secure location and tested on a regular basis?
- Does staff receive periodic updates and in-services on the electronic system and its procedures?