

2005

ARC

REVIEWER GUIDELINES TO PATIENT SAFETY
VERIFICATION SURVEY

Reviewers must follow these guidelines. The ARC User Board and the OMA Professional Affairs Department establishes the standards and guidelines. The Program Manager must approve any deviation from the guidelines.

The report to the practitioner is intended to improve office systems, documentation, and medical record keeping that impact patient safety in the ambulatory setting. As such, it is important that it contain relevant information by way of comments when there are deviations from standard. Therefore, the reviewer should generally go into the comment field to document their observations.

Reviewers may not review records that contain *inpatient drug or alcohol treatment* information.

In the case of large records that go back a period of years, the reviewer generally should look for documentation that has occurred in the last two years, although the reviewer may need to go back beyond that to obtain information on patient history, medication usage, consults and follow-up of unresolved problems.

Prior to your visit, the office personnel will have done a self-assessment survey. Before beginning the record survey, the reviewer will discuss the self-assessment survey with the designated office personnel. The purpose of the medical records **survey is to verify the self-assessment survey**. When the medical record survey is completed, the reviewer should do an exit interview to discuss variances between the self-assessment survey and the verification survey.

Scoring the survey - Odd numbered questions: "0" = non compliance, documentation is not found; "1" = partial compliance, documentation is generally found, but some components may be missing; "2" = full compliance, documentation is found. Even numbered questions: "0" = review of record does not confirm self-assessment survey; "1" = review generally confirms self-assessment survey with some discrepancies; "2" = review confirms self-assessment survey.

In this document, the guidelines are italicized and have "bullets". Preprogrammed laptop comments are in standard type.

MEDICAL HISTORY

1. IS THERE AN APPROPRIATE PAST MEDICAL HISTORY IN THE CHART THAT INCLUDES SERIOUS ILLNESSES, SURGERIES, FAMILY HISTORY, AND MENTAL HEALTH HISTORY?

CHILDREN AND ADOLESCENTS (18 YEARS AND YOUNGER): IS THERE DOCUMENTATION OF PRENATAL CARE, BIRTH, SURGERIES, AND CHILDHOOD ILLNESSES?

0 1 2 N/A

- *Applies to patients seen three or more times or who have been seen before the third visit for annual or wellness exam. Must be easily found in record.*
- *May be history form that is filled out by patient or guardian.*
- *If information is found but from another facility, give credit.*
- *Pediatric charts may have information on labor/delivery record from hospital.*
- *The history of adults should include general medical/surgical and family history.*
- *Accident and mental health history should be documented when significant.*
- *If the answer is no, document what was not found in the comment field and score "0".*
- *Give "1" for partial compliance if only one part, such as family history, is missing.*

Record organized on encounter basis and does not have past history.

Practitioner is a specialist. Record should contain past history and family history which is relevant to the referral.

Information is found in record, but on a form from another facility.

Information is not easily found in record.

The following is not found: History of serious illnesses.

The following is not found: History of surgeries.

The following is not found: History of mental health.

The following is not found: History of significant accidents.

The following is not found: Family history.

The following is not found: Prenatal care.

The following is not found: Birth history.

The following is not found: Childhood illnesses and/or surgeries.

Information is difficult to ascertain due to illegibility of many handwritten entries; some answers may be no due to illegibility.

Overall record is legible. There are some illegible entries which make it difficult to ascertain information.

Handwritten entries are illegible to two reviewers.

2. HISTORY: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY?

0 1 2 N/A

3. IF THERE IS CURRENT HISTORY OF TOBACCO USE, IS THERE DOCUMENTATION OF TOBACCO CESSATION ADVICE FOUND IN THE PAST YEAR?

0 1 2 N/A

- *Applies to patients 14 years or older who have been seen three or more times or who have been seen before third visit for annual or wellness exam.*
- *Score "N/A" if unable to find tobacco history.*

Information not easily found in record.

Information found in outside records, not in clinic records.

Designated location(s) blank.

Documentation of tobacco cessation advice not easily found.

4. TOBACCO CESSATION: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY?

0 1 2 N/A

PRESCRIPTION MEDICATIONS

5. IS THERE A SEPARATE MEDICATION SHEET IN THE CHART THAT LISTS ACUTE AS WELL AS CHRONIC MEDICATIONS?

0 1 2 N/A

- *Applies to all prescription medications and OTC medications that a patient is advised to take chronically, such as aspirin.*

Medication sheet is present but blank.

Medication sheet is incomplete.

Medications sheet lists only chronic medications.

Medication sheet not found.

Medications listed in chart notes only.

List of medications in chart notes is incomplete.

6. MEDICATION SHEET: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY?

0 1 2 N/A

7. IS THERE DOCUMENTATION OF REVIEW OF PATIENT'S MEDICATION USE, INCLUDING PRESCRIPTION MEDICINES AS WELL AS OVER-THE-COUNTER MEDICATIONS (OTC), THAT IS EASILY FOUND IN THE RECORD? (OTC MEDICATIONS INCLUDE VITAMINS, MINERALS, HERBAL PREPARATIONS AND SUPPLEMENTS.)

0 1 2 N/A

Information not easily found in record.

Unable to determine due to lack of documentation.

Unable to determine due to lack of documentation of herbal preparations and supplements.

8. MEDICATION USE REVIEW: DOES FINDING AGREE WITH SELF-ASSESSMENT?

0 1 2 N/A

9. ARE MEDICATION ALLERGIES PROMINENTLY DISPLAYED IN THE CHART? 0 1 2 N/A

- *Having an allergy notation in the text of the record does not suffice.*
- *If you find allergy information in the record which is inconsistent with what is prominently displayed, the answer is “0” and the specific observation should be documented in the comment field.*

Allergies found in record but not prominently displayed.

Allergy designated location blank.

Documentation of allergies not found in record.

Documentation found in record but on a document from another facility or practitioner.

Example:

Allergies found in designated location but not prominently displayed.

Allergy noted in chart note, but not reflected in designated location. Example:

Allergy List not current. Example:

There is conflicting information in the chart. Example:

10. ALLERGIES: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

ADMINISTRATION OF CONTROLLED SUBSTANCES FOR INTRACTABLE PAIN

- *Refer to the Oregon Medical Association Medical Legal Handbook pages 142-144, 215 or the Oregon Board of Medical Examiners website (<http://www.bme.state.or.us/PDFforms/MaterialRiskNotice.pdf>)*

11. IF CONTROLLED SUBSTANCES ARE PRESCRIBED FOR INTRACTABLE PAIN, IS THERE A “MATERIAL RISK NOTICE” AND A PAIN CONTRACT (OPTIONAL) FOUND IN THE CHART? 0 1 2 N/A

- *Pain Contract is optional. If Pain Contract not found, document observation in comment field. Do not score “0”.*
- *If Material Risk Notice is not found, document observation in comment field and score “0”.*

Information not easily found in record.

Unable to determine due to illegible entries.

Pain Contract not easily found in record.

Material Risk Notice not easily found in record. Refer to the Oregon Medical Association Medical Legal Handbook pgs 142-144, 215 or the Oregon Board of Medical Examiners website (<http://www.bme.state.or.us/PDFforms/MaterialRiskNotice.pdf>).

12. INTRACTABLE PAIN: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY?

0 1 2 N/A

FOLLOW-UP

13. IF LAB AND/OR IMAGING REPORTS ARE IN THE CHART, IS IT DEMONSTRATED THAT THE PRACTITIONER HAS REVIEWED THE REPORTS?

0 1 2 N/A

Ask the clinic contact person what you should look for to document practitioner review. (Will usually be hand initialed.)

- *If hand initialed and the initials are illegible, ask the clinic contact person to identify the practitioner's initials.*
- *If diagnostic tests are done in-house and are noted in the chart notes, the reports do not need to be initialed. (Only applies to in-house tests.)*
- *Electronic means, rubber stamp, etc. are acceptable.*
- *Give "1" for partial compliance if all but one report is initialed or signed.*

Unable to determine if the initials are those of the practitioner.

Not all reports are initialed or signed.

One report is not initialed or signed. Example:

Reports have writing on them but are not initialed.

Check mark used, not initials.

Stamp with date used, not initials.

Initialed but not by practitioner.

Office staff states it is not policy of clinic to initial these reports.

14. LAB/IMAGING REVIEW: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY?

0 1 2 N/A

15. IS THERE DOCUMENTATION OF FOLLOW-UP OF ABNORMAL TESTS AND/OR CONSULTANT RECOMMENDATIONS?

0 1 2 N/A

- *If unsure whether or not abnormality is significant enough for follow-up and it is not documented, copy for Medical Director review.*
- *May be documented in note to patient, instructions written on report, or note in Progress Notes.*
- *Look for follow-up of consultant recommendations when indicated.*
- *Not all consultations will require PCP follow-up. For example: patient referred to surgeon for carpal tunnel release and there has been no further problem.*
- *If practitioner is a specialist, look for report to PCP.*
- *Make note if unable to find consultation report. Does not effect score.*

Unable to find documentation of follow-up plan for: _____
Unable to determine due to illegible entries.
Patient recently referred to specialist, not sufficient time for report.
Unable to find documentation of communication to the PCP from the specialist.

16. ABNORMAL TEST AND/OR CONSULTANT RECOMMENDATIONS FOLLOW-UP: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

17. IF THERE IS NOT FOLLOW-UP OF ABNORMAL LABORATORY, IMAGING, AND/OR CONSULTANT RECOMMENDATIONS, IS IT BECAUSE PATIENT WAS NON-COMPLIANT? 0 1 2 N/A

Information not easily found in record.
Unable to determine due to illegible entries.
Unable to determine due to lack of documentation.

18. NON-COMPLIANT PATIENT: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

19. IF PATIENT WAS NON-COMPLIANT, IS THERE DOCUMENTATION OF FOLLOW-UP EFFORTS WITH THE PATIENT? 0 1 2 N/A

Information not easily found in record.
Unable to determine due to illegible entries.
Unable to determine due to lack of documentation.

20. NON-COMPLIANT PATIENT FOLLOW-UP: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

21. IS THERE DOCUMENTATION OF DIAGNOSTIC TESTS, WHEN INDICATED BY PATIENT'S PERSONAL OR FAMILY HISTORY, AND AGE APPROPRIATE PREVENTIVE TESTS? For purposes of this review we are looking specifically for colorectal cancer screening (persons > 50 yrs. or family history), but question may relate to other significant findings. 0 1 2 N/A

- *For purposes of this review we are specifically looking for colorectal cancer screening.*
 - *Includes diagnostic tests based on personal or family history, age appropriate preventive services.*
 - *Evaluate according to reasons for presenting problem.*
- Family history colon cancer or colon polyp. Flexible sigmoidoscopy recommended by age 50 then every 5 years until 70 is recommended but not found documented.
Colorectal cancer screening not easily found.
Colorectal cancer screening may include annual FOBT (lab not office test), or flex sigmoidoscopy within 5 yrs, or air contrast barium enema within 5 yrs, or colonoscopy within 10 yrs.

22. APPROPRIATE DIAGNOSTIC AND PREVENTIVE SERVICES: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

DISCHARGE FROM HOSPITAL OR EXTENDED CARE FACILITIES FOLLOW-UP

23. IF A PATIENT WAS HOSPITALIZED OR HAD AN EXTENDED CARE FACILITY STAY, IS THERE A COPY OF THE DISCHARGE SUMMARY IN THE CHART? 0 1 2 N/A

Information not easily found in record.

24. DISCHARGE SUMMARY: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

25. IS THERE DOCUMENTATION THAT THE DISCHARGE SUMMARY CAME TO THE PRACTITIONER'S ATTENTION? 0 1 2 N/A

- *Look for practitioner initials or ask the clinic contact person what you should look for to document practitioner review.*
- *Dictated hospital records of the reviewed practitioner do not need to be signed again.*

Unable to determine if the initials are those of the practitioner.
Not all reports are initialed or signed.
Reports have writing on them but are not initialed.
Check mark used, not initials.
Stamp with date used, not initials.
Initialed but not by practitioner.
Office staff states it is not policy of clinic to initial these reports.

26. REVIEW OF DISCHARGE SUMMARY: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A

HEALTH LITERACY

Health Literacy is the ability to read, understand, and use health information to make appropriate healthcare decisions and follow instructions for treatment. You probably see patients everyday that have trouble reading and understanding health information. Patients may be verbally

articulate and appear well educated and knowledgeable yet fail to grasp disease concepts or understand how to carry out medication regimens properly.

27. DOES THE PRACTITIONER DETERMINE IF THERE ARE LANGUAGE AND/OR COGNITIVE BARRIERS TO THE PATIENT'S ABILITY TO UNDERSTAND INSTRUCTIONS REGARDING MEDICATION USAGE, DIAGNOSTIC PROCEDURES AND FOLLOW-UP, INCLUDING CONSULTATIONS? 0 1 2 N/A

This portion of the survey may be conducted by interviewing the practitioner or designated staff or by chart review.

- *Score "2" if explicit instructions found, even if patients understanding not documented.*
- *Score "2" if documentation includes a statement such as "Patient voices understanding."*

Clinic states Health Literacy is assessed on an individual as-needed basis.

There is no formal Health Literacy assessment.

Language and/or cognitive barriers are not documented in this patient.

Language and/or cognitive barriers are documented in this patient.

Health Literacy assessment is not easily found in record.

Documentation of explicit instructions is found; however, documentation of patient's understanding is not found.

28. HEALTH LITERACY: DOES FINDING AGREE WITH SELF-ASSESSMENT SURVEY? 0 1 2 N/A