

210 S.W. Corbett Avenue  
 Portland, Oregon 97239  
 (503) 222-9590  
 FAX (503) 226-3450

**MUST  
 BE COMPLETED  
 PRIOR TO  
 CHART REVIEW  
 (ONE PER CLINIC)**

**ARC 2005**

***PATIENT SAFETY SELF-ASSESSMENT SURVEY***

The purpose of the Patient Safety Survey is to evaluate systems in your office which affect patient safety/loss prevention. Please complete the Patient Safety Self-Assessment Survey prior to reviewer arriving at your office. The ARC reviewer will conduct a chart survey to verify that systems are in place in your clinic. Some clinics may not have systems in place in which case, you may use the survey instrument to determine systems that need to be developed. The ARC reviewer may be able to provide suggestions or samples for you to implement. This is not a “pass/fail” review. The intent is to assist you in evaluating and developing systems that will improve patient safety and address risk management.

**Medical History**

**Please circle one response:**

<b>Is past medical history found in the chart?</b>	<b>0</b> <b>1</b> <b>2</b> Never                      Sometimes                      Always
<b>Is past surgical history found in the chart?</b>	<b>0</b> <b>1</b> <b>2</b> Never                      Sometimes                      Always
<b>Is family history found in the chart?</b>	<b>0</b> <b>1</b> <b>2</b> Never                      Sometimes                      Always
<b>If there is current history of tobacco use is there documentation of tobacco cessation advice found in the past year?</b>	<b>0</b> <b>1</b> <b>2</b> Never                      Sometimes                      Always
<b>Children and adolescents (18 years and younger): is there documentation of prenatal care, birth, surgeries and childhood illnesses?</b>	<b>0</b> <b>1</b> <b>2</b> Never                      Sometimes                      Always

## *Prescription Medications*

<p style="text-align: center;"><b>Is there a separate medication sheet in the chart that lists acute as well as chronic medication?</b></p>	<p style="text-align: center;"><b>0</b>                      <b>1</b>                      <b>2</b> Never                      Sometimes                      Always</p>
<p style="text-align: center;"><b>Is there documentation of review of patient's medication use, including prescription medicines as well as over-the-counter (OTC) that is easily found in record? (OTC medicines include vitamins, minerals, herbal preparations and supplements.)</b></p>	<p style="text-align: center;"><b>0</b>                      <b>1</b>                      <b>2</b> Never                      Sometimes                      Always</p>
<p style="text-align: center;"><b>Are medication allergies prominently displayed in the chart?</b></p>	<p style="text-align: center;"><b>0</b>                      <b>1</b>                      <b>2</b> Never                      Sometimes                      Always</p>

## **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>)

<b>Is there documentation in the chart of an assessment of the patient’s condition relative to the use of controlled substances for “intractable pain”?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always
<b>Is there a “Material Risk Notice” found in the patient’s chart?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always
<b>Is there documentation of actions taken in follow-up regarding the prescribing of controlled substance for “Intractable Pain”?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always
<b>Is a Pain Contract found in the chart (optional)?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always

# **FOLLOW-UP**

## **Results of Laboratory, Imaging and Consultations are obtained**

	<b>Laboratory Tests</b>	<b>Imaging Studies</b>	<b>Consults</b>
<b>If reports are in the chart is it demonstrated that the practitioner has reviewed the reports?</b>	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always
<b>Is there documentation of follow-up on abnormal reports?</b>	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	
<b>PCP: Is there documentation of follow-up on consultant recommendations? Specialists: Is there a report to the referring practitioner?</b>			<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always
<b>If there is no follow-up of abnormal laboratory, imaging, and/or consultant recommendations, is it because patient was not compliant?</b>	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always
<b>If patient was noncompliant, is there documentation of follow-up efforts with the patient?</b>	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always
<b>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 &gt; 50 yrs or family history), but question may relate to other significant findings.</b>	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always	<b>0</b> Never <b>1</b> Sometimes <b>2</b> Always

# **FOLLOW-UP**

## **Discharge from Hospital or Extended Care Facilities**

	<b>Hospital</b>			<b>Extended Care Facility</b>		
<b>If a patient was hospitalized, is there a copy of the discharge summary in the chart?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always
<b>Is there documentation that the discharge summary came to the practitioner's attention?</b>	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always	<b>0</b> Never	<b>1</b> Sometimes	<b>2</b> Always

