REVIEWER GUIDELINE

Please use this document to assist you as you perform your chart audit/review. It is intended to be a reference document to enable a consistent review of charts.

REQUIRED MEDICAL RECORD COMPONENTS

1. The legibility of the record to the auditor is satisfactory.
2. Documentation of the patient's name, gender, telephone number, address and date of birth is complete.
3. Documentation of the patient's MHSC and PHIN is complete.
4. Documentation of patient's next of kin and emergency contact person and contact number is complete.
5. For a consultation, documentation of the name of the primary care physician and of any health professional who referred the patient is present.
6. The date of each professional encounter with the patient is documented.
7. Patient histories are recorded appropriately.
8. Physical Exams are recorded appropriately.
9. Diagnoses are recorded.
10. Requests for investigations are recorded.
11. Investigation results and consult reports are present in the record, and there is evidence that they have been reviewed by the physician.
12. Each treatment prescribed or administered by the physician (dose, duration, quantity) is recorded appropriately.
13. Notation of professional advice given by the physician is recorded.
14. Notation of particulars of any referral made by the physician is recorded.
15. There is documentation of phone calls and emails.

RECORD KEEPING AND PATIENT MANAGEMENT TOOLS

1. The record system allows for ready retrieval of an individual patient file.
2. The record is well organized.
3. Patient Summary Sheet(s)(e.g. Cumulative Patient Profile) is/are present and up to date.
4. In the event that more than one physician is making entries in the patient chart, each physician entry is identified.
5. Growth charts are present and complete.
6. Prenatal charts are present and complete.
7. Allergies are recorded.
8. Immunization records are up to date.
9. Flow sheets for chronic conditions are in use and up to date.
10. Flow sheets for health maintenance are in use and up to date.
11. Documentation of the consultation report to the referring doctor is available.

NEW PRESENTATIONS/ACUTE CONDITION MANAGEMENT

1. The chief complaint(s) is/are clearly stated, the duration of symptoms noted, and a functional inquiry is performed.
2. Physical examinations performed with positive/negative physical findings recorded.
3. The family and past history (including significant negative observations, psychiatric illnesses, etc.) are recorded as appropriate to the presentation.
4. Requested lab tests, x-rays and other diagnostic investigations are clinically indicated and complete.
5. The chief complaint, history, physical findings and investigations lead to an appropriate diagnosis or differential diagnosis.
6. The treatment plan is appropriate.
7. Medications in type, dose, and duration are recorded and appropriate.
8. Discussions regarding medication side-effects are recorded.
9. Follow-up of acute conditions is appropriate.
10. Follow-up of abnormal test results is appropriate.
11. Requests for referrals are complete.
12. Emergent/urgent problems are dealt with quickly and appropriately.

MANAGEMENT OF PATIENTS WITH ON-GOING/CHRONIC CONDITIONS

1. The patient history is appropriate for the visit.
2. Physical examinations performed with positive/negative physical findings are appropriate.
3. Requested lab tests, x-rays and other investigations are clinically indicated and timely.
4. Co-morbidities are evaluated and considered in the treatment plan.
5. Management/treatment plan are periodically reviewed and appropriate.
6. Long-term medications are appropriate in type, dose and duration.
7. All medications are periodically reviewed and monitored as indicated.
8. Discussions regarding medication side-effects are recorded.
9. Follow-up of patients with chronic conditions is appropriate.
10. Follow-up of abnormal test results is evident.
11. Requests for referrals are complete and appropriate.
12. Narcotic addiction screening is recorded.
13. Narcotic addiction monitoring is evident.
14. Medication diversion (i.e. distribution of medications to other individuals) monitoring is evident.
15. Narcotic prescribing is appropriate.

HEALTH MAINTENANCE

1. Periodic discussion of health maintenance (e.g. regarding smoking, alcohol consumption, obesity, lifestyle etc.) is recorded.
2. Periodic general assessments are performed appropriately.
3. Use of age-related familial disease screening and population based screening (e.g. mammography and colorectal) is appropriate.
4. Well baby visits are conducted appropriately (e.g. immunizations, growth monitoring, developmental milestones, etc.).
5. Prenatal care is performed appropriately.
6. Adult immunizations are discussed/performed.

PSYCHOSOCIAL CARE

1. Takes history of psychiatric symptoms and social issues (assesses suicidality/work/home/family stressors/thought disturbances/mood, etc.).
2. In reference to specific clinical situations, patients are referred to support groups and patient education materials are made available.
3. The presence of physical illness is assessed to determine its influence, if any, on the psychiatric symptoms.
4. Utilization of local social services/agencies in the community is appropriate.
5. Psychotherapy sessions are appropriate (i.e. include documentation of critical interventions, the physician's input, the patient's response, future care plans, frequency of sessions, discharge planning, etc.).
6. Mental status examinations are performed as indicated.
7. Management of suicidality is appropriate.
8. Management of homicidal risk is appropriate.
9. Management of doctor-patient relationships (i.e., boundaries, transference, counter-transference, etc.) is appropriate.
10. The use of psychotropic medication(s) is appropriate.