MEDICAL MUTUAL Self-Assessment Form

PURPOSE:

The purpose of the self-assessment form is to highlight those areas within the non-clinical aspect of office practice including documentation of medical records, which have been identified as variables that can create problem practice patterns. By facing one’s awareness of potential problem practice patterns, the opportunity is yours to intervene and change those systems in order to reduce the likelihood of adverse effects on patient care. Medical record charting, patient scheduling, prescriptions and communication with patients are a few of the more common activities, which may affect the likelihood, or course of litigation.

DISCLAIMER:

The elements of the Risk Management Self Assessment Form should be viewed as a tool to aid in establishing systems and practices that will enhance patient care and safety. It is not a substitute for sound professional judgment. The form is intended to be educational and is meant to be adapted to the individual nature of your practice.

This self-assessment form is not intended to be nor should it be viewed as legal, or other professional advice. If specific legal or other expert assistance is required, the services of a competent professional should be sought.
### Part I. External Office Systems

1. Privacy and confidentiality of patient information is maintained.
   Describe: ________________________________________________
   _________________________________________________________
   Always       Sometimes       Never

2. The staff answers the phone in a professional manner, with an introduction and identifying themselves.
   Always       Sometimes       Never

3. The staff asks for the patients’ permission prior to placing them on hold.
   Always       Sometimes       Never

4. There is a written procedure for telephone triage.
   Yes         No

5. There is a written procedure for the scheduling of appointments.
   Yes         No

6. Messages are written on telephone message slips. If never –
   describe: ________________________________________________
   _________________________________________________________
   Always       Sometimes       Never

7. Messages are permanently affixed to the office chart.
   Always       Sometimes       Never

8. Medical information is only given out by the physician or designated medical personnel under written guidelines.
   Always       Sometimes       Never

9. The answering service/machine is checked for messages every day at designated times.
   Always       Sometimes       Never

10. The answering service/machine messages are documented.
    Always       Sometimes       Never

11. All calls are returned by the end of the day. If sometimes/never
    describe: ________________________________________________
    _________________________________________________________
    Always       Sometimes       Never

12. The physician accepts calls when requested to do so by the staff.
    Always       Sometimes       Never

13. The appointment schedule allows for emergency or other same-day appointments.
    Describe your process: _______________________________________  
    __________________________________________________________________
    Always       Sometimes       Never

14. Missed and cancelled appointments are documented in the chart.
    Always       Sometimes       Never

15. Patients who need to return are given a follow-up appointment prior to leaving the office.
    Always       Sometimes       Never

16. The staff follows up and tracks missed and cancelled appointments, and this is documented in the medical record.
    Describe: ________________________________________________
    __________________________________________________________________
    Always       Sometimes       Never

17. Patients are notified of lab results in a timely manner.
    Describe your process: ______________________________________
    __________________________________________________________________
    Always       Sometimes       Never
18. Prescription pads are kept out of sight of patients.  Always  Sometimes  Never
19. Controlled or restricted drugs are properly secured.  Always  Sometimes  Never
20. The staff renews prescriptions without a physician’s approval.  
    Describe: __________________________________________________________
     Always  Sometimes  Never
21. Chart entries are dated and signed.  Always  Sometimes  Never
22. Corrections made to the chart are made in chronological order, dated and signed.  Always  Sometimes  Never
23. Office chart contents are affixed to the chart jacket.  Always  Sometimes  Never
24. The office uses medication logs for the tracking of medications.  Always  Sometimes  Never
25. All lab work, diagnostic tests and consults are attached to the chart for review by the physician.  Always  Sometimes  Never
26. There is a follow-up and tracking system for lab work for certainty of completion.  
    Describe: __________________________________________________________
     Always  Sometimes  Never
27. Staff follow-up actions regarding referrals and consults are documented.  Always  Sometimes  Never
28. The office has a patient reminder system for repeat examinations, (i.e., paps, etc.)  Always  Sometimes  Never
29. The office has a follow-up tracking system for repeat exams.  
    Describe: __________________________________________________________
     Always  Sometimes  Never
30. After-hours calls are documented by the physician.  Always  Sometimes  Never
31. Appropriate, aggressive collection action can be pursued without the treating physician’s approval.  Always  Sometimes  Never
32. Handwashing techniques are used between patients and as necessary.  Always  Sometimes  Never
33. At least one staff member that is CPR certified is on duty during office hours.  Always  Sometimes  Never
34. Mid-level practitioners have written practice specific protocols, (i.e., co-signatures; prescription protocol, new patient).  
    Describe: __________________________________________________________
     Always  Sometimes  Never
35. The practice has a procedure for terminating physician-patient relationship.  Yes  No
Part II. Internal Charting System

1. A complete and adequate record is obtained on each visit, to include the following: Describe how frequently each is updated?
   A. Name
   B. Date of Birth
   C. Address
   D. Phone Number
   E. Next of Kin (or Significant Other)
   F. Current Insurance Information
   G. History & Physical
   H. Allergies & Adverse Reactions
   I. Chief Complaint
   J. Medication Sheet
   K. Problem List
   Always  Sometimes  Never

2. Informed consent process done by the physician and documented for all procedures and medications, including risks, complications and alternatives.
   Always  Sometimes  Never

3. All telephone calls regarding patient care are documented.
   Always  Sometimes  Never

4. The chart is organized in a consistent manner.
   Always  Sometimes  Never

5. There is an organized format for notes (i.e., SOAP).
   Always  Sometimes  Never

6. All lab work, diagnostic studies, referrals, etc. are reviewed, initialed and dated by the physician prior to being filed.
   Describe your process: ______________________________________
   __________________________________________________________
   Always  Sometimes  Never

7. Chart notes are legible.
   Always  Sometimes  Never

8. Dates for return visits documented.
   Always  Sometimes  Never
   Describe your process: ______________________________________
   __________________________________________________________

9. Prescriptions and refills are noted and initialed.
   Always  Sometimes  Never

10. Decision-making process is documented.
    Always  Sometimes  Never

11. Working diagnosis is documented and consistent with findings.
    Always  Sometimes  Never

12. Treatment plan documented and consistent with diagnosis.
    Always  Sometimes  Never

13. Office charts are routinely taken outside the office practice facility.
    Always  Sometimes  Never
    Describe: __________________________________________________
14. Dictated notes are reviewed and signed by the physician.  
Always  Sometimes  Never

15. Allergies are **prominently** noted.  
Always  Sometimes  Never

16. Follow-up instructions are documented.  
Always  Sometimes  Never

17. Post-op instructions are documented.  
Always  Sometimes  Never

18. Communication with consultants and/or primary care physician documented.  
Always  Sometimes  Never