SAMPLE: CLIENT RECORD AUDIT TOOL – EARLY YEARS TEAM

Keywords: client records, audit, chart audit

Scope

The following is an example of a client record audit tool used to improve service. Administrative and quality of service chart audits are combined in this two-part tool.

Procedures

MARVIN GARDENS SAMPLE ORGANIZATION
Chart Audit Tool – Early Years

Client/Chart ID #: _____
Date of Review: _____
Name and Position of Auditor(s): _____

PART 1: ADMINISTRATIVE AUDIT		**Yes**	**No**	**N/A**
1.	Is the record legible?			
2.	Is the date of each entry recorded?			
3.	Is each entry signed by the service provider?			
4.	Is a unique client identifier (e.g., client number) recorded on each page of the record?			
5.	Are allergies or other alerts clearly documented?			
6.	Does the record contain basic client information including name, date of birth, address, phone number and health card number?			
7.	Does the record contain all the forms required by the organization (e.g., registration form, Cumulative Patient Profile, Antenatal Record, Pediatric Assessment Records, Early Years assessment forms, nutrition assessments)?			
8.	Are all required forms (see above) completed?			
9.	Are the file contents organized in a manner consistent with Marvin Gardens guidelines?			
10.	Does the record contain progress notes?			
11.	Where appropriate, are the name and address of the referral source included?			
12.	Where appropriate, is there a summary note to close the record?			
13.	Is there documented evidence that the privacy policy has been discussed?			

Comments:

PART 2: QUALITY OF SERVICE AUDIT – EARLY YEARS		Yes	No	N/A
1.	Is the presenting problem, chief complaint or reason for visit recorded for each visit?			
2.	Is there an adequate description of the presenting symptoms or issue?			
3.	Is there a diagnosis or provisional diagnosis? (Must be assessed considering the scope of practice of each professional involved in the client's care)			
4.	Is the treatment plan clearly recorded?			
5.	When summary recording forms are used, do they conform with the expected standards for the profession?			
6.	Is the follow up of clients suffering from chronic conditions appropriate?			
7.	Is there documented evidence that health maintenance and health promotion strategies are discussed on a periodic basis or as needed?			
8.	Is the documented investigation and subsequent plan appropriate to the complaint/condition/problem?			
9.	If counseling or psychotherapeutic sessions have been provided, does the record indicate the content of discussions and the client's response?			
10.	Does the record indicate awareness of other resources in the community, which might benefit the client?			
11.	Do consultations with/referrals to other providers, including specialists, appear to be appropriate?			
12.	Does the record indicate that emergencies or crisis situations have been dealt with promptly and effectively?			
13.	Is there evidence of continuity of care in the absence of the primary provider?			
14.	In your professional opinion, does this record present a clear and accurate picture of the care provided to this client by the CHC staff?			
15.	Is there evidence in the health record that staff from different professions in the CHC have consulted each other about the care of the client, if appropriate?			
16.	Does the record indicate an assessment of the impact of education, housing, employment, income, social support, environmental risks, etc. on the health of the client as appropriate?			
17.	In your professional opinion, is this record an effective communication tool between interdisciplinary health care providers?			
18.	Where appropriate, has the child's developmental progress been identified?			
19.	Does the client record indicate shared decision-making between providers from different professional backgrounds / partnering agencies?			
20	Where appropriate, has a summary note been completed upon completion of program?			

Comments:

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