1.8.3 BIANNUAL CHART AUDIT

POLICY:

Chart audits are to be completed in January and July by all service sites.

The chart audit must be sent to ND FPP nurse consultant by the 15th day of January and July.

A total of 12 charts will be audited. Two charts will be selected for the audit from each of the previous 6 months. Charts should be selected randomly, using a variety of different dates, problem codes, practitioners, etc.

PROCEDURE:

Enter information for **Agency, Date,** and **Completed** at the top of the form.

Complete the graph:

Client Chart Number: Write in the client's chart number.
Document with "**+**" if all information/documentation is present in the client's medical record.
Document with "**-**" if not all the information/documentation is present in the client's medical record.
Document N/A if not applicable to the client's medical record.

See instructions for **Criteria not Met** and **Corrective action** steps below for all "**-** "responses.

Accuracy Level: On the right-hand side of the graph compute the accuracy level by dividing the number of "**+**" and NA with the total number of charts reviewed (12) for each of the 15 criteria.

Criteria definitions:

1. Client identification complete: The Income Worksheet (SFN 8625) must be completed and scanned into the EMR chart. The Income Worksheet should be filled out at least yearly.
Client identification must include emergency/secondary contact information that includes name, relationship, and telephone number, and how the client prefers to be contacted.

2. Request to receive services and confidentiality assurance statement present: The Request to Receive Family Planning Screening Services form must be present in the client's medical record and be signed, witnessed, and dated. The most recent version of the Request to Receive Family Planning Services should be scanned into the EMR record whenever the form is updated.

3. History complete: Client history is complete as required by QFP. A previous history from EMR may be reviewed, and the date of the previous history should be documented with a statement of no changes or updates noted.

4. Physical assessment/exam and vital signs complete: Age and appointment-appropriate physical assessment/exam are documented according to visit type, QFP checklist and Protocols.

5. Lab testing complete: Lab tests ordered are appropriate for client appointments and meet the current standards of care. All lab results must be entered in the client record or signed electronically if labs were performed at another location.

6. Deviations from normal (physical assessment/exam and laboratory) addressed/referrals made: Any deviation from normal on the physical assessment/exam and/or laboratory test(s) must have documentation that this was addressed. Any plans for follow-up and/or referral(s) must be documented, and correlate with applicable protocols or standards of care.

7. Method counseling and sexually transmitted infection (STI) and HIV counseling complete: Method counseling, client satisfaction with method, and education provided is documented. STI and HIV counseling and education follow CDC guidelines and is appropriate for the client's appointment.

8. Drug orders complete: All orders for medications must be signed and dated by the provider or referenced to use of standing orders. Medication orders must include the medication name, dosage, number prescribed, refills if applicable and instructions for use.

9. Plan/follow-up documented: Schedule for follow-up/revisits must be documented.

10. Refusal of services documented: Whenever a client refuses to accept a referral or recommendationfor follow-up, the Refusal to Accept Referral/Recommended Follow-Up Form may be completed and scanned into the client's chart. If client is unable or unwilling to sign refusal form, chartdocumentation must reflect the client was informed of recommendations, benefits and risks of recommendations were reviewed with the client, client understanding of refusal is documented, and services from the agency will be available in the future.

11. Allergies prominently displayed: Allergies must be prominently displayed in EMR client visits.

12. Required Adolescent counseling: Chart documentation could include the following:

- Family involvement must be addressed and encouraged with adolescent clients
- Discussion of abstinence
- Explanations of what sexual coercion is
- Strategies useful in helping adolescents to resist attempts of sexual coercion
- The importance of self-esteem and self-respect in avoiding coercive relationships
- The client's right to refuse sex at any time without negative consequences
- How peer-pressure, drugs and alcohol can affect behavior and decision making
- Use of condoms
- Methods of contraception, including LARCs
- Screen for abuse and trafficking risks on all minors
- Reason client is unable to have family involvement

13. Substance abuse screening/counseling done. SBIRT counseling should be used and documented for any client with a positive response to tobacco, alcohol or drug use questions.

14. Reproductive Life Plan counseling: An assessment should be made of the client's reproductive plan (which outlines personal goals about pregnancy).

15. PHQ2 and/or PHQ9 documented: A brief assessment should be made, using the PHQ screening tools, of the client's mental health status and potential need for referral. Document the clients score and any counseling and/or referrals, as appropriate. Any client acknowledging any positive score on PHQ2 screening should have documentation that this was addressed.

16. Referral for Medical and Social Services: Service sites should provide a written referral to a medical or social service site for the client when applicable. This information should include reason for referral, copies of applicable records and test results, and recommendations for follow-up from the provider the client was referred to.

Criteria not met: Write in the number of the criteria that was not met for the preceding medical record/chart number. Be specific as to what part(s) of the criteria are not met.

Corrective Action: Write in what corrective action will be taken so that the medical record will be compliant and staff education that will be provided to increase quality of care.

Medical Director Signature: Once the audit is complete, the medical director should have a chance to review the results and sign. Any feedback they may have can be documented below the signature line.

Follow-up by Family Planning Nurse Consultant: The Family Planning Nurse Consultant will document whether any additional follow-up is necessary with the agency submitting the chart review/audit.

RESOURCES:

https://www.hhs.nd.gov/cfs/family-planning/grantees

Chart Review/Audit Form