Professionals Advocate 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. Always Sometimes Never
   Describe: ____________________________________________________

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. Always Sometimes Never
   Describe your process: ____________________________________________

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. Always Sometimes Never
   Describe: _______________________________________________________

17. Patients are notified of lab results in a timely manner. Always Sometimes Never
   Describe your process: ____________________________________________
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. Always Sometimes Never
   Describe: ________________________________________________
   ________________________________________________________
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. Always Sometimes Never
   Describe: ________________________________________________
   ________________________________________________________
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. Always Sometimes Never
   Describe: ________________________________________________
   ________________________________________________________
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). Always Sometimes Never
   Describe: ________________________________________________
   ________________________________________________________
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: Always Sometimes Never
   B. Date of Birth: Always Sometimes Never
   C. Address: Always Sometimes Never
   D. Phone Number: Always Sometimes Never
   E. Next of Kin (or Significant Other): Always Sometimes Never
   F. Current Insurance Information: Always Sometimes Never
   G. History & Physical: Always Sometimes Never
   H. Allergies & Adverse Reactions: Always Sometimes Never
   I. Chief Complaint: Always Sometimes Never
   J. Medication Sheet: Always Sometimes Never
   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.
   Describe your process: 
   
   Always Sometimes Never

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.
    Describe: 
    
    Always Sometimes Never
14. Dictated notes are reviewed and signed by the physician. | Always | Sometimes | Never
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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

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