MEDICAL MUTUAL

Liability Insurance Society of Maryland

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. 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
Describe: _____
_____

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. Always Sometimes Never
   Describe your process: _____
   _____

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

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