Self-Assessment Checklist: Documenting Patient Healthcare Information

This resource is designed to help providers evaluate healthcare documentation policies and procedures. For additional risk control tools and information on a wide and growing range of topics, visit the CNA website.

Risk Control Measures	Present? Yes/No	Comments
Information System		
Are formal procedures established and implemented for compiling patient healthcare information, as well as for handling and accessing patient records?		
Is the filing system logical, making it easy to locate and hard to misplace patient healthcare information records?		
Are computerized records backed up daily, and is backup information stored off-site?		
Does the record-keeping system deter staff from making unauthorized entries in patient healthcare information records?		
Is a system in place for training new employees in office record-keeping methods?		
Record Confidentiality		
Are patient healthcare information records managed in a confidential manner, in compliance with federal and state laws?		
Is confidential information released to third parties only after obtaining written authorization from the patient?		
Are all patient authorizations included in the record (e.g., release of records, signature on file, etc.)?		
Is HIPAA compliance documented in the patient record?		
Do staff members refrain from placing confidential patient information (including health alert stickers) on the covers of patient files so that protected health information will not be inadvertently disclosed to other patients?		
Access to Information		
Are patients given access to all data in their healthcare information record?		
Does the practice have a written record release policy, and are staff members trained to comply with it?		
Is there a standard copying charge for patient healthcare information records?		
Record Retention and Record Purging		
Are patient records retained for a set period, which is at least as long as the statute of limitations for malpractice or record retention requirement within the state, whichever is longer?		
Are records of after-hours calls and telephone logs and diaries retained for an established period of time?		
Is there a system for storing inactive patient records and archiving retired policies and procedures?		

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Record Review and Quality Assurance		
Does the office have a system in place for record review/quality assurance, and are record audits performed on a regular basis?		
Are record audit findings discussed with staff, including such areas as:		
• Patient ledger?		
• Referral forms?		
• Consultation letters?		
• Recall cards?		
• Patient correspondence?		
• Telephone communications?		
Record-Keeping Practices		
Is there an individual record for each patient containing all healthcare related documents?		
Is the patient's name on every page of the record?		
Is the date recorded in full (month/day/year)?		
Is information recorded contemporaneously during patient visits?		
Are entries legible and written in dark ink?		
Are entries factual, objective and clear?		
Are entries comprehensive, addressing who, what, when, where and why?		
Do providers and staff use appropriate terminology and maintain a professional tone?		
Are records free of disparaging or subjective comments or abbreviations about the patient and/or providers?		
Are no blank lines left in the patient healthcare information record?		
Do providers and staff sign or initial each entry they make in the patient healthcare information record, and do they also note the date and time?		
Are there protocols governing late entries, and are such entries contemporaneously signed and dated?		
Are quotation marks used when appropriate, e.g., when noting verbatim patient complaints and comments?		
Based solely on written records, is it possible to determine what treatment the patient has received and why it was necessary?		
Are procedures in place to ensure that electronic communications related to patient care are included in the healthcare information record?		

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Patients' Personal Information		
Is there a comprehensive personal information section in the patient healthcare information record?		
Is this information up-to-date and checked at each visit?		
Does the practice maintain current emergency contact information, including cellular telephone numbers?		
Is there written documentation of guardianship for minors, especially in cases of minors with divorced parents?		
Health History		
Is a comprehensive medical history taken on every new patient?		
Are the patient's current medications and over-the-counter remedies documented and checked for potential interactions (e.g., by contacting the patient's pharmacist, if needed) before additional drugs are prescribed?		
Is there a system to alert providers of important medical conditions or other healthcare complications?		
Is critical medical information prominently displayed inside the record?		
Is the patient's medical history updated and reviewed at every treatment or consultation visit?		
Informed Consent and Informed Refusal		
Do providers and staff know the required elements of informed consent, as well as informed refusal?		
Do providers know when an informed consent discussion is necessary, as well as the special circumstances in which it may be omitted?		
Is informed consent documented in the patient healthcare information record as soon as it is obtained?		
Are written informed consent forms utilized, and if so, do they …		
• Have a patient-friendly title?		
• Describe the nature of the proposed treatment and any associated risks?		
• List alternative treatments?		
• Note potential complications?		
• Use lay language and minimize the use of medical jargon?		
• Allow for customization, as necessary?		
When possible, do providers give the informed consent form to the patient prior to the beginning of treatment so the patient has time to think about the decision?		
Is the signed informed consent form placed in the healthcare information record, and is a copy given to the patient?		

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Do providers also have a face-to-face discussion with the patient, giving him/her as much time as needed to ask questions?		
Do providers answer all questions to the patient's satisfaction?		
If a patient declines recommendations, is this refusal documented in the healthcare information record?		
Are the risks and potential consequences of refusal to follow recommendations explained to reluctant patients in writing and documented in the healthcare information record?		
Is a Refusal to Consent to Treatment/Procedure Form used in situations where the patient does not consent to the recommended treatment or procedure?		
Progress Notes		
Is every visit documented in the patient record?		
Is the following information noted at every visit:		
• Date in full (month/day/year) of examination or treatment?		
• Review of medical history?		
• Chief patient complaint?		
• Clinical findings and observations, both normal and abnormal?		
• Diagnosis?		
• Receipt of informed consent?		
• Referral, if necessary?		
• Prescriptions and medications?		
• Postoperative and follow-up instructions?		
• Plans for next visit?		
Does the patient healthcare information record note the rationale for not following a previously documented plan of care and other important medical decisions?		
Are canceled appointments and no-shows documented in the patient healthcare information record?		
Are patient satisfaction and dissatisfaction documented, including specific complaints and concerns?		
Are instances of noncompliance documented, as well as discussions with patients regarding consequent risks?		
Are treatment complications documented, as well as unusual occurrences and corrective actions taken?		
Are all pertinent discussions documented, whether in person or by telephone?		
Are all referrals to specialists and consultants documented in the patient healthcare information record?		
Is the patient given written postoperative instructions, which reflect the specific procedure and the patient's condition, and are these instructions documented?		

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Abbreviations and Symbols		
Are abbreviations and symbols used in the patient healthcare information record?		
If so, are they the standard pharmacology abbreviations and symbols endorsed by the American Medical Association?		
If other, nonstandard abbreviations and symbols are used in clinical records, is there a formal policy and list to ensure practice-wide consistency to reduce the likelihood of miscommunication and errors?		
Is the same abbreviation or symbol consistently used for the same item, and are abbreviations and symbols never used for more than one item?		
Correcting the Healthcare Record		
Are patient healthcare information records corrected properly, i.e., by initialing the revision and without obliterating the earlier, incorrect information?		
Are changes to the plan of care made in the next available space in the record, rather than in the margin or the body of a previous entry, and dated contemporaneously?		
Consultations		
Are telephone consultations documented in the patient healthcare information record, noting both the consultant's name and the information received?		
Is a copy retained of all written consultations with other healthcare providers?		
Referrals		
Are written referral forms used and a copy retained in the patient healthcare information record?		
Does the referral form minimally include the following information:		
• Patient name?		
• The diagnostics offered to the specialist, and the date they were collected?		
• The primary diagnosis?		
• The treatment completed to date?		
• The treatment the specialist is expected to complete?		
• The information needed from the specialist?		
Is a follow-up call made to all consulting providers?		
Do staff members check with patients to determine if referral recommendations were followed?		
Is the patient informed of potential consequences of refusing to follow through on a referral, and is this action documented in the patient healthcare information record?		
Is a written referral form required from all outside providers who refer patients to one's practice?		

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Telephone Calls		
Are providers alerted to after-hours calls from patients needing emergency care or information?		
Are all attempts to contact a patient by telephone noted, including the number called and message left?		
Do providers and staff document all patient-related information received via telephone, whether or not the call is received in the office?		
Electronic Health Records		
If patient care plans, medical histories or other patient data are stored on a computer, are the following measures in place?		
• An adequate backup system, which is updated at regular intervals?		
• A method to detect alteration or deletion of patient information?		
• A method for accessing the patient information before, during and after treatment?		
Are the software and operating system current and in compliance with healthcare information security requirements?		
Have a security risk analysis and "gap analysis" been conducted, and have the results been documented?		
If participating in electronic health information exchange (eHIE), have policies, procedures and training been implemented to ensure compliance and to obtain patient's eConsent?		
Documentation of Follow-up Visits		
Is there a system in place for documenting follow-up appointment reminders, with visit notifications recorded in the patient healthcare information record or in a follow-up visit log?		
Are canceled and missed follow-up appointments monitored and noted in the patient healthcare information record?		
Is there a written policy addressing patients who miss scheduled follow-up appointments on a routine basis?		
Insurance		
Is there an established office procedure for completing insurance forms and communicating with health plans?		
Are insurance forms reviewed for accuracy before they are sent to the insurance company?		
Does the provider's original signature appear on all insurance forms filed on behalf of a patient?		

This tool serves as a reference for organizations seeking to evaluate risk exposures associated with healthcare record management. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.