North Dakota Family Planning Program
CHART REVIEW/AUDIT
(Submit in January and July)

Agency: _____ Date: _____ Completed by: _____

	Client Chart Number													+ or NA	–	Accuracy Level (percentage of total # of charts reviewed)
1	Client identification complete.															
2	Request to receive services and confidentiality assurance statement present.															
3	History complete.															
4	Physical assessment/exam and vital signs complete.															
5	Lab testing complete.															
6	Deviations from normal (physical assessment/exam and laboratory) addressed/referral(s) made.															
7	Method counseling and sexually transmitted disease and HIV counseling complete.															
8	Drug orders complete.															
9	Plan/follow-up documented.															
10	Refusal of services documented.															
11	Allergies prominently displayed.															
12	Required adolescent counseling.															
13	Tobacco counseling (AAR) complete.															
14	Reproductive Life Plan counseling.															
15	PHQ2 and/or PHQ9 documented															

Key: + If all information/documentation is present in the client's medical record as outlined in the Chart Review/Audit Form Guidelines.
– If not all of the information/documentation is present in the client's medical record as outlined in the Chart Review/Audit Form Guidelines.
Must complete Corrective Action on opposite side of this form. Be specific as to what parts of the criteria are not met. Example: criteria not met: #1, no emergency/secondary contact listed.
NA If not applicable to the client's medical record.

Corrective action implemented for those criteria not met:

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Chart #: _____ Criteria not met: _____

Corrective action: _____

Medical Director Signature/Date _____

Comments: _____

_____

_____

Follow-up by Family Planning Nurse Consultant: ☐Yes ☐ No If yes, document reason for follow up: _____

_____

_____

North Dakota Family Planning Program
CHART REVIEW/AUDIT FORM GUIDELINES

Chart reviews/audits are to be completed in January and July. A total of 12 charts will be reviewed/audited. Two charts will be selected for the review/audit from each of the 6 months proceeding the month the review/audits are due. For example, the chart review/audit due in January will have two charts selected from July, August, September, October, November, and December. ***Charts should be selected randomly, using a variety of different dates, problem codes, practitioners, etc***. (To increase random selection, the clinic may choose to select every 10th chart from each month for a total of 2 from each month)

Agency: Fill in the name of your agency.

Date: Fill in the date that you are sending in your chart review/audit. The chart review/audit must be sent to the state family planning nurse consultant by the 15th day of January and July.

Completed by: Fill in the name(s) of the person(s) completing the chart review/audit.

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 of the information/documentation is present in the client's medical record. Must complete Corrective Action on opposite side of Chart Review/Audit Form. Be specific as to what part(s) of the criteria is not met. Example: Criteria not met: #1, no emergency contact listed.
- Document NA if not applicable to the client's medical record.

1. **Client identification complete**: *Client identification includes:
   - name
   - address
   - date of birth
   - marital status
   - race
   - years of education completed
   - name of employer
   - home/work/cellular telephone number
   - Emergency/secondary contact information that includes name, relationship and telephone number.
   - contact information regarding appointments or lab results that includes whether or not the client may be called or sent mail to the stated telephone number and address. If yes, the best time to call the client. If no, how the client can be contacted.

   **Not all client identification may be applicable or completed, such as telephone number if the client does not have a telephone*

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. The form must be signed, witnessed and dated. If your clinic uses Electronic Medical Records (EMR), this consent must be scanned into the clients chart once it is signed.

3. **History complete**: Client history is complete, all questions answered (as appropriate) and documented.

4. **Physical assessment/exam and vital signs complete**: Physical assessment/exam is documented. All areas must be assessed and have documentation. If an area was not assessed, you must determine if this was appropriate based on the client's problem/visit. Physical exam must be signed (either physically or electronically) by the health care provider performing the exam. Vital signs are documented. All vital signs listed must be completed. If a specific vital sign was not completed you must determine if this was appropriate based on the client's problem/visit.

5. **Lab testing complete**: Lab tests ordered/results are. All lab results must be initialed or signed electronically.

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 and a plan for follow-up and/or referral(s) was made when appropriate.

7. **Method counseling and sexually transmitted disease (STD) and HIV counseling complete**: Method counseling, STD and HIV counseling are. *For males, counseling and education are documented.

8. **Drug orders complete**: All orders for medications must be signed and dated (to include electronic signatures); and must also include medication name, dosage and duration of 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 recommendation for follow-up, the Refusal to Accept Referral/Recommended Follow-Up Form must be completed. In clinics using EMR, this form should be scanned into the clients chart.

11. **Allergies prominently displayed**: Allergies must be prominently displayed, such as on the front of the client's chart or EMR.

12. **Required Adolescent counseling**: Family involvement must be addressed and encouraged with adolescent clients. Strategies useful in helping adolescents to resist attempts of sexual coercion must be discussed. You must include explanations of what sexual coercion is, the client's right to refuse sex at any time without negative consequences, the right to set limits, and how peer-pressure, drugs and alcohol can affect behavior and decision making. The importance of self-esteem and self-respect in avoiding coercive relationships must also be addressed.

13. **Tobacco counseling (AAR) complete**: Ask if client uses tobacco and document their tobacco use along with vital signs. Advise: Ask if they are willing to make an attempt to quit at this time. Refer: ND quits. Document above info in client chart and document refusal to quit and/or refusal for referral. (Above info taken from ND quits.gov)

14. **Reproductive Life Plan counseling**: An assessment should be made of the client's reproductive plan (which outlines personal goals about pregnancy). For clients whose initial reason for coming in to the service site was not related to preventing or achieving pregnancy, asking these questions might help identify unmet reproductive health-care needs.

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. In clinics using EMR, document the clients score and any counseling and/or referrals, as appropriate.

+ or NA: Write in how many of the 12 charts had all the information/documentation present for that criteria, or was not applicable to the medical record.

-: Write in how many of the 12 charts did not have all of the information/documentation present for the criteria.

Accuracy Level: Figure out the accuracy level by dividing the number of "+" and NA with the total number of charts reviewed (12).

Example:

														+ or NA	–	Accuracy Level
11	Plan/follow-up documented.	+	+	+	+	+	+	+	+	+	+	-	+	11	1	92%
12	Referral/release of information form completed.	+	+	NA	NA	NA	NA	+	+	NA	+	NA	NA	12	0	100%

Chart #: Write in the chart number of the medical record that did not have all of the information/ documentation that was required for the specific criteria.

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.

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.