Medical Record Evaluation Tool
Arizona State Board of Nursing

Purpose: Medical Record Review Tool provides standards, directions, instructions, and parameters for the Board approved medical record review survey, and is used as a tool for measuring, evaluating, assessing, and medical/nursing management/documentation.

Scoring: Evaluation tool score is based on a review of 10 records per individual provider. Criteria determinations are found in the documented evidence found in the hard copy (paper) medical records and/or electronic medical records. A score of four (4) indicates the criterion was met. A score of one (1) point indicates the criterion was partially met (and needing improvement). A score of zero (0) points means the criterion was not met.

Directions: Award four (4) points if criterion is met. Award one (1) point if criterion is partially met but needing improvement. Award zero (0) points if criterion is not met. If the Criteria was not evaluated or not available, assign "n/a" as a score. Board approved reviewers are expected to determine the most appropriate method(s) to ascertain information needed to complete the survey.

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	Criteria	Reviewer Guidelines
1	**An individual medical record is established with patient identification is on each page**	Providers are able to readily identify each individual treated. A medical record is initiated on the initial visit. "Family charts" (Charts that contain more than one family member) are not acceptable. Patient identification includes first and last name, and/or a unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification.
2	**Chronic problems and/or significant conditions are listed.**	Documentation may be on a separate "problem list" page, or a clearly identifiable problem list in the progress notes.
3	**Current continuous medications are listed and allergies are prominently noted.**	Documentation may be on a separate "medication list" page, or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage. Discontinued medications are noted on the medication list or in progress notes. Controlled substances have date prescribed, dose, and quantity noted. Allergies and adverse reactions are listed in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA) is documented.
4	**Signed Informed Consents are present, when appropriate.**	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment.
5	**Treatment plan is consistent with national guidelines and or evidenced based practice.**	Treatment plan is consistent with national guidelines/evidenced based practice or contains documentation supporting deviation from guidelines.

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6	For chronic pain management, evidence of adherence to national guidelines and/or Advisory Opinion on the Use of Controlled Substances for the Treatment of Chronic Pain	A. An assessment of patient pain should include: 1. A medical history and physical examination; 2. Psycho-social assessment; 3. Periodic urine drug screen testing; 4. Diagnostic evaluations; 5. Exclusion criteria; 6. Assessment and reassessment to maintain control and safety of controlled drugs; B. Treatment Plan with measurable outcomes to evaluate therapeutic success that include: 1. Improvement in physical function and/or psychosocial function; 2. Exploration of other multimodal interventions and/or rehabilitation programs as indicted; 3. Ongoing assessment; C. Informed Consent with a written pain treatment agreement D. Consultation for additional evaluation to achieve treatment objectives. E. Documentation: 1. The health history and physical examination; 2. Diagnostic, therapeutic, and laboratory results; 3. Diagnosis 4. Evaluations and consultations; 5. Treatment objectives; including functional goals 6. Discussion of risks and benefits; 7. Treatments; 8. Medications (including date, type, dosage, and quantity prescribed); 9. Instructions and agreements; 10. Recurrent assessment and re-assessment of the pain and pain treatments for efficacy of pain control with rationale for any dosage changes, patient function, and patient compliance; and 11. Whether or not the patient is a candidate for controlled substance medications, based on the provider's safety and control assessment, including review of the Arizona Controlled Substance Prescription Monitoring Program, patient profile. F. Referral of Patients discovered to have an active substance abuse problem should be referred to a detoxification and rehabilitation program or to an appropriate maintenance program for substance abusers.

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7	**Medical record entries are made in accordance with acceptable legal medical documentation standards.**	All entries are signed, dated and legible. Date includes the month/day/year. Only standard abbreviations are used. Omissions are charted as a new entry. Late entries are explained in the medical record, signed, and dated. Electronically maintained records and printed records from electronic systems contain current date, name of staff member entering information on each page of the patient's office visit note. Note: Legibility means the record entry is readable by a person other than the writer.
8	**Working diagnoses are consistent with findings.**	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by patient/parent. "Objective" information such as assessment findings and conclusion that is documented relate to the working diagnoses.
9	**Treatment plans are consistent with diagnoses.**	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis.
10	**Unresolved and/or continuing problems are addressed in subsequent visit(s).**	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that provider follows up with patients about treatment regiments, recommendations, counseling, and/or referrals.
11	**Provider noted review of diagnostic test results and consult/referral reports.**	Consultation reports and diagnostic test results are documented for ordered requests. Records such as diagnostic studies, lab tests, X-ray reports, drug screening/testing, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports show documented evidence of provider review. Abnormal test results/diagnostic reports have explicit notation in the medical record. Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information.

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Criteria met: Give four (4) points **Criterion partially met - needing improvement:** Give one (1) point **Criteria not met:** Give 0 points **Criteria not applicable:** N/A		**MR#**		**MR#**		**MR#**		**MR#**		**MR#**		**MR#**		**MR#**		**MR#**		**MR#**	
	Patient Initials																		
	Age/Gender																		
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Comments:

Standard of Practice/Care:

Documentation:

Continuity of Care:

Chart Reviews for the Month of: _____

Reviewer Name and Credentials: _____ Reviewer Signature: _____ Date: _____