# Medical Record Audit Summary

**Trainee:** ____________________________________ **Patient ID:** ________________________

**Faculty:** ____________________________________ **Date:** ____________________________

**Type of patient note reviewed:**

◇ Hospital admission note ◇ Hospital progress note ◇ Hospital procedure note
◇ Hospital discharge note ◇ Outpatient visit note ◇ Other

**Quality and Consistency of the Note:**

*Consistency:*

1. Were all pertinent symptoms and concerns accurately documented and described?
   ◇ Yes ◇ No ◇ N/A
2. Were all pertinent changes in patient status, including adverse events, accurately documented and described?
   ◇ Yes ◇ No ◇ N/A
3. Were all pertinent physical exam findings accurately documented and described?
   ◇ Yes ◇ No ◇ N/A
4. Were all active medical issues listed, in order of appropriate priority, in the assessment?
   ◇ Yes ◇ No ◇ N/A
5. Were the medical issues listed in the assessment diagnostically accurate?
   ◇ Yes ◇ No ◇ N/A
6. Was an appropriate and complete plan or next step documented for each diagnosis or problem documented in the assessment?
   ◇ Yes ◇ No ◇ N/A
7. Was pertinent information provided in the note regarding communication, informed decision making or counseling accurately documented and described?
   ◇ Yes ◇ No ◇ N/A

*Review of Key Quality and Safety Indicators:*

8. Were this patient's medications reviewed for:
   a. Potential adverse reactions or side effects of any of the medications?
      ◇ Yes ◇ No ◇ N/A
   b. Whether any medications were unnecessary or inappropriate for this patient and should be discontinued?
      ◇ Yes ◇ No ◇ N/A
9. Has this patient’s vaccination status (pneumovaccine and/or Flu vaccine) been addressed?
   ◇ Yes ◇ No ◇ N/A
10. Has patient's ability to understand instruction and comply with treatment plan been evaluated?
    ◇ Yes ◇ No ◇ N/A

**Comments:** ________________________________________________________________

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**<u>Medical Record Audit of the Encounter Instructions:</u>**

1. Review the medical record note of the encounter you just observed.
2. If the observation did not require a note, then review the appropriate sections of the medical record.
3. *First* review the note for overall quality, with special attention to *consistency and clinical reasoning*.
4. **<u>Consistency</u>** relates to the flow and logic of the note. Specifically:
    a. Medical issues raised in the medical history portion of the note should be addressed in the physical exam, test sections, assessment, and plan sections of the note.
    b. An abnormal laboratory finding should be noted in the assessment and plan, and so forth.
    c. There are two types of *common errors*: **<u>errors of omission</u>** and **<u>errors of commission</u>**.
    d. Failing to address or mention an issue in the assessment and plan that was documented earlier in the note is an **<u>error of omission</u>**.
    e. Addressing an issue incorrectly (e.g. inadequate physical exam for presenting symptom, inadequate or incorrect management plan, etc.) is an **<u>error of co-mission</u>**.
    f. Both types of errors could be the result of errors in clinical reasoning and judgment – use these findings from your medical record review to assess the trainee’s clinical reasoning and judgment as this can provide valuable feedback.
5. Second, to complete the medical record audit, you will be required to review the chart for important **<u>quality performance measures</u>** involving preventive care (e.g. immunizations), discharge planning and safety (e.g. medications interactions/errors). These measures have all be tested and validated by national quality organizations.
6. You should review the medical record as soon as possible after the trainee has completed their note from the patient encounter you observed.