

**Pediatric Primary Care; Child Health "Sick Care" or "Treatment Visits"
 (FY 08-09) RECORD AUDIT TOOL**

Health Department: _____

Date: _____

Reviewers: _____

Patient Identifier

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1 [a] History of Current Problem

1 2 3 4 5 6 7 8 9 10

Condition Prior to Onset										
Symptoms: Onset										
Symptoms: Current Status										
Symptoms: Effect of Therapy and/or Home Remedy										
Review of Systems Pertinent to Problem										
Immunization History/Status*										
Record Compliant?										

*With referral or administration of vaccine as needed.

Comments

1 [b] Physical Exam for Current Problem

1 2 3 4 5 6 7 8 9 10

Exam of Body System(s) Related to Chief Complaint										
Pertinent Vital Signs										
Pertinent Laboratory Tests										
Record Compliant?										

Comments

<p><u>CODE</u> ✓ = Present 0 = Absent NA = Not Applicable</p>
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1 [c] Written Diagnosis for Each Identified Problem

	1	2	3	4	5	6	7	8	9	10
Record Compliant?										

Comments

1 [d.1] Documented Referrals (as indicated)

	1	2	3	4	5	6	7	8	9	10
Record Compliant?										

Comments

1 [d.2] Follow-up for Identified Problems or Referrals (as indicated)

	1	2	3	4	5	6	7	8	9	10
Record Compliant?										

Comments

<p><u>CODE</u> ✓ = Present 0 = Absent NA = Not Applicable</p>
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1 [e] Education/Counseling Concerning Current Problem(s)

	1	2	3	4	5	6	7	8	9	10
Record Compliant?										

Comments

1 [f] Referral or Follow-Up Appointment for Well Child Care

	1	2	3	4	5	6	7	8	9	10
Record Compliant?										

Comments

<p><u>CODE</u> ✓ = Present 0 = Absent NA = Not Applicable</p>
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Instructions for Completing the Record Audit Tool

Instructions for Specific Items

Items on this audit tool correspond with the Pediatric Primary Care Agreement Addendum. In addition, this audit tool should be used for records of children seen for sick or treatment visits. Records should be selected for children, who are seen at least once during the review period.

General Instructions

- Indicate with a "Check" (✓), "Zero" (0), or "NA" whether an item is present, not present or not applicable.
- If a particular clinical standard has multiple components, **all** components must be met/present for the standard to have been met.
- For audit items with more than one component, "Record Compliant" may be checked if **all** of the boxes above the Record Compliant line have either "Checks or "NA's" in them. If any box has a "Zero" (0) in it, then "Zero" (0) must appear in the Record Compliant line for that record for that standard.

Physical Exam for Current Problem	1	2	3	4	5
Exam of Body System(s) Related to Chief Complaint	✓	✓	✓	✓	✓
Pertinent Vital Signs	✓	NA	NA	✓	NA
Pertinent Laboratory Tests	✓	✓	0	✓	✓
Record Compliant?	✓	✓	0	✓	✓

For the above item, Record #3 was not compliant because one of the required components for the item was not completed.

Scoring

- All items should have 100% compliance.
- There is no formal scoring process.
- Items that are not compliant require an action plan to address findings.

CODE
 ✓ = Present 0 = Absent NA = Not Applicable

Instructions for Completing the Record Audit Tool

Children enrolled in Pediatric Primary Care or children receiving sick or treatment visits will be provided routine Well Child Care as defined in the Child Health Addendum to the Consolidated Agreement, or will be referred for Well Child Care. The following services are documented in their records:

a. Children Will Have a Medical History for Each Problem that Includes:

- 1. Condition Prior to Onset**
- 2. Description of Symptoms, Including Onset, Current Status, and Effect of any Therapy/Home Remedy**
- 3. Review of Systems Pertinent to the Problem**
- 4. Immunization History and Assessment of Immunization Status, With Referral or Administration of Vaccine if Needed.**

These items may be documented in the Progress notes, on the Review of Systems portion of the Child Health Flow Sheet, or the N.C. Immunization Registry.

Documentation of "Condition Prior to Onset" may include:

- Previously well, now presents with ...
- Ill X 3 days (assumes child was previously well)
- Flare-up of previously stable asthma
- 3 episodes BOM this spring (indicates chronic condition)

If immunizations that are due are not given at a particular visit, there should be at minimum a valid contraindication noted and a plan to administer vaccines as soon as possible.

b. Children Will Receive a Physical Examination for Each Problem, Which will Include:

- 1. Examination of Body System(s) Related to the Chief Complaint**
- 2. Pertinent Vital Signs**
- 3. Pertinent Laboratory Testing**

These items may be documented in the Progress notes or on the Physical Examination portion of the Child Health Flow Sheet. If the flow sheet is used, documentation should clearly indicate which body systems were not assessed.

c. Children Will Have a Written Diagnosis for Each Problem Identified

This may be found in a SOAP note, on the Problem List or with the physical examination findings on the flow sheet. If a diagnosis is pending, the screener or provider should document sufficient information to indicate why any action is being taken. Nurse screeners may document medical diagnoses if similar to the following:

- Bilateral Otitis media, per Dr. _____
- Scabies (per protocol)

d.1 Children Will Be Referred, as Indicated

"Referral" may include consultation with another provider in the same agency during the visit. If another provider sees the child during the visit, this must be noted in the record. Indicate plans for follow-up for referrals. If referrals are offered and refused, note this in the record.

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d.2 Children Will Have Follow-Up, as Indicated

Documentation of the plan of care may be found in the Progress Notes or on the flow sheet next to the identification of the problem. Follow-up may include planned rechecks, education, referral, consultation or any combination of these. A full SOAP note is not required if it is possible to discern the plan of care from the flow sheet and problem list. If referrals are made or planned, there should be documentation of when the provider will follow-up on the referrals. Reviewers must also check to see that problems uncovered during the visit, which may not have been part of the "Reason for Visit," receive appropriate follow-up.

e. Children Will Receive Education/Counseling Concerning Each Problem Identified.

This standard may be met through talking with the child and family and through sharing of appropriate literature. If an agency has specific handouts that are shared for specific problems or diagnoses, these should be noted in agency policies. An agency using standard packets of literature must assure that each child diagnosed with the same problem receives all items in the standard packet or must document which items were not given to the family.

There is no approved list of which items of anticipatory guidance should be covered for various medical conditions. At minimum, screeners or other members of the Child Health team should address anticipatory guidance topics related to problems or concerns identified during the visit.

f. Children Seen for Other Than Well Child Visits Will Receive a Referral for a Routine Well Child Visit, or Will Receive a Follow-Up Appointment for a Routine Well Child Visit.

This standard may be met if the chart indicates that a child has another appointment scheduled at the same agency or if there is an appointment already in place with the child's primary health care provider. It is not sufficient to chart "F/U @ next RHS" if there is no next visit scheduled. However, if the next routine visit would not occur for several years (as in the case of a six year old), indicate when the next visit is due.

CODE

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