Sample Agency Internal Health Record Audit

In a typical internal audit, you would want to select 10 active client charts with at least 3-5 prior visits: the most recent visit should have taken place within the past 3 months. If information should be present and is not, place an 0 in the box for that chart. If information is present, rate the quality of the information with 3 = Superior, 2 = Satisfactory, and 1 = Unacceptable. Use “NA” to score items that do not apply to a given chart (e.g., client has no allergies). Any section with a 0 or 1 should be followed up on by your quality review team and agency processes followed to notify the correct manager or service provider.

Chart number	1	2	3	4	5	6	7	8	9	10
Pages have client name and ID number (HMIS and/or Medi-Cal Member)										
Contains biographical and/or personal data										
Person providing care identified on each chart entry										
Entries are dated										
Entries are legible										
Location is complete and accurate										
Provider credentials are complete and accurate for service provided										
Housing needs assessment and list of barriers and client strengths (reason for service) is complete-										
Appropriate past medical and housing history documented in an assessment										
Client is authorized for housing Community Support services, authorization number included										
Plans of action (individualized services plan) are consistent with diagnosis(es)/medical necessity										
Plans of action (individualized service plan) are consistent with assessment										
Progress notes documenting services are consistent with plan of action (assessment and individualized service plan)										
Evidence of continuity and coordination of care between supportive housing provider and other health providers										
Chronology maintained/electronic records can be navigated by date they occurred										
Informed consent and release of information noted										

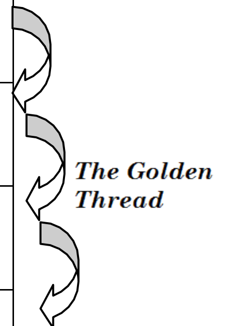

Chart number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Clients are adequately informed (i.e., there is documentation of client education on client rights, follow-up instructions)										
Re-assessments of need for supportive services occur at least annually, and are included in chart.										
Re-authorizations or extensions of authorization are documented and included in client record, including authorization number										
Follow-up occurred and was documented on missed/canceled appointments										
Telephone calls and electronic communication regarding client care noted										
Charts are organized in a consistent manner internally										
Transcription, if used, is accurate and supervisor review is noted										
There is a consistent, organized format for progress notes (i.e., is SOAP or similar format used?)										
Chart contents are securely fastened to the jacket (if paper) or kept secure through password protection and encryption (if electronic)										
No inappropriate information is in the chart (e.g., subjective or personal remarks about client, family, or other caregivers)										
No inappropriate alterations or omissions (e.g., erasures, missing pages)										

Credits: *The Medical Record Audit form was provided by the American Medical Association/Specialty Society Medical Liability Project.*

The Medical Record Audit Form is available for public use and public download at http://www.omic.com/medical-record-audit-form.

CSH has amended the Medical Record Audit form for practice use with supportive housing providers attending the CSH Medicaid Academy.