COLLEGE OF CHIROPODISTS OF ONTARIO
QUALITY ASSURANCE COMMITTEE
PRACTICE ASSESSMENT PROGRAM

Chart and Care Plan Review Tool

Member Name: _____

Assessment Date: _____

Total number of charts selected for review: _____

Date(s) selected for Chart and Care Plan Review: _____

A – Agree/True in 90% of Charts Reviewed

B – Agree/True in greater than 70% of Charts Reviewed

C – Agree/True in less than 70% of Charts Reviewed

D – Agree/True in less than 10% of Charts Reviewed

N/A – Not Applicable

J. Chart Review – Organization

		A	B	C	D	N/A
J1.	Are patient records organized for easy retrieval?	☐	☐	☐	☐	☐
J2.	Are the charts legible?	☐	☐	☐	☐	☐
J3.	Are all charts written in permanent ink?	☐	☐	☐	☐	☐
J4.	Are all corrections initialed?	☐	☐	☐	☐	☐
J5.	Is the information within the chart presented in a clear and logical format?	☐	☐	☐	☐	☐
J6.	Is there a glossary available if abbreviations are used?	☐	☐	☐	☐	☐
J7.	Do the notes identify the author?	☐	☐	☐	☐	☐
J8.	Is there a reference identifying the patient on each part?	☐	☐	☐	☐	☐

Overall Summary for Chart Review - Organization

_____

_____

K. Chart Review - Mandatory Content

Each chart must include the following:

		A	B	C	D	N/A
K1.	The patient's name and address.	☐	☐	☐	☐	☐
K2.	The date of each of the patient's visits.	☐	☐	☐	☐	☐
K3.	The name and address of the primary care physician.	☐	☐	☐	☐	☐
K4.	The patient health record card number. *	☐	☐	☐	☐	☐
K5.	A copy of every written consent.	☐	☐	☐	☐	☐
K6.	History of the patient is taken and documented.	☐	☐	☐	☐	☐
K7.	Current medications are documented.	☐	☐	☐	☐	☐
K8.	Allergies are documented.	☐	☐	☐	☐	☐
K9.	The primary complaint is documented.	☐	☐	☐	☐	☐

** Relevant for Podiatrist members only*

Overall Summary for Chart Review - Mandatory Content

L. Chart Review - Record Keeping Clinical Findings

Each chart must include the following:

		A	B	C	D	N/A
L1.	Reasonable information about every examination performed.	☐	☐	☐	☐	☐
L2.	Reasonable information about every **positive** clinical finding.	☐	☐	☐	☐	☐
L3.	Reasonable information about every **negative** clinical finding.	☐	☐	☐	☐	☐
L4.	Reasonable information regarding diagnosis and assessment.	☐	☐	☐	☐	☐
L5.	Reasonable information about every referral of the patient to another health professional, service or agency.	☐	☐	☐	☐	☐
L6.	Written reports received for examinations, tests, consultations or treatments performed by other health professionals.	☐	☐	☐	☐	☐
L7.	Reasonable information about all significant advice given.	☐	☐	☐	☐	☐

Overall Summary for Chart Review – Record Keeping Clinical Findings

M. Chart Review - General Record Keeping

Each chart must include the following:

		A	B	C	D	N/A
M1.	Reasonable information about every controlled act performed.	☐	☐	☐	☐	☐
M2.	Reasonable information about every controlled act delegated.	☐	☐	☐	☐	☐
M3.	Reasonable information about every post-operative visit.	☐	☐	☐	☐	☐
M4.	Reasonable information about every procedure that was commenced but not completed.	☐	☐	☐	☐	☐
M5.	Prescription medications are documented with dosage and duration.	☐	☐	☐	☐	☐
M6.	Reasonable information about any radiographs taken.	☐	☐	☐	☐	☐

Overall Summary for Chart Review – General Record Keeping

N. Care Plan Review

Each chart must include the following:

		A	B	C	D	N/A
N1.	Investigation is appropriate to the primary complaint.	☐	☐	☐	☐	☐
N2.	Primary complaint, history, investigation lead to the documented diagnosis.	☐	☐	☐	☐	☐
N3.	Management plan is appropriate to the diagnosis.	☐	☐	☐	☐	☐
N4.	Visit history is appropriate to management plan.	☐	☐	☐	☐	☐
N5.	There is documented periodic re-assessment of patients with chronic conditions.	☐	☐	☐	☐	☐

Overall Summary Care Plan Review