Indicate how many patient records were reviewed: 15 in addition to a cursory review of the Counseling Center and Athletic Medicine charts.
Describe how the records were selected: Two transfer, Women's Clinic, and random pulls.

Supporting and Summary Comments:

F. Old records are being scanned on disk and will continue to be done. Immunization records are not kept beyond approximately one year.

G. Format of clinical records is consistent in the clinical area.

I. There is a medicine sheet under the problem list on the left had side of the chart. The problem list is generally well used.

J. Some allergy notations have a zero with a slash when there is no allergy; NKDA still is used on others. Allergy notations are not always on the progress note.

K-1. A number of progress notes were signed off with initials only. There is an approved list of initials, which has been approved by the staff.

Consultative Comments:

As records are being scanned, suggest also doing the immunization records. However, a QI Study looking at how often these records need to be retrieved for students who have graduated might give the answer to whether or not they need to be scanned.

Suggest that NKA be used instead of the NKDA.

Suggest that the center look at the use of read stickers for only allergy notations. If used, the center may need to also list NKA with date and date any new allergies. Perhaps a stamp for vital signs could include allergy blank for documentation at each visit. Suggest that the allergy notation also be made in the psychiatry chart.

Suggest using name and professional designation when signing charts.