

**WRIGHT STATE PHYSICIANS
RISK ASSESSMENT SURVEY**

Name of Reviewer _____ Date _____

General Survey Assessment(s)			Comments
1.	Is there a system to manage diagnostic tests to assure you are aware of any missing results on a timely basis?	YES NO N/A	
2.	Is there a detailed protocol outlining when prescriptions may be renewed prior to physician's approval?	YES NO N/A	
3.	Are written instructions given to patients receiving sample medications?		
4.	Is there a patient complaint process?	YES NO N/A	
5.	Is there a process to determine patient satisfaction?	YES NO N/A	
6.	Are their protocols regarding phone triage written and approved by the physician?	YES NO N/A	
Storage Assessment(s)			Comments
1.	Are dispensed sample medications recorded by lot number?	YES NO N/A	
2.	Does significant clinical equipment receive at least annual preventive maintenance?	YES NO N/A	
3.	Is there a system to secure syringes and needles in exam rooms?	YES NO N/A	
4.	Does crash cart have a numbered tamper indicating tag that is tracked to match the last time it was checked for proper equipment or drug expiration dates?	YES NO N/A	
5.	Are narcotics kept in a medication inventory and double-locked cabinet or room?	YES NO N/A	
Office Protocol			Comments
1.	Is there a new patient brochure to introduce patients to the practice?	YES NO N/A	
2.	Does staff interacting with patients wear name tags?	YES NO N/A	
Medical Records			Comments
1.	Does the medical record include whether the patient referred to a specialist kept the referral appointment?	YES NO N/A	
2.	Are after hour phone calls between physicians and patients documented and filed into the medical record?	YES NO N/A	
3.	Is there a reason documented for the established patient who misses an appointment?	YES NO NA/	
4.	Is the physician apprised of the missed appointment to determine if follow-up is warranted?	YES NO N/A	

5.	Does physician review diagnostic reports and studies by initialing and dating his/her review?	YES NO N/A	
6.	Are emails between physicians and patients printed and put into the medical record?	YES NO N/A	
7.	Are allergies prominently displayed and updated annually?	YES NO N/A	
8.	Does documentation include how allergies are manifested?	YES NO N/A	
9.	Is the patient name printed on both sides of medical records documents?	YES NO N/A	
10.	Do post-it notes contained in the medical record include the patient's name, date of entry and individual's name or initials?	YES NO N/A	
11.	Are transcribed reports authenticated with the physician's signature?	YES NO N/A	
12.	Is there a strict policy prohibiting removal of medical records from the premises (except for court order or transfer)	YES NO N/A	
13.	Are all fields on chart forms completed or noted as "n/a"	YES NO N/A	
14.	Does the physician complete documentation on a timely basis?	YES NO N/A	
15.	Are all entries in the medical record initialed and dated by the person making the entry?	YES NO N/A	
16.	Are problem/medication sheets kept up to date?	YES NO N/A	

Safety

Comments

1.	Are clinical procedures documented in a procedural manual?	YES NO N/A	
2.	Is the clinical procedure manual reviewed annually by medical director?	YES NO N/A	
3.	Does staff receive annual fire safety training?	YES NO N/A	
4.	Does staff receive annual risk management training?	YES NO N/A	
5.	Are eye wash stations in place?	YES NO N/A	
6.	Are all staff aware of eye wash station locations and instructed in their use?	YES NO N/A	
7.	Is there a formalized procedure for terminating the physician/patient relationship?	YES NO N/A	
8.	Has informed consent explaining the risks, benefits and alternatives been discussed with the patient?	YES NO N/A	
9.	If chaperones are used for certain examinations, does the medical record reflect the name of the chaperone?	YES NO N/A	