EXAMPLE

COLLECTIVE QA REPORT: UTI MANAGEMENT

Review Period: ____Weekly ____Monthly ____Quarterly Date of Review: _____

Total # of patients seen: _____

SUMMARY STATEMENT: On the above date, _____ (insert #) charts, identifiers listed below were chosen at random and reviewed for quality monitoring. The charts were reviewed for the following UTI Management indicators:

1. Documentation of symptoms of dysuria
2. Documentation of previous UTIs
3. If Culture and Sensitivity Ordered were appropriate antibiotics initially prescribed?
4. Was Culture and Sensitivity Ordered was the culture NEGATIVE?

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

Chart #/Identifier			
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Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

MD/DO has reviewed / discussed all of the above with CRNP/CNM.

_____ MD/DO Date: _____

_____ CRNP/CNM Date: _____

EXAMPLE

COLLECTIVE QA REPORT: HYPERLIPIDEMIA

Review Period: ____Weekly ____Monthly ____Quarterly Date of Review: ____________________

Total # of patients seen: ____________

SUMMARY STATEMENT: On the above date, ___________ (insert #) charts, identifiers listed below were chosen at random and reviewed for quality monitoring. The charts were reviewed for the following Hyperlipidemia indicators:

1. Documentation of personal history of heart disease: (HTN, CVA, A-Fib, MI etc.)
2. Documentation of family and social history: (Smoking habits; family heart disease)
3. Were the following included in every visit: Weight, B/P, diet, and exercise education
4. If established dx of hyperlipidemia were lipids ordered per office protocol
5. If established dx of hyperlipidemia on a Statin drug were LFTs ordered per office protocol

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

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Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

MD/DO has reviewed / discussed all of the above with CRNP/CNM.

________________________________ MD/DO Date: ______________________

________________________________ CRNP/CNM Date: ______________________

EXAMPLE

COLLECTIVE QA REPORT: PRESCRIBED MEDICATIONS

Review Period: ____Weekly ____Monthly ____Quarterly Date of Review: ___________________

Total # of patients seen: ____________________

SUMMARY STATEMENT: On the above date, __________ (insert #) charts, identifiers listed below were chosen at random and reviewed for quality monitoring. The charts were reviewed for the following Prescribed Medication indicators:

1. Medications are prescribed per FDA guidelines (per PDR, NP/CNM Manual, or Product Insert)
2. Proper chart documentation of medication name, dosage, and directions for use and are legible
3. Medications prescribed are appropriate for the patient dx according to practice protocol
4. Controlled medications were ordered according to regulations of BME and ABN
5. No medications were ordered or refilled due to nature of visit

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

Chart #/Identifier			
Date of Service			
D = Discussed (noted changes which are needed) √ = Appropriate **NA**= Not Applicable **A**= Adverse Event	1. 2. 3. 4. 5.		

MD/DO has reviewed / discussed all of the above with CRNP/CNM.

______________________________ MD/DO Date: ______________________

______________________________ CRNP/CNM Date: ______________________

EXAMPLE

SUMMARY OF FINDINGS FROM QUARTERLY QA

Period of Review:_____

Name of Audit/QA:_____

Number of Charts Audited:_____

Summary of Findings:

□ No specific medical issues identified
□ Certain Medical Issues are in Question (see comments)
□ Adverse findings identified (see comments)
□ Follow-up with provider is needed

Comments/Discussions/Changes to be made (if any):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician name/
signature:_____

Date:_____

CRNP/CNM
name/signature:_____

Date:_____

EXAMPLE

ADVERSE EVENT REVIEW/ REPORT

Office Name
Address
Phone
number

Patient Identifier: _____ **DOB** _____

Physician Name: _____ **License #** _____

CRNP/CNM Name: _____ **License #** _____

Date of Adverse Event: _____ **Patient Age** _____ **Patient Gender** _____

Indicate the Adverse Event:

_____

Patient hospitalized: ____ **Yes** ____ **No**

Patient Outcome: _____ **Full Recovery** _____ **Disability** _____ **Death** _____ **Pending**

Provide a brief narrative description of the adverse event and include any recommendations for change:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of Physician: _____ **Date:** _____