



## Washington State Department of Health VFC Compliance Site Visit Record Selection Protocol

### Selecting Records for Review

- Ten records are to be reviewed for compliance with the required VFC site visit documentation
- For the reviewer to complete this task, the site visit reviewer needs to direct the provider as to which 10 records should be pulled.
  - For example, the reviewer could ask the provider for a list of patient names and/or chart numbers for children less than 19 yrs of age who received at least one immunization in the last couple of months. (The reviewer can go back further if needed.)
  - The reviewer will select the records to review randomly. (One method the reviewer could use would be to review every second or third chart until the reviewer reviewed 10 records.)
  - NOTE: The clinic cannot pull charts in advance of the VFC Compliance Site Visit.
- Charts eligible for review should meet the following criteria:
  - Patients less than 19 years of age.
  - Patients who received at least one immunization in this clinic, preferably in the last 12 months.
- If the clinic has less than 10 eligible patient records, the reviewer will need to review all of the eligible records and enter that number into the VFC-PEAR Reviewer Guide.

### Review Requirements

- Review 10 records for documentation of VFC-eligibility status screening at every visit.
- Review the same 10 records for documentation of all required vaccine administration information. This includes:
  - Date vaccine given
  - Vaccine given
  - Vaccine manufacturer
  - Lot number
  - Vaccine Information Statement (VIS) publication date
  - Date VIS given
  - Name and title of person administering the vaccine
  - Clinic address
- Use the [Washington State Department of Health Chart Review Documentation Worksheet](#) to document your record review.
- Choose one immunization per record to review for completeness of documentation. Use an immunization from the most recent visit.
- If any piece of documentation is missing from any of the ten records being reviewed, then mark the answer as incorrect in the VFC-PEAR Reviewer Guide and require corrective actions.
- The requirement to document all of the above information is federal law. If the provider office's electronic medical record (EMR) cannot currently show documentation of this information, they must provide a 'work around' until the EMR can be corrected to show all of the CDC required documentation. Examples of a 'work around' include, entering the missing information into another field in the EMR (such as, in the 'chart notes') or recording the missing information onto paper and scanning it into the electronic patient chart.