



## Medico-legal Clinical Record Audit

Response

*This section will audit the admission (including patient registration/election) and progress note documentation for the patient's last hospital admission.*

2.0	Is there documented evidence for the last admission of the patient consenting to relevant information regarding treatment / admission being provided to other health professionals involved their care? (e.g. GP, referring doctor, community service providers)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.0	Is there documented evidence for the last admission that the patient has discussed an Advance Health Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3.1	If yes: Is there documented evidence of an Advance Health Directive in place for the patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.2	If yes: Is it contained within the patient's medical record?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.0	Is there documented evidence for the last admission that the patient received a pamphlet or spoke to a staff member about the Australian Charter of Health Care Rights?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.0	Is there documented evidence for the last admission that the patient received a pamphlet or spoke to a staff member about how to convey your comments and concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.0	Is there documented evidence of a nursing history taken within 24hr of admission for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.1	If yes: Does the nursing care plan include: <ul style="list-style-type: none"> <li>• Mobility?</li> <li>• Manual handling?</li> <li>• Wound care?</li> <li>• Observations including weight and height?</li> <li>• Technical activities – e.g. sleep apnoea support?</li> <li>• Intravascular device present e.g. Portacath?</li> <li>• Sensory deficit e.g. dementia?</li> <li>• Infection control issues e.g. isolation required?</li> <li>• Hydration, nutrition and dietary requirements?</li> <li>• Activities of daily living – hygiene, continence requirements?</li> <li>• Special care plans?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7.0	Is there documented evidence of a medical officer history/assessment taken within 24hr of admission for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.1	If yes: Does the medical officer history/assessment include: <ul style="list-style-type: none"> <li>• Presenting symptoms and examination?</li> <li>• Medical and surgical history?</li> <li>• Current co-morbidities?</li> <li>• Medication history?</li> <li>• Alerts and allergies?</li> <li>• Social/family history?</li> <li>• Provisional diagnosis?</li> <li>• Plan of care?</li> <li>• All therapeutic and diagnostic orders clearly documented and signed?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
8.0	Does EACH page of ALL forms for the last admission have the correct patient identification label firmly affixed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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9.0	Does the patient identification label used in the last admission contain 3 unique patient identifiers? i.e. patient full name, date of birth, medical record number	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.0	<p>Do ALL entries for the last admission in the patient progress notes contain:</p> <ul style="list-style-type: none"> <li>• Date?</li> <li>• Time using the 24 hour clock?</li> <li>• Signature of the clinician making the entry?</li> <li>• Printed name of the clinician making the entry?</li> <li>• Designation of the clinician making the entry?</li> <li>• Specialty Unit of the clinician providing care? (e.g. Mental Health)</li> <li>• Examination / diagnostic procedures / treatment / results?</li> <li>• Continued plan of care?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
11.0	<p>Are ALL entries for the last admission in the patient progress notes:</p> <ul style="list-style-type: none"> <li>• Written in black pen or according to local policy (e.g. purple pen for pharmacy)?</li> <li>• Have ALL errors been crossed out and initialled with "written in error"?</li> <li>• Only use approved abbreviations? (according to facility policy)</li> <li>• Use whiteout?</li> <li>• Have gaps or lines between entries crossed through?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Medication Safety Clinical Record Audit		Response
<p><i>This section will audit documentation on the Medication Chart / National Inpatient Medication Chart (NIMC) / PNIMC for paediatric patients. These audit questions are also in the Standard 4 – Medication Safety Patient Audit Tool.</i></p>		
12.0	Is there evidence for the last admission that the (best possible) medication history was documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.1	If yes: Where is the medication history documented? Select <u>all</u> that apply.	<input type="checkbox"/> Medication chart <input type="checkbox"/> Medication action plan
13.0	If the patient is aged 12 years or under, is there evidence that the patient has a Paediatric National Inpatient Medication Chart (PNIMC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
14.0	Is there documented evidence for the last admission of medication allergies and adverse drug reaction (ADR) status (including nil known & unknown) in the medication chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.1	Where a patient has a documented medication allergy or ADR in the medication chart, do ALL charts containing medication orders have a visual alert (e.g. ADR alert sticker)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.0	Is there documented evidence for the last admission of medication reconciliation either on the Medication Action Plan (MAP) i.e. in the reconcile column or on the Discharge Medication Record or Interim Medication Administration Record i.e. the change column is completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
16.0	Is there documented evidence of a VTE risk assessment in the medication chart or site specific chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.1	If yes: Where is it documented?	<input type="checkbox"/> Medication chart <input type="checkbox"/> Site specific chart
17.0	Is there documented evidence for the last admission that the patient was provided with a Discharge Medication Record (DMR) or Interim Medication Administration Record (IMAR) when discharged or transferred?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
18.0	Is there documented evidence for the last admission of a medication management plan in the patient's clinical record?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.0	Is the patient identification (minimum of name, DOB, MRN, address) complete on all pages of the medication chart for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.0	Does the patient have documented evidence for the last admission of a medication order in the medication chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.1	If yes: Does each medication order have: <ul style="list-style-type: none"> <li>• Generic name of medication?</li> <li>• Route?</li> <li>• Start date?</li> <li>• Dose?</li> <li>• Frequency?</li> <li>• Authorised prescriber's signature?</li> <li>• Authorised prescriber's printed name?</li> <li>• Authorised prescriber's designation?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
21.0	Does the facility allow nurse initiated medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.1	If yes: Is there documented evidence for the last admission that the nurse initiated medication(s) have been prescribed / administered according to facility policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**Medication Safety Clinical Record Audit**

Response

*This section will audit documentation on the Medication Chart / National Inpatient Medication Chart (NIMC) / PNIMC for paediatric patients. These audit questions are also in the Standard 4 – Medication Safety Patient Audit Tool.*

22.0	Does the facility allow for verbal medication orders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.1	If yes: Is there documented evidence for the last admission that any verbal medication orders have been countersigned by the prescriber within 24 hours of the order being received?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
23.0	Does the facility allow for telephone medication orders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23.1	If yes: Is there documented evidence for the last admission that any telephone medication orders have been countersigned by the prescriber within 24 hours of the order being received?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

<b>Blood Products Clinical Record Audit</b>		<b>Response</b>
<b><i>Blood or blood product transfusion in the current admission</i></b>		
24.0	Has the patient received a blood or blood product transfusion in the current admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.1	If yes: What was the documented indication for the transfusion?	<input type="checkbox"/> Hb <input type="checkbox"/> Clinical indication <input type="checkbox"/> Hb & clinical indication <input type="checkbox"/> No indication
24.2	If yes to 24.0: Is there evidence of a Crossmatch Report?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.3	If yes to 24.2: Is there evidence that the:	
	• product type is complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• product number is complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• group is complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• patient/product/label checks have been undertaken and signed by TWO clinical staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• commenced time and date is complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.0	If yes to 24.0: Is there documented evidence of previous adverse reaction to a blood or blood product transfusion? (Note: can be found on the fluid prescription chart or observation record) N/A – no history of blood or blood product transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b><i>Blood and blood products transfusion consent</i></b>		
26.0	If yes to 24.0: Is there evidence of a Blood and Blood Products Transfusion Consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26.1	If yes: Is there evidence that the:	
	• blood product/s accepted have been documented on the first page?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• patient's name, signature and date are complete <b>OR</b> Advance Health Directive (AHD) is complete <b>OR</b> substitute name, signature, relationship, date and source are complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• doctor's/delegate's name, designation, signature and date are complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><i>Blood Prescription</i></b>		
27.0	If yes to 24.0: Is there evidence of a blood prescription order? (Note: can be found on the fluid prescription chart or IV & SC fluid order form)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Blood Products Clinical Record Audit		Response
27.1	<p>If yes: Is there evidence on the order form of:</p> <ul style="list-style-type: none"> <li>• Date for transfusion</li> <li>• Type of blood product</li> <li>• Volume/quantity/number to be given</li> <li>• Special requirements listed</li> </ul> <p style="padding-left: 40px;">If yes to special requirements listed: what were they?</p> <ul style="list-style-type: none"> <li>• Rate of transfusion</li> <li>• Doctor's signature</li> <li>• Doctor's printed name</li> <li>• Fluid order form signed by TWO nurses</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Frusemide <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV requirement <input type="checkbox"/> Warmer <input type="checkbox"/> Premeds  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Transfusion</b> (Note: can be found on the fluid prescription chart, progress notes or observation record)		
28.0	If yes to 24.0: Is there documented evidence that the patient's Full name, DOB and MRN was confirmed against the transfusion department report and patient's arm band?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29.0	If yes to 24.0: Is there documented evidence that the product type was checked against the fluid order, transfusion department report and compatibility label?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30.0	If yes to 24.0: Is there documented evidence that the product bag is intact, no signs of deterioration, contamination, clots or discolouration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31.0	If yes to 24.0: Is there documented evidence of confirmation the blood product will not expire before transfusion is complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32.0	<p>If yes to 24.0: Is there documented evidence that the following were completed?</p> <ul style="list-style-type: none"> <li>• Transfusion start time?</li> <li>• Transfusion stop time?</li> <li>• Volume infused?</li> <li>• Non-urgent blood been given out of hours (20:00 to 07:00)?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
33.0	If yes to 24.0: Is there evidence of baseline observations completed prior to transfusion? (Tip: within 60 mins of commencement of transfusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No
33.1	<p>If yes: Is there documented evidence that the following vitals were completed?</p> <ul style="list-style-type: none"> <li>• Pulse?</li> <li>• Temperature?</li> <li>• Respirations?</li> <li>• Blood Pressure?</li> <li>• Oxygen saturation?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
34.0	If yes to 24.0: Is there evidence of commencement observations completed? (Tip: within 15 mins of commencement of transfusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Blood Products Clinical Record Audit		Response
34.1	If yes: Is there documented evidence that the following vitals were completed? <ul style="list-style-type: none"> <li>• Pulse?</li> <li>• Temperature?</li> <li>• Respirations?</li> <li>• Blood Pressure?</li> <li>• Oxygen saturation?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
35.0	If yes to 24.0: Is there evidence of hourly observations during transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
35.1	If yes: Is there documented evidence that the following vitals were completed? <ul style="list-style-type: none"> <li>• Pulse?</li> <li>• Temperature?</li> <li>• Respirations?</li> <li>• Blood Pressure?</li> <li>• Oxygen saturation?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
36.0	If yes to 24.0: Is there evidence of observation on completion of transfusion? (Tip: within 2hrs of completion of transfusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No
36.1	If yes: Is there documented evidence that the following vitals were completed? <ul style="list-style-type: none"> <li>• Pulse?</li> <li>• Temperature?</li> <li>• Respirations?</li> <li>• Blood Pressure?</li> <li>• Oxygen saturation?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
37.0	If yes to 24.0: Was the blood infused within four (4) hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
37.1	If no: Please state why.	
38.0	If yes to 24.0: Is there evidence that the patient had an adverse reaction to the blood transfusion? (E.g. Symptoms include: fever >1° C above baseline, rigors, chest or abdominal pain, hypotension tachycardia, rash/itching)	<input type="checkbox"/> Yes <input type="checkbox"/> No
38.1	If yes: Is there evidence the medical officer was notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
38.2	If yes to 38.0: Is there evidence the adverse reaction was recorded in the facility incident management system (e.g. PRIME)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
39.0	If yes to 24.0: Is there evidence of the transfusion outcome in the chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><i>Surgical procedure in the current admission</i></b>		
40.0	If patient has undergone a surgical procedure <b>AND</b> there is evidence of informed consent: Is there evidence that the: <ul style="list-style-type: none"> <li>• consent includes the patient being aware that the procedure may include a blood transfusion?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"> <li>• patient has been given the Blood and Blood Products Transfusion Information Sheet?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Blood Products Clinical Record Audit**

Response

***Declined specified blood or blood product transfusion in the current admission***

41.0	Has the patient <b>declined</b> blood or blood product transfusion <b>OR declined a specified</b> blood or blood products to be transfused in the current admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
41.1	If yes: Is there evidence of a refusal form (if facility has one)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
41.2	If yes: Is there evidence that the: <ul style="list-style-type: none"><li>• blood product/s accepted have been documented on the form?</li></ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"><li>• patient's/substitute's name, signature and date are complete?</li></ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<ul style="list-style-type: none"><li>• doctor's/delegate's name, designation, signature and date are complete?</li></ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

*This section applies to the 41 QH birthing facilities and audits the following standardised documentation: Intrapartum Record, Assisted Birth Record and Perinatal Morbidity Form*

42.0	For maternity patients; Is there evidence for the last admission of perinatal documentation of the following on the intrapartum record in the clinical record: <ul style="list-style-type: none"> <li>• Date of rupture of membranes recorded?</li> <li>• Time of rupture of membranes recorded?</li> <li>• Method of rupture of membranes recorded?</li> <li>• Indication for induction/augmentation recorded?</li> <li>• Type of labour recorded?</li> <li>• Date and time of stages of labour?</li> <li>• Labour pain relief?</li> <li>• Collection of cord blood recorded?</li> <li>• Vaginal examination recorded?</li> <li>• Second stage observations recorded?</li> <li>• Fetal heart rate recorded?</li> <li>• Perineal assessment recorded?</li> <li>• If a tear, Is the degree of tear recorded?</li> <li>• If a tear, Is the suture material and anaesthetic recorded?</li> <li>• Indication for operative intervention recorded?</li> <li>• Obstetric complications recorded?</li> <li>• Skin to skin contact recorded?</li> <li>• 2hr post partum observations recorded?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
43.0	Is a copy of the perinatal morbidity/statistical form filed in the clinical record?	<input type="checkbox"/> Yes <input type="checkbox"/> No
43.1	If yes: Is the information recorded on the perinatal morbidity/statistical form consistent with the documentation recorded in the Intrapartum Record notes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
44.0	Is there evidence for the last admission of assisted birth documentation in the clinical record?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
44.1	If yes: Does the assisted birth record include for EACH manoeuvre: <ul style="list-style-type: none"> <li>• Date &amp; time</li> <li>• Fetal heart rate</li> <li>• Time of abandonment</li> <li>• Printed name, staff category and signature</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
45.0	Was the newborn 'rooming in' on the ward with its mother?	<input type="checkbox"/> Yes <input type="checkbox"/> No
45.1	If yes: Has the newborn's identification been checked and is correct within 24hr of birth as documented in the neonatal pathway?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Surgical Patient Clinical Record Audit

Response

### Surgical Safety Checklist

*This section applies to the Surgical Safety Checklist documentation. Audit questions for the Surgical Safety Checklist are also covered in Standard 5 – Patient Identification Patient Audit Tool.*

46.0	Was the patient admitted for a surgical procedure in the last admission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
46.1	If yes: Does the patient have a surgical safety checklist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
46.2	If yes to 46.1: Is there a patient label or are all of the patient details written legibly at the top of the form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
46.3	If yes to 46.1: In the 'sign in' section: <ul style="list-style-type: none"> <li>Has the patient's identity box been completed?</li> <li>Has the site/side box been completed?</li> <li>Has the procedure box been completed?</li> <li>Has the consent box been completed?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
46.4	If yes to 46.1: In the 'sign in' section, has the site marked box (either yes or N/A) been completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
46.5	If yes to 46.1: In the 'time out' section: <ul style="list-style-type: none"> <li>Has the patient confirm box been completed?</li> <li>Has the site/side box been completed?</li> <li>Has the procedure box been completed?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

### Perioperative Patient Record (PPR)

*This section applies to the Perioperative Patient Record documentation. Audit questions for the Perioperative Patient Record are also covered in Standard 5 – Patient Identification Patient Audit Tool.*

47.0	Was the patient admitted for a surgical procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.1	If yes: Does the patient have a Perioperative Patient Record (PPR)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.2	If yes to 47.1: Is there a patient label or are all of the patient details written legibly at the top of the form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.3	If yes to 47.1: Has 1. full name, DOB and ID band matching box been completed for ALL checks 1, 2 and 3?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.4	If no: Has it been partially completed i.e.: for either 1 or 2 checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.5	If yes to 47.1: Has 2. procedure consent box been completed for ALL checks 1, 2 and 3?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.6	If no: Was it partially completed i.e.: for either 1 or 2 checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.7	If yes to 47.1: Has 3. procedure stated box been completed for ALL checks 1, 2 and 3?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.8	If no: Has it been partially completed i.e.: for either 1 or 2 checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.9	If yes to 47.1: Has 4. surgical site marked box been completed for ALL checks 1, 2 and 3?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
47.10	If no: Has it been partially completed i.e.: for either 1 or 2 checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Surgical Patient Clinical Record Audit		Response
<b>Procedure Informed Consent Form</b>		
<i>This section applies to the specific procedural informed consent form that applies to the patient for EACH procedure. Audit questions for the Procedural Informed Consent are also covered in Standard 5 – Patient Identification Patient Audit Tool.</i>		
48.0	Was the patient admitted for a procedure/s?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.1	If yes: Is there a written and signed consent form for EACH procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.2	If yes: Does the patient have the capacity to provide consent i.e.: the 'patients who lack capacity' box is not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.3	If yes to 48.1: Is there a patient label or are all of the patient details written legibly at the top of EACH PAGE of EACH form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.4	If yes to 48.1: Has the patient consented to EACH procedure by completing their name and signed and dated the form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48.5	If yes to 48.1: Has the doctor/delegate section been completed with name, designation, signature and date for EACH procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Intraoperative Record</b>		
<i>This section applies to the Intraoperative Record documentation.</i>		
49.0	Is there an Intraoperative record or print out from ORMIS in the patient clinical record for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
49.1	If yes: Is there documented evidence on the Intraoperative record of: <ul style="list-style-type: none"> <li>• Surgeon/proceduralist name and designation?</li> <li>• Assistant surgeon(s) and attending staff names?</li> <li>• Operation/procedure performed?</li> <li>• Date of operation/procedure?</li> <li>• Time in and time out of theatre/procedure room?</li> <li>• Indications/reason for operation/procedure?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Operation Record</b>		
<i>This section applies to the Operation Record documentation.</i>		
50.0	Is there an operation report (either from ORMIS or written record) in the patient clinical record for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
50.1	If yes: Does the operation report contain: <ul style="list-style-type: none"> <li>• Date of operation?</li> <li>• Indication for operation?</li> <li>• Results of the operation/procedure?</li> <li>• Details of the operation/procedure/outcomes including surgical findings?</li> <li>• Follow-up arrangements?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

## Surgical Patient Clinical Record Audit

Response

### Sterility Validation Tracking and Prosthesis Used

*This section applies to the Sterility Validation Tracking and Prosthesis Used Record documentation.*

51.0	Is there a Sterility Validation Tracking and Prosthesis Used chart to record sterile stock used, present in the patient clinical record for the last admission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
51.1	If yes: Does the Sterility Validation Tracking and Prosthesis Used chart contain evidence of sterile stock used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Perioperative Count Record

*This section applies to the Perioperative Count Record documentation.*

52.0	Is there a perioperative count record present in the patient clinical record for the last admission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
52.1	If yes: Does the count sheet contain: <ul style="list-style-type: none"> <li>• Signature of instrument nurse?</li> <li>• Printed name of instrument nurse?</li> <li>• Designation of Instrument nurse?</li> <li>• Signature of circulating nurse(s)?</li> <li>• Printed name of circulating nurse(s)?</li> <li>• Designation of circulating nurse(s)?</li> <li>• Record of first and second count as a minimum?</li> <li>• Evidence that proceduralist was notified of count correct or any discrepancies?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
53.0	Is there evidence in the chart that the count discrepancy was reported in the facility incident management system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A (no count discrepancy)

### Anaesthetic Record

*This section applies to the Anaesthetic Record documentation (on standardised anaesthetic record or print out from AARK Automated Anaesthetic (Perioperative) Record ).*

54.0	Is there an anaesthetic record present in the patient clinical record for the last admission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
54.1	If yes: Are the following recorded: <ul style="list-style-type: none"> <li>• Date on the anaesthetic chart?</li> <li>• Evidence on the anaesthetic chart that the Anaesthetist conducted a pre operative interview with the patient?</li> <li>• Evidence of assessment and recording of patient allergies/previous reactions?</li> <li>• Evidence of medications and doses given during anaesthesia, including route of administration?</li> <li>• Evidence of monitoring data and intravenous fluid therapy?</li> <li>• ASA score documented?</li> <li>• Anaesthetic type? (e.g. GA, Regional, Sedation)</li> <li>• Anaesthetist's printed name present?</li> <li>• Anaesthetist's signature present?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

**Diagnostic Procedures (e.g. radiological procedures, electrophysiology, coronary angiography)**

Response

**Consent**

*This section applies to the recorded consent for diagnostic procedure either using a specific procedural informed consent form or generic consent form.*

55.0	Was the patient admitted for a procedure or throughout admission underwent a diagnostic procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55.1	If yes: Is there a written and signed consent form for EACH diagnostic procedure undertaken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55.2	If the patient underwent a diagnostic procedure and has a written and signed consent form: Does the patient have the capacity to provide consent i.e.: the 'patients who lack capacity' box is not completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55.3	If the patient underwent a diagnostic procedure, is competent to consent and has a written and signed a consent form: Is there a patient label or are all of the patient details written legibly at the top of EACH PAGE of the form for EACH procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55.4	If the patient underwent a diagnostic procedure, is competent to consent and has a written and signed a consent form: Has the patient consented to EACH procedure by completing their name and signed and dated the form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55.5	If the patient underwent a diagnostic procedure, is competent to consent and has a written and signed a consent form: Has the doctor/delegate section been completed with name, designation, signature and date for EACH procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Results**

*This section applies to the recorded results of the diagnostic procedure either using a procedure report record or as reported in the progress notes.*

56.0	Is there a diagnostic report in the patient clinical record (e.g. in progress notes) for EACH diagnostic procedure undertaken?	<input type="checkbox"/> Yes <input type="checkbox"/> No
56.1	If yes: Does the EACH diagnostic report contain: <ul style="list-style-type: none"> <li>• Date of diagnostic procedure?</li> <li>• Indication for diagnostic procedure?</li> <li>• Results of the diagnostic procedure?</li> <li>• Follow-up arrangements?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Discharge Summary / Letter Clinical Record Audit		Response
<i>This section applies to the discharge letter or printed electronic discharge summary documentation.</i>		
57.0	Is there documented evidence for the last admission that discharge planning commenced on admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
58.0	Does the discharge information recorded in the progress notes by nursing staff contain details of: <ul style="list-style-type: none"> <li>• Discharge destination?</li> <li>• Discharge time?</li> <li>• Discharge date?</li> <li>• Accompanying person?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
59.0	Is there documented evidence for the last admission that a discharge summary/letter been completed by the medical officer for this admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
59.1	If yes: Does the discharge summary/letter contain: <ul style="list-style-type: none"> <li>• Patient details - 3 unique identifiers?</li> <li>• Referring Doctor /GP - Name/Contact Details?</li> <li>• Consultant's name?</li> <li>• Hospital unit of discharge?</li> <li>• Admission and discharge date?</li> <li>• Discharge destination?</li> <li>• Principal diagnosis?</li> <li>• Other current complications/comorbidities?</li> <li>• Allergies and adverse reactions?</li> <li>• Details of any procedure(s)?</li> <li>• Significant investigations / results documented?</li> <li>• Discharge plan / recommendations for GP / follow-up?</li> <li>• Discharge unit and contact number?</li> <li>• Medications on discharge, including any medications ceased during admission?</li> <li>• Signature of the authorising medical officer?</li> <li>• Printed name of the authorising medical officer?</li> <li>• Designation of the authorising medical officer?</li> <li>• Date of completion by the medical officer?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
60.0	If documented evidence for the last admission that a discharge summary/letter has been completed: Has the discharge summary/letter been filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
60.1	If documented evidence for the last admission that a discharge summary/letter has been completed: Is there evidence that the discharge summary/letter has been sent to the clinician assuming responsibility for the patient post discharge (e.g. GP) within 48hr of discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
61.0	Is there documented evidence for the last admission that referrals to appropriate primary health providers/community services has been organised?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Pressure Injury Clinical Record Audit		Response
<p><i>This section applies to clinical documentation in relation to Pressure Injury prevention and management. Audit questions for Pressure Injuries are also covered in Standard 8 – Pressure Injury Patient Audit Tool.</i></p>		
62.0	Is there documented evidence that a pressure injury risk assessment was undertaken on admission to the facility for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
62.1	If yes: What is the patient's documented category of risk?	<input type="checkbox"/> No risk <input type="checkbox"/> Low risk <input type="checkbox"/> At risk <input type="checkbox"/> Medium risk <input type="checkbox"/> High risk <input type="checkbox"/> Very high risk
62.2	If yes to 62.0: Within what timeframe from facility admission was the pressure injury risk assessment undertaken?	<input type="checkbox"/> <2hr <input type="checkbox"/> <4hr <input type="checkbox"/> <8 hr <input type="checkbox"/> <12hr <input type="checkbox"/> < 24 hr <input type="checkbox"/> >24hr <input type="checkbox"/> Not available
63.0	Is there documented evidence for the last admission that a comprehensive skin inspection was undertaken on admission to the facility? (Note: Comprehensive skin inspection involves checking for signs of erythema, blanching response, localised heat, oedema, induration and skin breakdown)	<input type="checkbox"/> Yes <input type="checkbox"/> No
63.1	If yes: Within what timeframe from facility admission was the comprehensive skin inspection undertaken?	<input type="checkbox"/> <2hr <input type="checkbox"/> <4hr <input type="checkbox"/> <8 hr <input type="checkbox"/> <12hr <input type="checkbox"/> < 24 hr <input type="checkbox"/> >24hr <input type="checkbox"/> Not available
64.0	Is there documented evidence of a Pressure Injury Prevention and Management Plan for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
65.0	Is there documented evidence of referral to a wound management service for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no pressure injury)
66.0	Is there evidence in the chart for the last admission that the pressure injury was reported in the facility incident management system?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no pressure injury)



Clinical Deterioration Clinical Record Audit		Response
<p><i>This section applies to clinical documentation in relation to Clinical Deterioration including observation charts such as Q-ADDS and CEWT. Audit questions for Clinical Deterioration are also covered in Standard 9 – Clinical Deterioration Patient Audit Tool.</i></p>		
67.0	Is there evidence in the chart of a general observation chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
67.1	If yes: Is this chart the Adult Deterioration Detection System (Q-ADDS) chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
67.2	If yes to 67.0: Is this chart the Children's Early Warning Tool (CEWT)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
67.3	If not an Q-ADDS or CEWT, select the system in use (Select one)	<input type="checkbox"/> Single parameter tool (track and trigger) <input type="checkbox"/> Aggregate scoring system <input type="checkbox"/> Combination system e.g. Q-MEWT <input type="checkbox"/> Non track and trigger
68.0	If yes to 67.0: Is the patient clearly identified on all pages of the general observation chart? (includes MRN, Name and DOB)	<input type="checkbox"/> Yes <input type="checkbox"/> No
69.0	If a CEWT tool: Was the correct age group chart used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
70.0	If a Q-ADDS or CEWT tool: Have there been modifications to the tool?	<input type="checkbox"/> Yes <input type="checkbox"/> No
70.1	If yes: Indicate where modifications have been made.  (select all that apply)	<input type="checkbox"/> Respiratory rate <input type="checkbox"/> O <sub>2</sub> saturation <input type="checkbox"/> O <sub>2</sub> flow rate <input type="checkbox"/> Blood pressure <input type="checkbox"/> Heart rate <input type="checkbox"/> Temperature
71.0	Is there a monitoring plan documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No
71.1	If yes: Were the observations recorded at the recommended minimum frequency for the past 24 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
72.0	If yes to 67.0: Which core observations have been recorded in the latest set of observations within the last 8 hrs?  Select <u>all</u> parameters that have been recorded.	<input type="checkbox"/> Respiratory rate <input type="checkbox"/> O <sub>2</sub> saturation <input type="checkbox"/> Blood pressure <input type="checkbox"/> Heart rate <input type="checkbox"/> Temperature <input type="checkbox"/> Consciousness <input type="checkbox"/> None recorded <input type="checkbox"/> Other (specify) <hr/>
73.0	If the observation chart has a scoring system: Were <u>all</u> the last recorded set of observation scores summed up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
74.0	If yes to 73.0: Was the last set of observation scores summed up correctly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
74.1	If no to 74.0: What was the numerical difference between the recorded and actual scores?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> >=3
75.0	If Q-ADDS, CEWT or Other trigger chart: Was an escalation of care identified (If appropriate)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Clinical Deterioration Clinical Record Audit**

Response

*This section applies to clinical documentation in relation to Clinical Deterioration including observation charts such as Q-ADDS and CEWT. Audit questions for Clinical Deterioration are also covered in Standard 9 – Clinical Deterioration Patient Audit Tool.*

75.1	If yes: Was the escalation acted upon?	<input type="checkbox"/> Yes <input type="checkbox"/> No
75.2	If yes to 75.1: Was it within the allocated time period (depending on the trigger/score)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
75.3	If yes to 75.1: Was it escalated to the appropriate medical personnel (depending on the trigger/score)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
76.0	If Q-ADDS or CEWT tool: Did observations yield a score of 8 or higher, OR fall in the purple coloured band?	<input type="checkbox"/> Yes <input type="checkbox"/> No
76.1	If yes: Was an emergency call placed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
77.0	If other observation chart (not Q-ADDS or CEWT) that has a trigger OR scoring system: Did the patient meet the criteria for an emergency call?	<input type="checkbox"/> Yes <input type="checkbox"/> No
77.1	If yes: Was an emergency call placed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Falls Clinical Record Audit

Response

*This section applies to clinical documentation in relation to Falls prevention and management. Audit questions for Falls are also covered in Standard 10 – Falls Patient Audit Tool.*

78.0	Is there documented evidence for the last admission that the patient's care plan includes the use of a mobility aid? (N/A for patients who can mobilise independently)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
79.0	Is there evidence for the last admission that the patient has experienced a fall while in hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
79.1	If yes: Is there evidence for the last admission the incident has been entered in the incident management system e.g. PRIME?	<input type="checkbox"/> Yes <input type="checkbox"/> No
80.0	Is there documented evidence for the last admission that the patient was screened for history of falling on admission? (note: screening identifies if the patient is at increased risk of falling and then should be assessed)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Incomplete
81.0	Is there documented evidence for the last admission that the patient was assessed for risk of falling on admission? (note: an assessment of risk identifies modifiable risk factors)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Incomplete
82.0	If assessment of risk is completed, what is the patient's documented risk of falling?	<input type="checkbox"/> At risk <input type="checkbox"/> Not at risk
83.0	If the patient is at risk of falling, have they been reviewed by the Physio / OT?	<input type="checkbox"/> Yes <input type="checkbox"/> No
83.1	If yes, which one?	<input type="checkbox"/> Physio <input type="checkbox"/> OT
84.0	Is there documented evidence for the last admission that there is a multifactorial falls prevention plan (FPP)? (i.e. documented actions corresponding to identified risk factors).	<input type="checkbox"/> Yes <input type="checkbox"/> No
85.0	Is there documented evidence for the last admission of the level of supervision / assistance required for mobilisation in the patient's care plan? (N/A for patients who can mobilise independently)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
86.0	Does the patient have documentation (i.e. in the care plan) that an assessment has been undertaken for continence and continence aid requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
87.0	Was there documented evidence of referrals to appropriate primary health providers/community services being organised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
87.1	If yes: To whom?	<input type="checkbox"/> Physio <input type="checkbox"/> OT <input type="checkbox"/> Dietitian <input type="checkbox"/> Nutritionist <input type="checkbox"/> AH Asst <input type="checkbox"/> Nursing Home Placement <input type="checkbox"/> HACC <input type="checkbox"/> Other: Specify _____

Malnutrition Clinical Record Audit		Response
<i>This section applies to clinical documentation in relation to Malnutrition prevention and management</i>		
88.0	Is the admission weight recorded for the last admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
89.0	If the LOS is greater than 7 days, has a follow-up weight been recorded on Day 7 or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
90.0	For the last admission, was the patient screened for nutrition risk on admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
90.1	If yes, is the patient at risk of malnutrition?	<input type="checkbox"/> At risk <input type="checkbox"/> Not at risk
91.0	Is there evidence for the last admission at the bedside of a documented nutrition care plan? (tip: plan may include diet +/- supplements, monitoring of weight and food intake)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

**The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.**

**Please email Patient Safety and Quality Improvement Service on [PSQIS\\_Comms@health.qld.gov.au](mailto:PSQIS_Comms@health.qld.gov.au) for feedback or comments.**

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