NSQHS Standard 1 Governance – attachment 3

Client Clinical Record Audit Tool – COMMUNITY (Collection of Patient da)

Hospital and Health Service:	Facility:	Audit Date/Period:
Community Team:	Client Medical Record Number (MRN):	

Client audit tool: collects client level data from the community clinical record, use one audit tool for each client audited. Choose which documentation domains of the clinical record you wish to audit.

Notes:

- *Each facility needs to determine those audit questions that are applicable to their facility / health service circumstances for review*
- *Some questions and responses may not be applicable (e.g. at a unit level) and can be adapted to suit individual requirements*
- *The measurement plan details each audit question and the action/criteria it aligns to in the standard*
- *This audit can be used prospectively or retrospectively. When used for retrospective chart audit, all questions relate to the last community admission*

Medico-legal Clinical Record Audit		Response
This section will audit the admission (including Client registration) and progress note documentation for the Client's last admission.		
1.0	Is there documented evidence on admission to community in the client clinical record (i.e. Client registration form) of:	
	• Medical record number?	☐Yes ☐No
	• Name?	☐Yes ☐No
	• DOB?	☐Yes ☐No
	• Gender?	☐Yes ☐No
	• Residential/postal address?	☐Yes ☐No
	• Home phone number?	☐Yes ☐No
	• Marital status?	☐Yes ☐No
	• Medicare number?	☐Yes ☐No
	• Entitlement cards e.g. health care card, DVA (including card colour), Pension card, safety net card?	☐Yes ☐No
	• Details of a main contact person?	☐Yes ☐No ☐N/A
	• Details of next of kin?	☐Yes ☐No ☐N/A
	• Details of the Client's general practitioner?	☐Yes ☐No
	• Details of the Client's referring doctor?	☐Yes ☐No
	• Cultural requirements?	☐Yes ☐No ☐N/A
	• Indigenous status?	☐Yes ☐No

Medico-legal Clinical Record Audit		Response
This section will audit the admission (including Client registration) and progress note documentation for the Client's last admission.		
2.0	Is there documented evidence for the last community admission of the client consenting to relevant information regarding treatment / admission being provided to other health professionals involved there care? (e.g. GP, referring doctor, community service providers)	☐Yes ☐No
3.0	Is there documented evidence for the last community admission that the client received a pamphlet or spoke to a staff member about the Australian Charter of Health Care Rights?	☐Yes ☐No ☐N/A
4.0	Is there documented evidence for the last community admission that the client received a pamphlet or spoke to a staff member about how to convey their comments and concerns?	☐Yes ☐No ☐N/A
5.0	Is there documented evidence for the last community admission of a medical history/assessment taken on admission?	☐ Yes ☐ No
6.0	Does EACH page of ALL forms for the last community admission have the correct client identification label firmly affixed?	☐ Yes ☐ No
7.0	Does the client identification label used in the last community admission contain 3 unique Client identifiers? i.e. Client full name, date of birth, medical record number	☐ Yes ☐ No
8.0	Do ALL entries for the last community admission in the client progress notes contain: • Date? • Time using the 24 hour clock? • Signature of the clinician making the entry? • Printed name of the clinician making the entry? • Designation of the clinician making the entry? • Specialty Unit of the clinician providing care? (e.g. Mental Health)	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9.0	Are ALL entries for the last community admission in the client progress notes: • Written in black pen or according to local policy (e.g. purple pen for pharmacy)? • Have ALL errors been crossed out and initialled with "written in error"? • Only use approved abbreviations? (according to facility policy) • Use whiteout? • Have gaps or lines between entries crossed through?	 ☐Yes ☐No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A
10.0	Is there evidence for the last community admission that the (best possible) medication history was documented?	☐ Yes ☐ No
11.0	Is there documented evidence for the last community admission of medication allergies and adverse drug reaction (ADR) status (including nil known & unknown) in the client record?	☐ Yes ☐ No
11.1	Where a client has a documented medication allergy or ADR in the client record, do ALL charts containing medication orders have a visual alert (e.g. ADR alert sticker)?	☐ Yes ☐ No

Discharge Summary / Letter Clinical Record Audit		Response
This section applies to the discharge letter or printed electronic discharge summary documentation.		
12.0	Is there documented evidence for the last community admission that discharge planning commenced on admission (to community)?	☐ Yes ☐ No
13.0	Does the discharge information recorded in the progress notes by staff contain details of: • Discharge destination? • Discharge time? • Discharge date? • Accompanying person?	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
14.0	Does the client have a discharge summary/letter documented in the client record?	☐Yes ☐No
14.1	If yes: Does the discharge summary/letter contain: • Client details - 3 unique identifiers? • Referring Doctor /GP - Name/Contact Details? • Consultant's name? • Hospital unit of discharge? • Admission and discharge date? • Discharge destination? • Principal diagnosis? • Other current complications/comorbidities? • Allergies and adverse reactions? • Details of any procedure(s)? • Significant investigations / results documented? • Discharge plan / recommendations for GP / follow-up? • Discharge unit and contact number? • Medications on discharge, including any medications ceased during admission? • Signature of the authorising nursing staff? • Printed name of the authorising nursing staff? • Designation of the authorising nursing staff? • Date of completion by the nursing staff?	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐N/A ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
15.0	If documented evidence for the last community admission that a discharge summary/letter has been completed, has the discharge summary/letter filed?	☐Yes ☐No
15.1	If documented evidence for the last community 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 client post discharge (e.g. GP or specialist)?	☐Yes ☐No
16.0	Is there documented evidence for the last community admission that referrals to appropriate primary health providers has been organised?	☐Yes ☐No

Pressure Injury Clinical Record Audit		Response
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 Client Audit Tool.		
17.0	Is there documented evidence for the last community admission that a pressure injury risk assessment was undertaken on admission?	☐ Yes ☐ No
17.1	If yes: What is the client's documented category of risk?	☐ No risk ☐ Low risk ☐ At risk ☐ Medium risk ☐ High risk ☐ Very high risk
18.0	Is there documented evidence for the last community admission that a comprehensive skin inspection was undertaken on admission? (Note: Comprehensive skin inspection involves checking for signs of erythema, blanching response, localised heat, oedema, induration and skin breakdown)	☐ Yes ☐ No
19.0	Is there documented evidence for the last community admission of a Pressure Injury Prevention and Management Plan?	☐ Yes ☐ No
20.0	Is there documented evidence for the last community admission of referral to a wound management service?	☐ Yes ☐ No ☐ N/A (no pressure injury)

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 Client Audit Tool.		
21.0	Is there documented evidence for the last community admission that the client was screened for history of falling on admission? (note: screening identifies if the Client is at increased risk of falling and then should be assessed)	☐ Yes ☐ No ☐ Incomplete
22.0	Is there documented evidence for the last community admission that the client was assessed for risk of falling on admission? (note: an assessment of risk identifies modifiable risk factors)	☐ Yes ☐ No ☐ Incomplete
23.0	If assessment of risk is completed, what is the client's documented risk of falling?	☐ At risk ☐ Not at risk
24.0	If the client is at risk of falling, have they been reviewed by the Physio / OT?	☐ Yes ☐ No
24.1	If yes, which one?	☐ Physio ☐ OT
25.0	Is there documented evidence for the last community admission that there is a multifactorial falls prevention plan (FPP)? (i.e. documented actions corresponding to identified risk factors).	☐ Yes ☐ No
26.0	Is there documented evidence for the last community admission of the level of supervision/assistance required for mobilisation in the Client's care plan? (N/A for clients who can mobilise independently)	☐Yes ☐No ☐N/A
27.0	Does the client have documentation (i.e. in the care plan) that an assessment has been undertaken for continence and continence aid requirements?	☐ Yes ☐ No

Malnutrition Clinical Record Audit		Response
This section applies to clinical documentation in relation to Malnutrition prevention and management		
28.0	Is there documented evidence for the last community admission of the client's weight on admission?	☐Yes ☐No ☐N/A
29.0	For the last community admission was the client screened for nutrition risk on admission?	☐Yes ☐No ☐N/A
29.1	If yes: Is the client at risk of malnutrition?	☐ At risk ☐ Not at risk
30.0	Is there evidence for the last community admission of a documented nutrition care plan? (tip: plan may include diet +/- supplements, monitoring of weight and food intake)	☐Yes ☐No ☐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 for feedback or comments.