The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

NURSE PRACTITIONER / NURSE

Clinical record review self-audit checklist

Introduction

General practices deliver a service that must be managed effectively to ensure that they meet the needs of patients. The patient's clinical record is integral to maintaining good patient care and continuity of care.

Patient records should describe and support the health care that has been provided. They should be understandable to a newcomer to the practice. The structure of the records should allow information to be obtained easily. It is important that adequate information is recorded for each consultation and that the person making the entry is identified – this includes telephone consultations.

Conducting a record review helps to establish and improve the quality of clinical records and supports the safe care of patients.

This clinical record review self-audit checklist can be used by practices that are conducting self-assessments in preparation for practice certification processes. The checklist enables doctors, practice nurses and practices to ensure that they are meeting Indicator 10, criterion 10.1 in the RNZCGP Foundation Standard: "The practice ensures all medicines prescribed, administered or supplied are recorded in the Practice Management System (PMS). Medical warnings are noted".

There are two versions of the clinical record review: One to be completed by general practitioners and one to be completed by nurse practitioners/nurses. Nurse practitioners/nurses can choose either one to complete.

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Instructions

This clinical record review requires a random audit of 10 patient records (each nurse practitioner/nurse in the practice must complete a self-audit of 10 records). Applications that generate lists of random numbers are available online. However, the easiest way to generate a random sample is to select consecutive patient appointments, beginning at a random time on a randomly selected day.

All records selected should be electronic and have an entry in the past 12 months. The review should not focus on a single consultation but rather on a series of the most recent consultations for a particular record.

Part 1, the **patient record system** review, can be completed by administration staff. **Part 2**, the **clinical record review**, must be completed by the nurse practitioner or nurse whose notes are being reviewed.

- Randomly select 10 patient clinical records
- Complete the **patient record system** section and the **clinical record review** section by marking the boxes in columns numbered 1 to 10 for each of the records reviewed as follows
  - **Y** present and adequate
  - **IN** present but inadequate
  - **N** not present
  - **N/A** not applicable/necessary in this case
- Evaluate each of the criteria by selecting ‘met’, part met’, ‘not met’ or ‘n/a’ (not applicable) for each of the rows.
- Complete the Report and Plan template, identifying areas for development and a plan for improvement.

PART 1

Patient record system

In the table below, please note the NHI number of each of the 10 patients whose records are to be reviewed, and then proceed to the clinical audit on the following page.

Record:	1	2	3	4	5	6	7	8	9	10
NHI:										

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Clinician's name:

NCNZ number:

Date:

PART 1

Patient record system

Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
1. Patient records are electronic, secure and traceable:														
All clinical information is:														
recorded electronically														
password protected														
reliably backed up														
Clinical notes:														
are dated														
reliably identify the author														
2. Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements:														
Information stored for each patient includes:														
NHI number														
name														
gender														
address														
date of birth														
ethnicity														
registration status														
Information held for enrolled patients includes:														
contact phone number														
contact in case of emergency (ICE)														
next of kin – where applicable														
significant relationships														
hapū/iwi for Māori patients														
primary language if not English														
Need for an interpreter:														
Any need for an interpreter is flagged for patients with English as a second language.														

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PART 2

Clinical record review – nurse

In the table below, please note the NHI number of each of the 10 patients whose records are to be reviewed, and then proceed to the clinical audit on the following page.

Clinical record review – 10 patient records chosen at random										
Record:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
NHI:										

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Clinician's name:

NCNZ number:

Date:

PART 2
Clinical record review

Must be completed by nurse practitioner/nurse, not administration staff

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
1.	**The clinic notes are:**														
	logical and concise and not compromised by abbreviations or templates (i.e. are comprehensible to others)														
	timely – notes are completed as soon as possible after contact, and any delay is documented														
	intentioned – contain the reason for the encounter														
	recorded objectively and do not contain inappropriate or judgmental comments														
	complete – includes all necessary observations such as blood pressure, weight etc. and triage (if acute)														
	collaborative – there is a plan of treatment/management, including follow-up where necessary														
	adherent to the Code of Rights – Informed consent is documented for any procedures/treatments														
2.	**Screening history and recalls include:**														
	The patient's screening history and results are all recorded (including declines) for routine screening (e.g. cervical smears, mammograms, cardiovascular risk assessment, diabetes screening)														
	Recalls are added to the patient record (e.g. cervical smear, mammogram, CVRA etc.)														
	An alert being placed on the patient's record if they are overdue a recall														
	The patient being identified as overdue for a recall has been followed up														

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Must be completed by nurse practitioner/nurse, not administration staff														
	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
3.	**Test results and referral include:**														
	Notification of test results to the patient are recorded, including how and by whom														
	Any follow-up actions are recorded														
	Nurse-initiated referrals (e.g. to district nurses, podiatry etc. include: urgency, reason/expectation of referral, relevant findings, classifications, warnings and current treatment) are recorded														
	Advice or activities related to programmes that improve, maintain, or restore health (e.g. Green Rx, healthy lifestyle, smoking, alcohol) are recorded														
	If a certified cervical smear taker: tests are tracked, the GP is notified of the result and any follow-up referrals made for abnormal smears														
4.	**Immunisations include:**														
	Immunisations are provided in accordance with the national schedule														
	If not an authorised vaccinator, a GP directive has been documented in the notes or a standing order is in existence														
	Informed consent is obtained from the patient or caregiver														
	Vaccinations given that are not on the National Schedule show informed consent and updating of the patient's immunisation status														

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Report and Plan template

After completing the **clinical record review**, summarise your findings and plan any necessary improvements.

Audit finding:	Area(s) of omission:	Plan for improvement:
1. Clinical notes		
2. Screening and recalls		
3. Test results and referrals		
4. Immunisations		

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