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

Clinical record review self-audit checklist

Introduction

General practices deliver a service that must be managed effectively to ensure that it meets 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." The criteria in this checklist also link to a number of other criteria in the Foundation Standard.

This clinical record review self-audit checklist is also a component of the General Practice Education Programme (GPEP) and can be used as an audit activity for the continuing professional development (CPD) programme.

The tool has two parts:

- **PART 1** includes requirements for the practice patient record system and the demographic details that it records.

  If this has been done in the practice within the past three years, it does not need to be completed by doctors undertaking Part 2 for the training programme or for professional development purposes.

- **PART 2** contains criteria that should be assessed for **practice certification, training programme(s) and professional development purposes**.

Instructions

Parts 1 and 2 of the checklist require a random audit of **10** patient 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 can be completed by practice administration staff. Part 2 must be completed by the clinician whose notes are being audited.

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Part 1 and 2

- Randomly select 10 patient clinical records.
- Complete the Part 1 or Part 2 template attached by marking the boxes in the 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.

GPEP registrars

It is your responsibility to check whether the practice has completed Part 1 of the checklist in the past three years, and if not, to compete it as part of your audit requirements. If your practice has completed Part 1, please provide a copy with your completed Part 2.

You are required to submit the completed clinical record audit checklist to the College. Complete and return both the Recording Sheet and the Report and Plan sheet to your GPEP Programme Advisor. **You are encouraged to discuss the results of this audit activity with your medical educator, collegial relationship provider, or a peer**.

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:

MCNZ/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														

† This part is completed at practice level to meet the Foundation Standard certification. Provided it has been done at practice level in the past three years, it does not need to be completed by doctors undertaking Part 2 for other purposes. If not doing this section themselves, GPEP2/3 registrars must attach a copy of the completed Part 1 done by their practice.

PART 2

Clinical record review

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:										

The Royal New Zealand College of General Practitioners
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Clinician's name:

MCNZ/NCNZ number:

Date:

PART 2
Clinical record review

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
1.	**The record is appropriate, contemporaneous and sources are identified:**														
	Notes are completed as soon as possible after contact, and any delay is identifiable.														
	Information is recorded objectively and does not contain inappropriate, judgmental comment.														
	When information is provided other than by the patient, the source is identified.														
2.	**Clinical notes can be understood by someone not working regularly at the practice:**														
	The notes are logical, intelligible and sequential.														
	The use of keywords or templates does not compromise the validity of the notes.														
3.	**Important background issues, warnings and alerts are displayed for all records:**														
	Past medical history is available.														
	Significant social history is included.														
	The PMS is used to effectively display important warnings, and alerts.														
	Allergies or the absence of known allergies is recorded for each patient.														
4.	**Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point:**														
	Patient needs recorded include any directives by patient, disabilities, drug dependencies, end-of-life and special needs (e.g. communication, mental health issues).														
5.	**The recorded history is relevant and sufficient for both safe management and evidential purposes:**														
	The reason(s) for the encounter recorded or apparent from the notes.														
	The record includes date, place of consultation (if different from usual) and mode of contact if not face to face.														
6.	**The record includes all findings essential to diagnosis and management:**														
	Sufficient positive and negative history and examination findings are present to justify management decisions.														
	Objective measurements (BP, pulse, temp., respiratory rate, PaO2 etc) are recorded, where relevant.														

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
7.	**The working diagnosis/differential or problem being managed is apparent and consistent with supporting information:**														
	The diagnosis (and any differential) and level of certainty is clear from the notes.														
8.	**The patient management plan is clear and identifies and addresses uncertainty and conjecture:**														
	The plan for care can be identified from the record.														
	Important assumptions and remaining uncertainties in diagnosis and management are noted.														
9.	**The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent:**														
	Notification of test results and clinical findings is recorded.														
	The record supports adequate consenting processes.														
10.	**All important clinical decisions and interventions are recorded:**														
	Treatment plans, including interventions, contingency plans, safety netting and follow-up arrangements are recorded as necessary.														
	Clinical management decisions made outside consultations (e.g. telephone calls) and off-site contacts (home visit, aged care facilities etc.) are recorded.														
11.	**The record identifies all medication treatment provided, including the type, dosage and total amount of any medications prescribed:**														
	There is a record of all prescriptions issued, including drug name, administration instructions and quantities ordered.														
	Medications initiated or changed outside the practice are reconciled with the PMS.														
	Current and long-term medications are differentiated and the status is clear.														
	Where long-term medications are changed, reasons for alteration or discontinuation are clear.														
12.	**The record identifies all investigations requested and tracks high-risk tests:**														
	All requests for tests and investigations are recorded.														
	High-risk tests (e.g. histology, cervical smears) are tracked for completion.														
13.	**The record supports effective and timely referral for treatment or transfer of care:**														
	The record shows that referrals are completed within a reasonable time frame.														
	Copies of referral letters to and from the practice, certifications, referrals and responses, discharge summaries and test results are included in the patient PMS record or accessibly filed.														

	Record:	1	2	3	4	5	6	7	8	9	10	Met	Part met	Not met	N/a
	Referrals include urgency, reason/ expectation of referral, relevant findings, classifications, warnings and current treatment.														
	The transfer of responsibility for care can be verified from the records.														
14.	**Follow-up of test results is clearly documented and actions recorded:**														
	Follow-up actions on test results and referrals are recorded.														
15.	**Screening history and results (or declined screening) are recorded:**														
	Screening history and results (including declines) are evident for routine screening areas (eg cervical smears, mammograms, cardiovascular risk assessment, diabetes screening).														
	Screening recall status can be easily tracked.														
	There is evidence of patient risk assessment and opportunistic screening for high-risk conditions.														
16.	**Immunisation history and status is recorded:**														
	There is evidence that recommended immunisations are provided in accordance with the national schedule.														
	Records show advice given and immunisation status for non-scheduled immunisations.														
17.	**There is a systematic record of individual risk factors:**														
	Diseases are classified for chronic conditions, including all conditions for which the patient is on long-term treatment.														
	Family history for major risk factors, such as diabetes, early CVD, bowel and breast cancer etc.														
	Current employment (where relevant) and any history of at-risk occupations.														
	Blood pressure monitoring as clinically indicated.														
	Baseline weight/BMI and monitoring as clinically indicated.														
	Smoking status and history and cessation support offered, where relevant.														
	Alcohol and drug usage.														
	Regular review of chronic conditions as per current best practice (e.g. INR, diabetes, CVR).														

Report and Plan template

After having completed parts 1 and/or 2 of the tool, summarise your findings and plan any necessary improvements on the template below. The template lists each of the indicators in parts 1 and 2. In column 1 under each indicator, record the proportion of records that did not meet the criteria. In column 2, give the areas that need improvement, and in column 3, briefly describe your plan for improvement.

Audit finding:	Area(s) of omission:	Plan for improvement:
Part 1		
1. Patient records are electronic, secure and traceable:		
2. Basic demographic information is sufficient to allow for patient identification and to meet national enrolment requirements:		
Part 2		
1. The record is appropriate, contemporaneous and sources are identified:		
2. Clinical notes can be understood by someone not working regularly at the practice:		
3. Important background issues, warnings and alerts are displayed for all records:		

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Audit finding:	Area(s) of omission:	Plan for improvement:
4. Specific patient needs and instructions are recorded and are available in easily accessible form at the clinically relevant point:		
5. The recorded history is relevant and sufficient for both safe management and evidential purposes:		
6. The record includes all findings essential to diagnosis and management:		
7. The working diagnosis/differential or problem being managed is apparent and consistent with supporting information:		
8. The patient management plan is clear and identifies and addresses uncertainty and conjecture:		
9. The record identifies information given to the patient, including risks and benefits of treatments and, where relevant, consent:		
10. All important clinical decisions and interventions are recorded:		

Audit finding:	Area(s) of omission:	Plan for improvement:
11. The record identifies all medication treatment provided, including the type, dosage and total amount of any medications prescribed:		
12. The record identifies all investigations requested and tracks high-risk tests:		
13. The record supports effective and timely referral for treatment or transfer of care:		
14. Follow-up of test results is clearly documented and actions recorded:		
15. Screening history and results (or declined screening) are recorded:		
16. Immunisation history and status is recorded:		
17. There is a systematic record of individual risk factors:		