**Clinical Record Audit Summary Form**

Using this form:

Each client record is given a reference number for use on the Clinical Record Audit Summary Form. A rating is then noted against each criterion, which represents the degree to which the record complies with the criterion.

Audit criteria rating system

The rating system is described in the following table.

|  |  |  |
| --- | --- | --- |
| **The audit criteria rating** | **Is noted as** | **Rating given when** |
| **Met** | 3 | Performance against the criterion in the audit form is substantially confirmed, (for example more than 85% compliance), and when safety is not compromised |
| **Partially met** | 2 | Performance against the criterion in the audit form is not substantially confirmed (for example, less than 85% compliance). This may apply when safety is compromised, or when both performance and safety are compromised. |
| **Not met** | 1 | The information required to comply with the criterion in the audit form is substantially unconfirmed (for example, less than 30% compliance) or completely absent. |
| **Not applicable** | N/A | The criterion is not relevant to the organisation doing the audit, due to the organisation’s size, role, or setting. The reason for rating a criterion Not Applicable should be stated in the audit summary report. |

|  |  |
| --- | --- |
| **Audit information** | |
| **Name of clinician:** |  |
| **Service delivery location(s):** |  |
| **Date of audit:** |  |
| **Client name and reference number:** |  |
| **Record type:** | 🞏 Electronic 🞏 Hard copy |
| **Client record active:** | 🞏 Yes 🞏 No |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Audit criteria Ratings and values are: Met = 3, Partially met = 2, Not met = 1, Not applicable = N/A | Reference number of client record audited | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **LEGAL REQUIREMENTS** | | | | | | | | | | |
| Every entry in the client record is legible |  |  |  |  |  |  |  |  |  |  |
| Every entry in the client record is signed and dated |  |  |  |  |  |  |  |  |  |  |
| Mistakes crossed out and initialled- no correction fluid used |  |  |  |  |  |  |  |  |  |  |
| Each record indicates (for example, by a note at the beginning of the record) that client was informed about privacy laws |  |  |  |  |  |  |  |  |  |  |
| Informed consent has been obtained for recording client information and MDS for program reporting requirements. |  |  |  |  |  |  |  |  |  |  |
| **REGISTRATION DETAILS** (for paper based records only, each page of the client record contains the following identifying information) | | | | | | | | | | |
| Client name |  |  |  |  |  |  |  |  |  |  |
| Client date of birth |  |  |  |  |  |  |  |  |  |  |
| Client record number |  |  |  |  |  |  |  |  |  |  |
| **INFORMATION INCLUDED ON THE CLIENT RECORD** | | | | | | | | | | |
| Contact details |  |  |  |  |  |  |  |  |  |  |
| Copy of relevant documentation e.g. MHCP, Referral, consent forms |  |  |  |  |  |  |  |  |  |  |
| Source of referral and copy on file |  |  |  |  |  |  |  |  |  |  |
| Ethnicity or language spoken at home |  |  |  |  |  |  |  |  |  |  |
| Relevant cultural issues accommodated |  |  |  |  |  |  |  |  |  |  |
| Occupation |  |  |  |  |  |  |  |  |  |  |
| Medicare or Health Care Card number |  |  |  |  |  |  |  |  |  |  |
| **ASSESSMENT AND CARE PLANNING** Client record includes the following information | | | | | | | | | | |
| Previous relevant history |  |  |  |  |  |  |  |  |  |  |
| Date of each visit recorded in client record, including failure to attend |  |  |  |  |  |  |  |  |  |  |
| Evidence of informed consent obtained for management plan and care |  |  |  |  |  |  |  |  |  |  |
| Specific measurement of outcomes e.g. K10, DASS21, risk assessment |  |  |  |  |  |  |  |  |  |  |
| Demonstrated use of evidence-based best practice interventions |  |  |  |  |  |  |  |  |  |  |
| Referrals made where appropriate and/or information EG) community support programs, acute care team and helplines, websites, information pamphlets, initial and final reports to referrer |  |  |  |  |  |  |  |  |  |  |
| **DISCHARGE OR EXIT SUMMARY** | | | | | | | | | | |
| Is there any evidence of change linked to the intervention (e.g. behaviour, attitude, knowledge, physical improvement or deterioration)? |  |  |  |  |  |  |  |  |  |  |
| Is there a clear summary of the last session and any future plans made with the client (e.g. on- referral to another agency, self-management strategies, resources and tools)? |  |  |  |  |  |  |  |  |  |  |
| Relevant correspondence (e.g. case summaries, case closure letter, consumer satisfaction survey) given to client |  |  |  |  |  |  |  |  |  |  |

*Reference: adapted from 2013 Australia Medicare Locals Alliance (ATAPS Clinical governance framework).*