CLINICAL NOTES AUDIT

High-quality clinical notes are important to ensure the accurate documentation of the consultation and provide pertinent information for other clinicians. Auditing notes helps identify areas of weakness, drives quality improvement and will result in improved patient outcomes.

All doctors should have their notes audited at least once every three years (registrars must submit them in the first three months of the training programme).

Notes submitted to the College MUST be anonymised, prepared, and sent as per the instructions below.

Submitting notes to the College

1. Request for a shared folder to be made available for CNA by emailing admin@rnzcuc.org.nz. The office team will create a folder for you and send the link.
2. Print twenty consecutive records
    1. Patients presenting **for the first time**for a particular episode.
    2. Include **all** clinically relevant notes, for the patient, including nurse triage notes, wherever they are stored in your facility's record management system, including medications, allergies, and past medical history.
3. Mark each page with a case number (1 to 20, handwritten on the page) and ensure it is clear which case each page of notes belongs to.
4. Make sure that the patient's age (not DoB), gender, and ethnicity are included *(add by handwriting notes on the first page for that patient if necessary).*
5. Anonymise all other personal information. **It is the responsibility of the person sending the notes to ensure that all identifiers have been removed.**
    1. Information that must be removed includes –
        - Names
        - Date of Birth
        - Personal addresses
        - NHI numbers
        - Personal phone numbers
        - ACC numbers
        - Radiology and Laboratory identifier numbers if including reports
        - Any other information that could identify a patient (job details, accident locations etc.)
    2. Notes/recommendations:
        - Obscure details with post-it notes (or similar), liquid paper (tippex etc), before scanning. *Simply crossing out details using a pen or marker is inadequate as it is possible to see through the paper still and if the notes are subsequently scanned/copied the scanner can see through the pen.*
        - Physically removing the header of notes that contains all patient details is a quick and effective way of anonymising notes, especially those printed from MedTech, *as the latter includes a line at the bottom of each page that often includes patient identifiers.*
        - Ensure all pages are read through completely to check for any details. *ACC numbers and Radiology/Laboratory numbers can be overlooked, as can patient names and other specific details within the body of notes.*
        - If you are able to copy and paste from your practice management system, copying notes into a word file enables editing out of all patient details.
    3. Scan all documents into a pdf and save in the shared folder.
    4. Email admin@rnzcuc.org.nz to let us know that you have saved the notes into the folder. The DPD or DCT will review the notes and provide feedback.
    5. Review the feedback and instructions. This includes reflection before or at the SAC.
        1. What could I improve?
        2. What changes should I consider so that I can make those improvements?

3. How will I know that the changes are working, and that the improvements are continuing?
4. How could the note keeping system or template be improved?

Further information is available on the revised recertification page on clinical notes audit.