CLINICAL NOTES AUDIT (CNA)

A note-keeping audit is a compulsory part of urgent care accreditation and reaccreditation. To complete this, send clinical notes to RNZCUC for review (instructions below).

Requirement

Registrars must complete a CNA in the first three months of joining the training programme. A pass is required prior to attempting UCPEX, and every three years thereafter.

Fellows complete a note-keeping audit once every three years, though the audit reviewer can stipulate another timeframe. Typically this happens if the notes are outstanding (in which case the reviewer may grant dispensation to 'skip' one cycle), or if they have only just passed (in which case the reviewer may require the CNA to be completed within one year).

When a doctor fails a CNA, the repeat CNA is required within three months, or as stipulated by the reviewer.

Employer or other Vocational branch activities

Any CNA undertaken as part of your employment, or another vocational branch's CPD activities are acceptable alternatives, providing this is an independent review of your clinical documentation, and the CNA meets the following criteria:

- Minimum of 20 consultation notes (must be "new" presentations, not reviews)
- Must assess all the domains in the table below, including a qualitative assessment of the clinical documentation.

Item	Pass / fail criteria
History of presenting complaint?	Must be present and adequate
Past medical history adequate?	Must be present and adequate
Medications record adequate?	Must be present and adequate
Allergies or alerts recorded?	Must be present and adequate
Baseline recordings adequate?	Case appropriate
Examination findings adequate?	Case appropriate – should include all relevant systems
Diagnosis or impression recorded?	Must be present and adequate, or demonstrate thinking (eg working diagnosis, differential diagnosis, etc).
Plan?	Must be present and adequate
Comments, or qualitative assessment of notes, or suggestions for improvement of documentation.	Eg Important findings were not recorded, or that an important diagnosis may have been overlooked.

Doctors who wish to submit an alternative CNA should apply to the Director of Professional Development for approval.

(**need a mechanism for this – maybe the DPD reviews all alternative CNAs submitted??**).

Note, while self-audits may be a useful CPD activity, they are not acceptable for the purposes of this CNA audit as they are not an independent or peer reviewed assessment of your clinical documentation (they may be eligible for Peer review or CME points providing the criteria are met for these activities). Note, there is an optional self-audit for clinical documentation listed in the optional audit section which can be done in conjunction with the CNA. (link please)

Different clinical environments

RNZCUC acknowledges our members work in a range of different clinical environments where the CNA in its current form may not be easily transferred – these doctors may apply to the Director of Professional Development with a plan to adapt or modify the CNA to suit their environment while meeting the requirements for peer reviewed notes audit.

Introduction

Good note-keeping is particularly important in urgent care, and often done poorly. It is usual for urgent care clinical notes to be passed on to another doctor – be it another clinic doctor, a hospital doctor, or the usual GP. For this reason the quality of the clinical notes is particularly important in urgent care, and RNZCUC insists that its note-keeping standards be met as a condition of Fellowship. Good notes that are well presented in conventional format are easy for other doctors to understand. The underlying clinical practice may be sound despite poor note-keeping. Often though, poor note-keeping means poor clinical practice and a failure to think systematically – unsound clinical methods. If a patient complains about medical treatment, the notes will often decide the case.

Audit components

The notekeeping audit checks for the following basic elements:

- History, including Presenting Complaint, Past Medical History, Current Medications and Allergies.
- Examination findings, including Basic Observations
- Diagnosis
- Plan

In addition, the auditor will comment on any clinical concerns arising from the notes review.

Instructions to audited doctor

1. Print off TWENTY consecutive records of patients **presenting for the first time** for a particular episode. Be sure to print off 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.
2. Anonymise by removing all identifying patient details, but leave clinically relevant fields visible, including ethnicity, age, and sex.
3. Please note any special or unusual features of the consultation, e.g. resuscitation case, difficult consultation, diagnosis uncertain, errors, or alternative approaches to the problem.
4. If you choose to add an optional self audit of your notes, you should review your note keeping at this stage using the self audit instructions (please link to self notes audit here) see appendix for draft self audit
5. Send to RNZCUC for independent review:

By post: RNZCUC 110 Lunn Avenue Remuera Auckland 1072 Signed-for courier is recommended to avoid loss	By email:Scan all documents.Email to: admin@rnzcuc.org.nz

Common problems with note keeping

The commonest problems are failures to record a patient's past medical history and current medications.

This is especially common in apparently-well patients with an incidental presenting complaint, and in children.

However, patients may claim to be perfectly well, but on enquiry, are taking medication, for example, for asthma and peptic ulcer disease.

In the case of infants, an additional comment on the delivery and pregnancy is expected as part of the Past Medical History.

Failure to record Allergies is another common audit finding.

Sometimes very broad or vague or unconventional diagnoses are used, e.g. 'visual problem, not related to injury' or 'Allergy'. Sometimes a symptom is recorded as a diagnosis, e.g. 'sore throat'. This is seldom acceptable. Occasionally, a diagnosis is not recorded at all.

In many cases the audited doctor appears to have a haphazard approach to note-keeping, with information found in different places in different cases, and often not recorded. In some cases, it seems that if the nurse does not record data, such as PMHx, usual meds and allergies, it is not recorded at all.

Such notes are very hard to follow and call the doctor's clinical methods into question.

Coping with poor facility note-keeping systems

A poor template and / or poor systems encourage poor note-keeping and poor practice. RNZCUC encourages urgent care physicians to pass on any concerns they have to RNZCUC and to their facility management.

When a facility's note-keeping template is defective or missing, you may be able to create your own using the facility software – for example, a keyboard shortcut that produces the text 'Past Medical History: Medications: Allergies:"

In many facilities, the nurse routinely records elements of history, past medical history, and basic observations. The responsibility for the medical notes remains with the doctor, and RNZCUC encourages doctors to both check the nurse's history with the patient and acknowledge this in the notes, e.g., 'per above nurse notes, verified.' However, this should not constitute the entire history.

Sample clinical notes

An anonymised specimen clinical note follows. It is included as an example of a well-structured note-keeping system (and not for detailed scrutiny of the doctor's management). It follows a conventional format as above. All information is in the expected place (e.g. all history findings under 'history') and in the conventional order. Even though it is an incidental injury in a seemingly well person, the doctor has enquired about PMHx, regular medications and allergies.

In this doctor's audit, ALL notes followed this format. No information was omitted and it was evident that the doctor being audited had a consistent, logical and conventional note-keeping system.

Such notes are easy for another doctor to follow.

Add example here