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, either by submitting them to the College (mandated for some) or having them checking by an MD or other appropriate person.

Some doctors may, with College approval, have notes assessed at their workplace. All others are required to submit notes to the College for audit.

Workplace-assessed notes

The following may (with College approval) have their notes assessed at their workplace:

- Fellows working in an accredited Urgent Care Clinic who have been granted an exemption (use this form). The Medical Director regularly performs internal audits of note quality.
- Fellows working in other locations who have received College dispensation (use this form) for their notes to be marked by an appropriate person in the workplace.

In all cases, comments and feedback should be recorded, reviewed, and action taken to make the necessary adjustments. The feedback and actions taken (or to be taken) should be discussed at the annual conversation and may be claimed as CPD.

Those who have their notes assessed in this manner must also complete an alternative audit of your choosing as the annual audit of the recertification programme.

If the Medical Director/appropriate person feels the doctor's notekeeping is below the standard required, they may discuss their concerns by emailing dpd@rnzcuc.org.nz.

College-audited notes

The following must submit notes to the College for audit:

- Registrars (within three months of joining the training programme, and subsequently every three years unless advised otherwise by the DCT).
- Fellows who have not received College dispensation to have their notes reviewed at their workplace.
- Doctors completing a regular practice review.
- Doctors who have been told to submit notes by the PSC, DPD, EdC, or DCT.

Notes submitted to the College for audit counts as one audit for recertification purposes. Notes from telehealth consultations are not accepted for the clinical notes audit.

When submitting notes to the College for audit, they MUST be anonymised, prepared, and sent to the College 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. *See* Advice and recommendations *section below.*
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.**
    - 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.)
    - 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.
    - Scan all documents into a pdf and save in the shared folder.
    - 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.
    - Review the feedback and instructions. This includes reflection before or at the SAC.
        - What could I improve?
        - What changes should I consider so that I can make those improvements?
        - How will I know that the changes are working, and that the improvements are continuing?
        - How could the note keeping system or template be improved?

Notes audit marking

Once you have uploaded the scanned documents, and informed us, the DPD or DCT reviews your notes. They will advise you of any comments or findings.

If it is decided that they are below the standard required for an urgent care doctor, they may require that you repeat the notes audit within a few months, or again in a year.

The note keeping audit checks for the following basic elements.

Item	Pass / fail criteria	Notes
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	Includes all current meds, longterm and short term. '0' if only short term meds are mentioned.

Allergies or alerts recorded	Must be present and adequate	
Baseline recordings adequate	Case appropriate	e.g. T/P/BP in abdominal pain
Examination findings adequate	Case appropriate	e.g. neurovascular status of limb in, suspected fracture; SLR in low back pain
Diagnosis recorded	Must be present and adequate	Using conventional diagnostic terms, e.g. 'contact dermatitis L arm', and not 'rash'
Plan	Must be present and adequate	

The marker records a '1' if the record is adequate and a '0' if not. If an item was not recorded and in the opinion of the marker, not needed, the marker records a '1'.

The audited doctor is asked to supply ALL relevant records from all parts of the facility's record storage system. If information is not provided because it is recorded elsewhere on the facility's system, the marker records a '0' and suggests re-doing the audit with all the records.

The marker will record a '0' if they felt uneasy about the patient management, e.g. that important findings were not recorded, or that an important diagnosis may have been overlooked.

In addition, the auditor will comment on any clinical concerns arising from the notes review, noted patterns of missing information, etc.

Advice and recommendations

This is an example of a well-structured notekeeping 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 notekeeping system. Such notes are easy for another doctor to follow.

Admission Date: 13/10/2012
Discharge Date: 13/10/2012
Discharge Status: TREATED & DISCHARGED
Acc Number:

Reason for Admission: LAC R EYEBROW

Principal Diagnosis: laceration right face

SmokeFree Information:
Smoking status: Not Selected · Smoking advice: No
Smoking referral: null · Smoking medication: null

Additional Diagnoses/Problems:
contusion right orbit/temple

Followup:

Presenting history:

around 18 hours ago was assaulted by other people and hit with fist and possibly a ring against right face
not ko-ed; no vomiting
could walk home and slept ; had alcohol on board
denies vomiting or headache
pain right orbit and temple
Pmx: asthma
Meds: Ventolin
NKDA
o/e:
afebrile,RR16,Sats 99%
small already crusted flapwound above right eyebrow;flap already attached to underlying tissue;tender upper lateral orbital rim but not lower orbital rim
tender and bruised right temple
no infraorbital numbness
full ROM in eyes
mild subconjunctival haemorrhage right lateral eye
PEARL; vision clear, no hyphaema
no obvious bleeding in mouth or right ear; reports mild pain right temple when biting
ADT given im
flapwound cleaned and dressed-too late for stitching
started on Augmentin
x-ray facial views: no obvious #
Script: Augmentin 625mg oral tds
Ibuprofen 400mg oral prn qid

advised to see GP on Monday
advised that CT might be needed if any worsening and to come back to ED in this case
3 days off work

ACC:

Common problems

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 overly broad, 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 extremely 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.'