Generic

Internal Audit Clinical Tool (IACT)

June 2017

IACT Background

The IACT was developed in a project with East Grampians Health Service and the Victorian Managed Insurance Authority (VMIA).

IACT Content

The generic IACT provides the basis for an internal audit of any clinical program or service. The IACT will require modification in terminology and scope to suit the context in which it will be used. The IACT comprises four sections:

1. Quality Systems Evaluation – a review of the implementation of the main quality systems of service delivery in the clinical area.
2. Clinical Process Evaluation- a review of the documents that support clinical processes in the clinical area.
3. Clinical Data Review – a review of patient related data routinely monitored and analysed by the organisation for quality improvement purposes in the clinical area.
4. Patient Record Review – a review of patient records for appropriate clinical processes required in all patients and specific clinical processes required in defined sub populations.

Using the IACT

The IACT is used by an internal auditor with an independent clinical expert appointed by the health service. The complete tool can be used for a comprehensive review of the area or select criteria to focus in on areas of risk (for example: assessment or discharge and outcomes). The scope of the audit the number of criteria and the patient groups are agreed by the team before starting. Part 4 of the IACT can be applied to all patient populations in the service/unit and/or higher risk-complex sub populations.

The IACT columns as follows

* *Criteria*: Definition of what is being measured
* *Desired processes to address criteria*: Lists the processes that are examined to provide evidence of meeting the criterion
* *Evidence to support processes*: Lists the possible sources of evidence used to determine if the process for each criterion are present. Additional evidence may be sought by the audit team
* *Method of data collection*: Lists possible methods of collecting evidence related to each process
* *Phase*: Suggestions as to whether the evidence could be reviewed onsite or offsite. This assists in planning the requirements for pre audit offsite documentation and documentation required onsite
* *IA+/-ED expert*: Who is involved with each phase of evidence collection and review
* *Rating:* The column for recording the rating of the evidence

Recording the results

This tool is used to record information from the internal audit. The ‘Evidence to Support Process’ column is populated with the evidence for each criterion.

Part 4: The patient file data from individual patient files for is documented on separate data collection sheets provided and the aggregate score for each criterion is recorded in the evidence columns in this tool. A record of the aggregate score for each criteria audited in section four **must** be made to enable the organisation to re-audit post implementation of the internal audit recommendations. Also recorded is a severity rating of the findings (see part 4 for instructions).

Criteria rating

Each organisation will have their own system of rating of controls and the priority of recommendations. In part 4 of the tool the clinical expert rates the aggregate findings in terms of severity (as described below). This allocation of rating, by the clinical experts allows the internal auditor to incorporate clinical findings and recommendations from Part 4 into the final audit report.

Severity rating for Part 4

For each of the aggregate criterion results the clinical expert (with the assistance the internal auditor if required) makes a severity rating in terms of therisk, the omissions in care or documentation, represent to the organisation and the urgency with which it is required to be addressed.

The rating scale used needs to be confirmed by the internal auditor suggested is to follow the form of *high, medium* and *low* ratings based on consideration of the following criteria:

* likelihood of the error to potentially cause signiﬁcant harm
* the likelihood to expose the health service to successful litigation
* urgency with which it needs to be addressed by the organisation

This first section of the IACT is used to evaluate the implementation and effectiveness of all (or selected parts depending on the scope of the audit) of the organisation wide quality structures and systems that support quality care and control risk in the service/unit.

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| --- | --- | --- | --- | --- | --- |
| CRITERIA | DESIRED PROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA+/-CLINICAL EXPERT |
| **POLICIES AND GUIDELINES** | | | | | |
| 1. Service/Unit level policies and procedures guide appropriate delivery of care through the client pathway | 1. Periodic monitoring of compliance with Service/Unit level policies and procedures, protocols occurs through audit or other evaluation processes | *Audits and Clinical audit schedules and reports*  *e.g. Documentation schedules and individual audit reports* | *Staff Interview,*  *Document Review* | *Offsite/Onsite* | IA |
| 1. Policies, procedures and protocols are regularly reviewed/updated | *Clear process documented for regular review of policies, procedures and protocols*  *Sample of policies and procedures have last review date and next review date documented*  *(\*record evidence in worksheet)* | *Document review* | *Offsite* | IA |
| 1. A clear process by which Service/Unit policies and procedures are distributed to and understood by employees. | *Clear process documented for distribution and staff acknowledgement e.g. employee acknowledgment of* *their receipt of the information, confirmation that they have read it and understand it,* | *Staff interview*  *Document review* | *Onsite* | IA |
| **WORKFORCE** | | | | | |
| 1. New staff receive appropriate orientation to the Service/Unit | The Service/Unit has orientation guidelines, procedures, checklists and logs to ensure comprehensive orientation for the clinical workforce in key areas identified through a risk based approach | Service/Unit *orientation procedures, guidelines, checklists*  *Sample of staff have orientation to* Service/Unit *recorded in appropriate documentation/log*  *(\*record evidence in worksheet)* | *Staff interview*  *Document review* | Offsite/Onsite | IA |
| 1. Individual scope of practice is defined and periodically reviewed | The scope of practice of individual staff in Service/Unit is documented and there is evidence of regular review after recredentialling | *Log of scope of practice or*  *addendum to position description documenting approved scope of practice such as:*   * *(list procedures specfic to service/unit that require approval and credentialling check prioir to being included in indivdiual scope of practice e.g. procedural sedation)* | Document review | Onsite | IA + Clinical Expert |
| 1. New staff have appropriate skills and knowledge of maternity services | New staff undergo initial credentialling [[1]](#footnote-1) to ensure skills and knowledge are current and approriate to the individual scope of practice | *Credentialling policy/procedure*  *Audit of new staff personnel files for initial credentialling including:* | Document review | Onsite | IA and Clinical Expert |
| 1. Existing staff are competant to undertake their defined scope of practice | Periodic re credentialling of staff occurs to ensure skills and experience are appropriate to deliver defined scope of practice | *Evidence of system to periodically review currency of training, qualifications, registration, experience and currency of skills required to deliver defined scope of practice*  *Includes all visiting staff*  *Service Unit requirements include:*   * registration status and any restrictions of scope of practice * review of recent practice * review of current organisaton mandatory training | Document review | Onsite | IA+ Clinical Expert |
| 1. Staff undertake professional development relevant to the Service/Unit and their individual scope of practice | 1. The Service/Unit has an education plan based on:    * Type and frequency of competency based requirements for Service/Unit and    * needs analysis of staff    * and consideration of presentation risks | *Service/Unit Education Plan which includes at education to be provided by the organisation and the frequency required (e.g. annual)*  *Regional collaboration agreement re access to education* | Document review, staff interview | Onsite | IA and Clinical Expert |
|  | 1. The education program is periodically evaluated | *Education evaluation, analysis and recommendations*  *Frequency of evaluation* | Document review | Offsite | IA |
|  | 1. Individual professional development for Service/Unit is planned and implemented | *Professional Development Plans in Personnel file*  *% of sampled staff with service /unit specific qualifications*  *(\*record evidence in worksheet)* | Document review | Onsite | IA and Clinical Expert |
| 1. The Service/Unit periodically reviews the scope of services provided | The conditions under which specific diagnostic groups will be transferred or admitted from the Service/Unit have been clearly defined in documentation | *e.g. Service/Unit Admission Policy* | Document review | Offsite | IA+Clinical Expert |
| 1. Appropriate levels of staffing in the Service/Unit | The rosters demonstrate appropriate staffing in Service/Unit with respect to medical, nursing, administrative and other personnel. |  | Document review  Staff interview | Onsite | Clinical Expert |
| 1. Appropriate access to specialist consultation | The rosters demonstrate there is appropriate access to specialist consultation | *e.g. 24 hour access to general surgery, orthopaedics, general medicine, anaesthesia, intensive care and paediatrics*  *Evidence of contact list for external specialists*  *Regional collaboration agreement re access to specialists/telemedicine* | Document review | Onsite | Clinical Expert |
| 1. Appropriate access to support services | The rosters demonstrate there is appropriate access to support services | *e.g. 24 hour per day access to pathology, radiology and operating theatres* | Onsite  Document review | Onsite | Clinical Expert |
| 1. Staff culture in the Service/Unit is at an acceptable level | Workforce Culture at the Service/Unit level is assessed, analysed and responded to | *Workforce culture evaluation and analysis may include :*   1. *Staff satisfaction evaluation and analysis for Service/Unit* 2. *sick leave rate analysis for Service/Unit* 3. *turnover rate analysis for Service/Unit* | Offsite  Document review | Offsite/Onsite | IA |
| **RISK MANAGEMENT** | | | | | |
| 1. Risk identification and assessment occurrs regularly | 1. The Service/Unit undertakes the identification and analysis of risks (including clinical) | *Risk profile or register for Service/Unit includes clinical risks* | Review risk register | Onsite | IA |
|  | 1. A risk based methodology is applied to the approval of new procedures and equipment, within the Service/Unit | *Applications for use of new equipment/procedures with evidence that a risk assessment has been undertaken* | Staff interview. Document review | Onsite | IA+  Clinical Expert |
| 1. Monitoring of risk occurs regularly | 1. Service/Unit risks that have been identified as requiring action have assoIACTed action plans with strategies for risk reduction, timelines and responsibilities |  | Document review | Onsite | IA |
|  | 1. Risk rating of identified Service/Unit risks changing over time (mitigating) | *Risk register shows progression of risk management* | Document review | Onsite | IA |
|  | 1. Service/Unit Risk escalation is consistent with the organisation’s risk management framework | *Evidence if risk escalation to appropriate position* | Document review | Onsite | IA |
| 1. Controls put in place to manage key risks are monitored for effectiveness | Testing of contols identified in risk assesssment (procedures, clinical guidelines compliance) occurs periodically | *Audit occurs against known high risks* | Document review | Onsite | IA+Clinical Expert |
| 1. Risk reporting and communication is effective | 1. The risk profile of the Service/Unit is reported to relevant risk committee | *Periodic risk profiling and reporting* | Document review | Offsite | IA |
|  | 1. Communication to staff occurs regarding key Service/Unit risks and emerging risks and management strategies (minutes, agendas, bulletins) |  | Staff interview, document review | Onsite | IA |
|  | 1. There is clear ownership of risk management through allocation of risk portfolios to Service/Unit staff | *Risk register demonstrates risk ownership* | Document review | Onsite | IA |
| 1. All incidents and near misses are reported, appropriately documentated and managed | 1. Service/Unit incidents, adverse events and near misses are recorded in the incident system | *Review of incident register*  *Review of audits from patient file review for coverage of all incidents* | Incident database review | Onsite | Clinical Expert |
| 1. Management are able to track the incident trends in the Service/Unit and there is evidence of action taken | *Incident reporting finding trends data over 3yr period* | Report review | Onsite | Clinical Expert |
|  | 1. Service/Unit Staff are familiar with the process for reporting incidents and for open disclosure |  | Staff interview | Onsite | IA+Clinical Expert |
|  | 1. Root casue analysis of serious incidents or adverse events is undertaken in the Service/Unit | *Sample of highest category incidents have had root cause analysis undertaken*  *(\*record evidence in worksheet)* | Report review | Onsite | Clinical Expert |
| **QUALITY IMPROVEMENT** | | | | | |
| 1. Responsibility for quality improvement is clearly assigned in the Service/Unit | All relevant responsbilities for quality have been allocated in Service/Unit and individuals understand and enact their responsbilities in relation to quality | *e.g. Responsibilities for*   * *quality plan oversight and implementation* * *Audits and Clinical audits* * *Monitoring and reporting on quality* * *Development of clinical pathways* * *Sentinel event monitoring* * *Complaint investigation and resolution* | *PD’s of managers and staff,*  *Staff interview* | *Offsite/ onsite* | IA |
|  |
| 1. The accountability and reporting mechanisms for quality of care in the Service/Unit are documented and followed | 1. Clear accountabilities for the service quality of care are reflected through relevant metrics/reports provided in line with a reporting framework to the board, relevant committees and management in relation to the Service/Unit quality of care? | *Evidence of scheduled reports or reporting framework with specification of reporting frequency, accountability and responsibility. Data reported may include:*   * *Mandatory indicators - Victorian Minimum Dataset and SOP KPI’s* * *non mandatory indicators– ACHS Clinical Indicators* * *Clinical audit reports* | Document review | Onsite | IA+Clinical Expert |
|  | 1. Data is used to improve processes in the Service/Unit | *Reports and minutes to committee show monitoring data over time and improvement in processes as a result of monitoring* | Document review  Staff interview | Onsite | IA and Clinical Expert |
|  | 1. There is a process in place and regular meetings to feedback results of any monitoring or audits and any action arising to Service/Unit staff | *Reports and minutes , newsletter demonstrate communication to staff in relation to monitoring and related quality improvement actions* | Document review  Staff interview | Onsite | Clinical Expert |
| 1. Quality improvement is a planned coordinated activity | There is a quality improvement plan for the Service/Unit that has:   * clear links to whole of hospital strategic quality initiatives * timeframes, responsibilities * evaluation * resulted in improvement | *Service/Unit quality plan demonstrating requirements that has been evaluated* | Document review  Staff interview | Onsite | Clinical Expert |
| **PATIENT EXPERIENCE** | | | | | |
| 1. Patient experience is periodically evaluated with appropriate tools in the Service/Unit according to organisation policy | The analysis of patient experience/satisfaction in Service/Unit is undertaken and analysed periodically to improve quality of care | *Recommendations from patient experience assessment implemented and evaluated e.g.*   * *Understanding of interventions* * *Understanding of discharge self-management* * *Involvement in care planning* * *Understanding of medication management* * *Understanding of follow up appointment* | Document review | Onsite | IA and Clinical Expert |
| 1. Patient complaints in the Service/Unit are resolved within organisational timelines | There is analysis and action in relation to Service/Unit complaints   * Timely response to complaints * Majority of complaints resolved   Staff are aware of the organisation’s open disclosure process | *Complaints policy and procedure*  *Analysis of complaints process effectiveness (timeliness and resolution)*  *Open disclosure policy understood by staff* | Document review  Staff Interview | Onsite | IA |
| **INFRASTRUCTURE** | | | | | |
| 1. IT systems support recording and reporting on key data | A functional electronic patient information management system that enables data reporting in Service/Unit | *A safe effective data system that allows:*   * *Timely reporting of Clinical Expert data* * *Data presented in a format that enables analysis e.g. trends* * *Secure system with password protection and timeout* | Staff Interview | Onsite | Clinical Expert |
| 1. The financial resources of the Service/Unit are managed appropriately | A departmental budget is linked to the Service/Unit operational plan (which aligns with the organisation’s strategic plan) | *Service/Unit budget with links to unit operational plan and organisational strategy* | Document review | Offsite | IA |
| 1. The infrastructure resources of the Service/Unit are managed appropriately | 1. There is an equipment maintenance register that is current | *Equipment such as:*   * *resuscitation* * *monitoring(ECG, BP, )* | Document review | Onsite | IA+  Clinical Expert |
| 1. Equipment appropriate to the service is available when needed |  | Staff interview | Onsite | Clinical Expert |
|  | 1. There is an effective system for restocking essential items |  | Document review  Staff interview | Onsite | IA |

This second section of the clinical internal audit tool is used to evaluate the appropriateness of documents (policies, procedures and guidelines) that support all (or selected parts) of the clinical related processes that control risk in the service/unit under internal audit.

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| CRITERIA | DESIREDPROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA+/-Clinical Expert |
| **ACCESS** | | | | | |
| 1. Document/s support the prioritisation of patients in a timely manner | There is a current policy/procedure for patient prioritisation which addresses the requirements for:   * A uniform approach to undertaking the assessment of priority category * How to document priority category * Any prioritisation compentency requriements for staff * Orientation to prioritisation for all new staff | *Document contains all elements* | Document Review  Staff interview | Offsite | Clinical Expert |
| **ASSESSMENT** | | | | | |
| 1. Document/s support the initial assessment[[2]](#footnote-2) of patient clinical status | There is a current procedure/protocol/template for patient initial assessment that outlines:   * key clinical observations to be recorded * Timeframes for initial assessment to be undertaken | *Document contains all elements* | Document Review  Staff interview | Offsite | Clinical Expert |
| 1. Document/s support the provision of a comprehensive assessment | There is a current procedure/protocol for patient comprehensive assessment with a minimum standard defined for comprehensive assessment including:   * Structured history * Objective examination * Timeframes for comprehensive assessment to be undertaken | *Document contains all elements* | Document Review  Staff interview | Offsite | Clinical Expert |
| 1. Patient informed consent for intervention has been obtained | There is a current policy/procedure for patient informed consent in Service/Unit that has been implemented | Policy/procedure for informed consent available and accessible  Identification of procedures requiring consent is understood by staff | Document Review  Staff interview | Offsite/Onsite | Clinical Expert |
| 1. Document/s support the periodic monitoring of patient clinical status | There is a current procedure/protocol for patient monitoring and documentation of clinical status with:   * Physiological monitoring required * Clear clinical deterioration escalation triggers * Clear requirements for use of emergency codes | *Documented process includes mechanisms for additional assistance with clinical deterioration* | Document Review  Staff interview | Offsite | Clinical Expert |
| 1. Document/s support timely medical/ specialist review | There is a current procedure/protocol outlining:   * communication of deterioration and handover protocols * timeframe for medical/speciality consultant reviews to be carried out to faciliatate treatment and discharge/disposition | *Documented process for communIACTion and handover for specialist review or*  *receiving drug order by phone* | Document Review  Staff interview | Offsite | Clinical Expert |
| 1. Document/s support the referral of patients to support services in a timely manner | There is a current procedure/protocol for referral to support services including*:*   * Pathology, Imaging, Pharmacy,Surgery,   Acceptable turnaround times |  | Document Review  Staff interview | Offsite | Clinical Expert |
| **INTERVENTION** | | | | | |
| 1. Service/Unit procedures and protocols are evidence based and reviewed periodically | Service/Unit clinical procedures and protocols reference current clinical standards and guidelines. This is supported by a system to make readily available clinical standards and guideline | *Sample of clinical procedures and protocols have clear references to clinical guidelines upon which they are based and evidence that they have been reviewed periodically e.g.*   * *Nurse initiated medication protocols* * *Airways management procedure/protocol* * *Patient transfer procedure/protocol* * *Pneumothorax procedure/protocol* * *(Specificy any condition specific protocols relevant to service/unit e.g. head injured, post surgical )*   *(record evidence in worksheet)*  *Readily available standards and guidelines include: emergency medicine textbooks, journals, Clinical management guidelines and protocols are available on site. There should also be access to electronic sources of medical information[[3]](#footnote-3)* | Document Review  Staff interview | Offsite | Clinical Expert |
| **DISCHARGE** | | | | | |
| 1. Document/s support the provision of a comprehensive timely discharge plan to all of: the person, their family and other providers involved in their care. | There is a current procedure/protocol for discharge from Service/Unit that address the requirements for:   * Safe discharge * After hours discharge * transfer to another hospital * Discharge communication * Follow up appointments * Medication reconciliation | *Safe admission policy/protocol*  *Transfer policy* | Document Review  Staff interview | Offsite | Clinical Expert |

This third section of the clinical internal tool is used to evaluate the type of patient related data that is collected and analysed in the ED/UCC for quality improvement purposes. The data is separated in to process and outcome data. The audit does not collect and verify the raw data but looks at the units own collection and analysis of this data.

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| CRITERIA | DESIRED Expert DATA TO ADDRESS CRITERIA | EVIDENCE  (record evidence sighted) | METHOD |
| **DEMAND DATA** | | | |
| 1. Admissions/demand data is collected and analysed in the Service/Unit | Total admissions | Evidence of collection and analysis of demand and peak demand times | All data reviewed onsite by Clinical Expert |
| **PROCESS DATA** | | | |
| 1. Complaints data is collected and analysed in the Service/Unit | Number and type of complaints /10,000 admissions and trend over time | Evidence of collection and analysis |  |
| 1. Incident data is collected and analysed in the Service/Unit | Number and type of incidents /10,000 admissions and trend over time | Evidence of collection and analysis |  |
| 1. Length of stay data is collected and analysed | Percentage of patients with a length of stay longer than ( specify) or average length of stay | Evidence of collection and analysis |  |
| 1. Unplanned re-attendances are monitored and analysed | Percentage of discharged patients who have unplanned re attendances within 48 hours[[4]](#footnote-4) | Evidence of collection and analysis |  |
| 1. Admission type is analysed | Presentation analysis may include:  Reason for presentation via ICD-10 diagnosis  Percentage of patients over 65 years of age | Evidence of collection and analysis |  |
| 1. Mortality data is collected and analysed in the Service/Unit | Evidence of analysis and benchmarking of mortality data  Evidence of mortality data analysis used to inform action  E.g.Percentage in hospital mortality for admissions from Service/Unit | Evidence of collection and analysis | Document review |
| 1. Infection Rate data is collected and analysed |  |  |  |
| 1. Falls data is collected and analysed |  |  |  |
| 1. Pressure area data is collected and analysed |  |  |  |
| 1. Unplanned representation/readmission rates (within 48 hours) for Service/Unit are collected and analysed | Evidence of analysis and benchmarking of data  Evidence of data analysis used to inform action | Evidence of collection and analysis | Document review |
| 1. Time to radiology services | Average time to CT  Average time to MRI  Average time to Plain X ray | Evidence of collection and analysis | Document review |
| 1. Time to Pathology Results | e.g.  Average time to ABG results  Average time to Cardiac enzymes results  Average time to FBE&UE results  Average time to Blood GROUP/cross match) results | Evidence of collection and analysis | Document review |
| 1. Functional Patient Outcomes | Measures of patient mobility/independence |  |  |

Sampling

The audit sample comprises a minimum of 10 randomly selected files for each subpopulation group selected in the scope of the internal audit with admissions in the last 12 months. All general criteria are examined on an agreed random sample of these files and the population specific criteria would be examined in all the relevant medical files of patients falling in the specified subpopulation. An additional consideration in the selection of files is to cover different shifts in the clinical area, for example some files randomly selected from the evening/night shift.

For rural health services it may not be possible to get a large numbers of cases in the specific subpopulation in the last 12 months. A minimum of 5 randomly selected files for each subpopulation group selected in the scope of the internal audit with admissions in the last 12 months. All general criteria would be examined on an agreed random sample of these files (minimum of 10) and the population specific criteria would be examined in all the relevant medical files of patients falling in the specified subpopulation.

Patient files need to be checked for suitability prior to the internal audit and there needs also to be provision made for additional files if needed at the onsite visit.

How to document data

The patient file data from individual patient files for Part 4 are documented on the separate data collection sheets for the general and sub population specific criteria. The aggregate data from all the patient records is recorded in the evidence columns in this document. In most cases the aggregate data required to be entered in this document is an indication of the total number of files that demonstrate the criterion (the numerator) over the total number of files examined (the denominator).

For some criterion the calculation of an average and or median time for an activity to occur is required. The average or mean is the arithmetic average of a set of numbers. The mean is used for values that fall in a normal distribution. The median relates to a value lying at the midpoint of a distribution of observed values. The median is generally used for skewed distributions. The mean is not a robust metric since it is largely influenced by outliers. The median is better suited for skewed distributions to derive at central tendency as it is more robust. In scoping the internal audit a decision will need to be made regarding the use of the mean or the median for criterion listed in Part 4. Generally the median is a more representative measure of the time for an activity to occur.

Assessment of Severity Rating

For each of the aggregate criterion results demonstrating a significant omission of care the clinical expert (with the assistance the internal auditor if required) needs to make a severity rating in terms of therisk, the omissions in care or documentation, represent to the organisation the and the urgency with which it is required to be addressed.

The rating scale used needs to be confirmed by the internal auditor but would generally follow the form of *high, medium* and *low* ratings based on consideration of the following criteria:

* likelihood of the error to potentially cause signiﬁcant harm
* the likelihood to expose the health service to successful litigation
* urgency with which it needs to be addressed by the organisation

Recommendations

For each of the criterion with a severity rating the clinician should provide a brief recommendation to improve practice.

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| --- | --- | --- | --- | --- | --- |
| General Criterion | No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| **ACCESS** | | | | | |
| 1. Date and time of admission is documented |  |  |  |  |  |
| **INITIAL ASSESSMENT/INITIAL CLINICAL OBSERVATION[[5]](#footnote-5)** | | | | | |
| 1. Time of initial assessment/ clinical observations commenced is documented |  |  |  |  |  |
| 1. Respiratory rate is documented |  |  |  |  |  |
| 1. Oxygen saturation is documented |  |  |  |  |  |
| 1. Heart Rate is documented |  |  |  |  |  |
| 1. Blood pressure is documented |  |  |  |  |  |
| 1. Temperature is documented |  |  |  |  |  |
| 1. Conscious state is documented |  |  |  |  |  |
| 1. (specify other relevant to service/unit) |  |  |  |  |  |
| **COMPREHENSIVE MEDICAL ASSESSMENT** | | | | | |
| 1. Documentation of date and time of comprehensive medical assessment |  |  |  |  |  |
| 1. Average and/or median time between initial assessment /clinical observation and comprehensive assessment |  |  |  |  |  |
| 1. Tailored patient assessment was undertaken and documented |  |  |  |  |  |
| 1. Tailored examinations undertaken |  |  |  |  |  |
| * Neurological |  |  |  |  |  |
| * Respiratory |  |  |  |  |  |
| * Cardiovascular |  |  |  |  |  |
| * Other relevant exams |  |  |  |  |  |
| 1. Falls risk assessment has been undertaken and documented |  |  |  |  |  |
| **DIAGNOSIS AND MANAGEMENT PLAN** | | | | | |
| 1. Differential diagnoses were documented |  |  |  |  |  |
| 1. Management plan documented |  |  |  |  |  |
| **INTERVENTIONS** | | | | | |
| 1. An appropriate clinical response and communication to recognised escalation triggers or deterioriation is documented |  |  |  |  |  |
| **MONITORING** | | | | | |
| 1. Appropriate types of monitoring of clinical condition were undertaken and documented (e.g. respiratory rate, oxygen saturation, heart rate, BP, Temp, conscious state) |  |  |  |  |  |
| 1. Frequency of monitoring occurred at reasonable time intervals (as appropriate to patient condition or as specified in Service/Unit protocol)? |  |  |  |  |  |
| 1. Documentation was made of escalation communication/use of emergency code (if applicable) |  |  |  |  |  |
| **DISCHARGE PLANNING** | | | | | |
| 1. Copy of discharge plan in records |  |  |  |  |  |
| 1. If transfer indicated , appropriate transfer documentation is recorded |  |  |  |  |  |
| 1. Date and time of discharge documented |  |  |  |  |  |
| 1. Date and time of discharge plan documented |  |  |  |  |  |
| 1. Record of follow up appointment date and time in discharge plan |  |  |  |  |  |
| 1. Record of Medication prescribed and reconciliation in discharge plan |  |  |  |  |  |
| 1. Interventions provided in Service/Unit recorded in discharge plan |  |  |  |  |  |
| 1. Key contacts recorded in discharge plan |  |  |  |  |  |
| 1. Self management strategy recorded in discharge plan |  |  |  |  |  |

This next section of the patient record review examines criteria in specific sub populations. The subpopulation included in the audit and the sample size would be confirmed in the planning process and scoping of the internal audit. An example of criteria developed for a high risk population is shown below.

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| --- | --- | --- | --- | --- | --- |
| Population:  For example altered conscious state | Number of patients who meet criteria (Numerator) | Total number  of patient files examined  (Denominator) | Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| 1. Glasgow coma scale undertaken and documented |  |  |  |  |  |
| 1. Pupillary size and reaction to light documented |  |  |  |  |  |
| 1. Orientation to person, place and time documented |  |  |  |  |  |
| 1. Behaviour documented |  |  |  |  |  |
| 1. Post traumatic amnesia ( tested via A-WPTAS) documented |  |  |  |  |  |
| 1. Blood Sugar level documented |  |  |  |  |  |
| 1. CT/MRI ordered where indicated |  |  |  |  |  |
| 1. Average and/or median time from patient presentation to CT/MRI (ASAP but less than 24hr) |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| Population:  Additional specific population agreed with organisation | Number of patients who meet criteria (Numerator) | Total number  of patient files examined  (Denominator) | Percentage  (Numerator/ Denominator  x 100) | Average and Median Time | Assessment of severity rating  (high, medium and low) and Recommendations |
| Agreed criteria for population  (e.g. % patients over 65 years, paediatric, obstetric, infectious patients) |  |  |  |  |  |

1. Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments. [↑](#footnote-ref-1)
2. Initial assessment refers to the time at which an ED/UCC observation chart is created [↑](#footnote-ref-2)
3. Royal Children’s Hospital Clinical Practice Guidelines <http://www.rch.org.au/clinicalguide/>, NHMRC Clinical Practice Guidelines Portal <http://www.clinicalguidelines.gov.au/> [↑](#footnote-ref-3)
4. DH Redesign Hospital Care program, National Partnership Agreement Key Performance indicator C43 [↑](#footnote-ref-4)
5. Initial assessment refers to the time at which an ED/UCC observation chart is created [↑](#footnote-ref-5)