APPENDIX 1

ESSEX PARTNERSHIP NHS FOUNDATION TRUST		
Audit of Health Records – Part A		
Service:	***Ward/Team:***	***Record ID:***
Auditors:	***Date:***	***Period Covered By Audit: (suggest last six months)***

Is the following information clearly documented in the notes?

1. Initial details:	**YES**	**NO**	**PARTIAL**	**NA**	**COMMENTS**
Name of client/patient on every page					
Gender					
Address					
Postcode					
Telephone No.					
Date of birth					
GP					
Religion					

Ethnic origin					
Occupation					
First language (where this is not English)					
Confidentiality issues e.g. No correspondence home; share information about client with others (or not)					
Source of referral					

2. Is there evidence of:	YES	NO	PARTIAL	NA	COMMENTS
Diagnosis					
Reason for admission/referral/ visit					
Communication with GP					
Copies of communication with GP sent to patient					
Initial history					
Initial physical examination					
Regular progress notes/observations/reports					
Legal status as defined in the MH Act 1983					
Diagnostic tests being ordered					

Diagnostic test results recorded e.g. microbiology, pathology, X ray etc.					
Patient/ client informed of test results					
Consent to treatment (as appropriate)					
Identification of follow on care					
Medication records – are they up to date, and authorised according to service standards					
System for 'alert' notation in place e.g. for violence, allergies, suicide and self harm					

3. Discharge:	YES	NO	PARTIAL	NA	COMMENTS
Is there a copy of the discharge plan					
Has the appropriate communication been actioned for other professions and agencies e.g. Social Services, Carer and Allied Health Professionals					
Is there a copy of the discharge summary and letter					
Has the discharge information been communicated to the GP					

4. Record entry	YES	NO	PARTIAL	NA	COMMENTS
Entries in the record are dated					
Entries in the record where appropriate should be timed as well as signed. *(Nursing records should be signed and timed to ensure they are contemporaneous)*					
Entries in the record are signed					
Entries in the record give designation of signatory					
All entries are made in black ink					
Abbreviations and symbols are kept to the minimum					
All typed notes are signed by their author within a specified time as agreed					

4. Record Entry	YES	NO	PARTIAL	NA	COMMENTS
Record errors are scored through once with a single line					
Additions are dated					
Additions are timed					

Additions are signed					
Is a line drawn through the empty space at the end of the report (*this is to discourage additions being entered at a later date)*					
Are records in chronological order and numbered					
Are records locked in a secure environment					
Has Tippex been used *(in no circumstances should it be used)*					
No spaces or missed lines					
No extra words squeezed in					
No ditto marks used					
Are any offensive comments about user/carer recorded *(use individual judgement)*					

Auditors are encouraged to add any additional comments or information that may contribute to the improvement of / or content of records

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Audit of Health Records – Part B

	BENCHMARKING STANDARDS	YES	NO	COMMENTS
1.	Access to current health care records *(patients clients are **able** to access all their current records if and when they choose to)*			
2.	Integration – patient professional partnership *(patients/clients are **actively involved in continuously negotiating** and influencing their care)*			
3.	Integration of records – across professional and organisational boundaries *(patients /clients have a **single structured, multi-professional/ agency** record which supports integrated care)*			
4.	Holding life long records *(**Patients/clients hold** a single life long/multi-professional /agency record)*			
5.	High quality practice –evidence based guidelines *(Evidence based guidance detailing best practice is available and has an **active and timely review process**)*			

6.	High quality practice *(Patients clients records demonstrate that their care* ***follows evidence based guidance or supporting documents*** *describing best practice, or that there is an* ***explanation of any variance****)*			
7.	Security/confidentiality (***Patient/clients records are safeguarded*** *through* ***explicit*** *measures with an active and timely review process)*			
8.	Can you identify potential barriers where access to health records in the format that is relevant to the individual is not possible (*e.g. patients clients who are suffering from a sensory disability, for example blindness or deafness, patients clients who have a limited capacity to e.g. read or understand information)*			