Documentation Audit Tool

Evaluation of Emergency Nurse Practitioner's Clinical Case Notes

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DAT Reference Number ☐☐☐

Guidance Notes
Documentation Audit Tool (DAT)

Background
The tool (DAT) has been developed to rate the clinical notes of Emergency Nurse Practitioners and A&E Senior House Officers. DAT is designed to measure the number of essential items of information (or criteria) which have been recorded in the notes of certain types of *minor injury*.

These items of essential information have been chosen by a panel composed of A&E consultants, middle grade A&E doctors and emergency nurse practitioners. The criteria listed in the tool are the items of essential information the panel felt should *always* be recorded in the clinical notes of the different types of minor injury.

Layout of documentation audit tool
The items of information have been grouped into sections. These sections relate to the different types of minor injuries the ENPs and SHOs treat. The sections have been colour coded to make it easier to use the tool. Not all sections will be relevant to all notes. The sections are:

- Section 1 - Core criteria - *for use with all notes*
- Section 2 - Investigations, medication and discharge
- Section 3 - Wounds & Burns
- Section 4 - Limb injuries - i.e. Sprains, strains and fractures etc.
- Section 5 - Minor head injuries

Section 1 is used with all notes. Section 2 will have certain sections relevant to many notes and sections 3-5 will be used only when the notes detail these types of injury. Each section contains a number of *groups of criteria* that are for more specific types of injury. Not all groups of criteria in any one section will always be applicable. Instructions on the use of any particular group of criteria are given in each section.

As you would expect certain types of injury warrant more detail written in the notes than others. For example minor head injuries have eleven criteria that should always be recorded in a head injury whereas a minor burn only has five criteria listed.

Using the Documentation Audit Tool
To use the Documentation Audit Tool, read the notes and decide which sections of the tool are necessary for auditing a particular set of notes. The core criteria listed in section 1 will always be applicable.

Further sections may be relevant depending on the type of injury. Within sections there are further groups of criteria that are specific to certain types of injury. Groups of criteria with grey shading in the heading can be used on their own. Groups of criteria with no shading must always be used in conjunction with a proceeding group. *Specific instructions are written by each group of criteria. All will hopefully become clear on using the tool!*

A separate score sheet is included to record the total scores for each of the relevant sections and groups of criteria. Please write the 'DAT reference number' on the top of the score sheet and on the front of the DAT booklet. This number can be found highlighted on the front of the A&E notes.

Go through each group of criteria you have chosen to use and tick the appropriate box if the information is present. It is hoped that the tool is fairly objective, however for several of the criteria a subjective clinical judgement may need to be made. For example, surrounding the accuracy of the time of injury or the detail about the exact location of a wound. The importance of the level of accuracy will depend on the specific injury and other information recorded in the notes. This is where your clinical experience and judgement will be needed. After completing each section enter the total score for each group onto the score sheet.

The total score given to a set of notes will be calculated from the maximum possible score available in each of the sections and groups of criteria you have used.

Finally, as the notes are copies of the original A&E notes some have notes written in the clinics or notes written by the clinician who accepted the referral. This information should not be reviewed, as the tool is designed to measure the quality of the notes written by the ENP or SHO who originally saw the patient. The information has, however, been left in the copies of the notes to allow you to see the record in its entirety.

If you have any queries please do not hesitate to get in touch. As this is the final stage of development of the tool I would be extremely interested in any comments you have regarding problems you've experienced using the tool or any suggestions you have for improvements which could be made. I apologise about it's bulky nature and its apparent complexity. However, I hope you will agree that once you've used it a couple of times it is fairly straightforward.

To calculate final score

Add up the total number of criteria correctly documented in the notes [Total score]. Add up the maximum possible score for that particular set of notes (i.e. the maximum score in each of the groups of criteria used in each section) [Maximum possible score].

Divide the *total score* by the *maximum possible score* and multiply by 30. This will give you your final score for that set of notes.

Good luck!

Section 1 - Core criteria

The core criteria must be used for all notes

Core criteria - ALL NOTES	
Demographic criteria	*Tick if present*
The A&E number on every page *(i.e. on each sheet on the notes)*	☐
The patients name on every page *(i.e. on each sheet on the notes)*	☐
Date of birth	☐
Gender	☐
Address *or documented 'No fixed Abode'*	☐
Area of residence code (i.e. Postcode –*at least first part*)	☐
A person to notify in an emergency (next of kin) *or documented 'no next of kin'*	☐
The patient's General Practitioner *or documented 'No GP'*	☐
The time the patient books in (including the date)	☐
The time the patient is seen by the triage nurse	☐
General Criteria	
The time the patient is first seen by a doctor or ENP	☐
Notes are legible *(i.e. the reviewer is able to read!)*	☐
Only appropriate abbreviations used *(Listed on page 12)*	☐
No personal comments have been made	☐
Notes have been signed by the clinician	☐
The time of injury or onset of illness/condition *(detailed enough to be clinically relevant)*	☐
The mechanism of injury is documented	☐
Details of physical examination are documented	☐
Final diagnosis	☐
Arrangements for follow-up/referral/discharge	☐
The name of the doctor or ENP should be clearly documented	☐
Total	☐☐/21

Section 2 - Investigations, medication and discharge

Investigations

Use these criteria whenever any investigations have been conducted

All Investigations (e.g. X-rays, ECG, Blood tests etc.)	*Tick if present*
Any investigations that are performed are listed	☐
All results of investigations (if conducted)	☐
Total	☐/2

X-rays

Use these criteria whenever x-rays have been taken and show a fracture or dislocation

Only X-rays with fractures or dislocations	*Tick if present*
The location of any fracture should be clearly described	☐
The type of fracture	☐
Any displacement should be documented *if no displacement this should be stated*	☐
Any angulation should be documented (if present) *if no angulation this should be documented (e.g. in alignment)*	☐
Total	☐/4

Use this criterion only when displacement of a fracture is mentioned use in conjunction with the above criteria on x-rays which show fractures and dislocations

Displaced fractures	*Tick if present*
The type of displacement should be documented	☐
Total	☐/1

Medication

*Use these criteria whenever a drug has been administered **excluding local anaesthetic**. If several drugs have been administered then the box can only be ticked if the information is present for all of the drugs.*

Medication administered	*Tick if present*
The name of the drug(s)	☐
The dosage(s) prescribed	☐
The frequency of administration	☐
The duration the medication(s) should be taken or the total amount of medication given	☐
Any allergies the patients has, if none then this should be recorded	☐
The route of administration	☐
Total	☐/6

Discharge

Discharge criteria should be used for all notes where the SHO or ENP has discharged the patient from the department.

Do not use if the patient was directly referred to another clinician whilst in A&E or admitted.

Discharge criteria *(only if SHO/ENP has discharged the patient)*	*Tick if present*
The advice given to the patient is documented in summary form	☐
A letter to the GP	☐
Total	☐/2

Section 3 - Wounds & Burns

Wounds

These criteria should be used in all cases where a wound is mentioned excluding burns (there are separate criteria for burns and scalds listed on the next page)

Wounds *(Excluding burns)*	*Tick if present*
The tetanus immunisation status of the patient	☐
The type of wound	☐
The location of wound *including the side of the body (description or diagram)*	☐
The direction and shape of the wound *(description or diagram)*	☐
The size (i.e. length/width) of the wound	☐
Nerve and tendon function distal to the wound	☐
Details of any contamination or infection of the wound	☐
Total	☐/7

Use this criterion along with the previous group on wounds, for wounds with potential foreign bodies

Wounds with potential Foreign bodies	*Tick if present*
Consideration for x-ray should be documented in cases where a FB may be present	☐
Total	☐/1

Use this criterion along with the previous group on wounds for which have needed suturing

Sutured wounds	*Tick if present*
What cleaning was done	☐
Number of sutures	☐
The length of time sutures should remain in situ	☐
Instructions on removal of sutures *e.g. where to get sutures removed i.e. GP*	☐
The type of local anaesthetic used *(includes strength if relevant)*	☐
The volume of local anaesthetic used	☐
Total	☐/6

Burns

Use these criteria for all burns and scalds only- there are separate criteria for all wounds created by different mechanisms of injury

Burns and scalds	*Tick if present*
What first aid / other treatment has already been performed	☐
The location of burn on the body *including the side of the body (description or diagram)*	☐
The size of burn	☐
The depth of burn	☐
The tetanus immunisation status of the patient	☐
Total	☐/5

Use this criterion, plus the above criteria on burns, if the burn was sustained in a house fire

Burns caused in house fires	*Tick if present*
In 'house fires' whether there is any evidence of inhalation of smoke or fumes	☐
Total	☐/1

Section 4 –Limb injuries (Sprains, strains and fractures etc.)

All Limb Injuries

Use the following criteria for all limb injuries - addition criteria follow for various upper and lower limb injuries

All limb injuries	*Tick if present*
The point of maximum tenderness	☐
The function of the limb	☐
The side of the injury (Left or Right)	☐
Total	☐/3

Use this criterion along with the criteria on limb injuries for any injuries that involve joints

Joint Injuries	*Tick if present*
The presence or absence of any swelling or effusion	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries for any fractures or dislocations

Fractures or dislocations	*Tick if present*
Examination of distal circulation and sensation	☐
Total	☐/1

Now go to:-

Page 8 *for further criteria on* ***upper limb injuries***
Page 9 *for further criteria on* ***lower limb injuries***

Further Criteria for Upper limb injuries

Use this criterion along with the criteria on limb injuries for any injuries that involve fingers

Finger Injuries	*Tick if present*
The digits should always be named and never numbered	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries for any injuries that involve thumb injuries with no fracture

Thumb Injuries with no fracture	*Tick if present*
If thumb injury, stability of thumb joint(s) (if fracture excluded)	☐
Total	☐/1

Use these criteria along with the criteria on limb injuries for any injuries that involve wrist and/or forearm injuries

Wrist and forearm injuries (traumatic)	*Tick if present*
In traumatic injuries to the forearm examinations of elbow, wrist and radio-ulna joints should be conducted and documented	☐
The anatomical snuff-box should be palpated and findings documented	☐
Total	☐/2

Further Criteria for Lower limb injuries

Use this criterion along with the criteria on limb injuries for any injuries that involve injuries to the lower limb(s)

Lower limb injuries	*Tick if present*
The patient's ability to weight bear	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that are non-weight bearing

Non-weight bearing injuries	*Tick if present*
Consideration for an x-ray if can't weight bear or an x-ray	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that involve toe injuries

Toe Injuries	*Tick if present*
The toes should be identified correctly	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that could include a possible Achilles tendon injury

Possible Achilles tendon injury	*Tick if present*
If there is any possibility of an Achilles tendon injury, Simmond's test should be performed	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that involve a fractured upper fibula

Fractured upper fibula	*Tick if present*
The popliteal nerve should be examined in all cases with a fracture of the upper fibula	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that involve a forefoot injury in patients with a documented history of peripheral vascular disease

Forefoot injuries with a history of PVD	*Tick if present*
If there is a history of peripheral vascular disease then distal pulses should be recorded	☐
Total	☐/1

Use this criterion along with the criteria on limb injuries and the criterion on lower limb injuries for any injuries that involve non-traumatic calf pain

Non-traumatic calf pain	*Tick if present*
Documentation should reflect the fact that a DVT has been considered	☐
Total	☐/1

Section 5 – Minor Head Injuries

Minor Head Injuries

Use these criteria whenever a minor head injury has been sustained

Minor head injuries	*Tick if present*
Any loss of consciousness. If no loss of consciousness this should be recorded	☐
Any change in consciousness/drowsiness should be documented	☐
Any nausea or vomiting should be inquired about and recorded	☐
Any headache should be inquired about and documented	☐
The GCS	☐
Any associated wounds, bruises etc.	☐
Any signs of a basal skull fracture? should be looked for	☐
Whether a responsible adult is able to care for the patient overnight	☐
Enquiry and documentation of post traumatic amnesia	☐
Examination and documentation of pupils	☐
Enquiry and documentation of any visual disturbance	☐
Total	☐☐/11

Acceptable abbreviations

#	Fracture
ACJ	Acromio-clavicular joint
AF	Atrial fibrillation
ATT	Anti tetanus toxoid
Bk PoP	Below knee plaster of Paris
C/O	Complaining of
CN	Cranial nerves
CP	Chest pain
CSM	Circulation Sensation Movement
D/W	Discussed with
DIPJ	Distal interphalangeal joint
DOA	Dead on arrival
EMV	Eyes Motor Vocal
F/U	Follow up
FB	Foreign body
FROEM	Full range of eye movements
FROM	Full range of movement
FWB	Fully weight bearing
FXR	Facial x-rays
GCS	Glasgow Coma Scale
HI	Head injury
LBBB	Left bundle branch block
MCPJ	Metacarpo phalangeal joint
MI	Myocardial infarction
MTPJ	Metatarsal phalangeal joint
NAD	No abnormality detected
NBI	No bony injury
NOF	Neck of femur
NSAID	Non steriodal anti-imflammatory drug
NT	Non tender
OD	Overdose
PED	Pedestrian
PERLA	Pupils equal and reactive to light and accommodation
PIPJ	Proximal inter phalangeal joint
POP	Plaster of Paris
PTE	Pulmonary thrombo embolism
PWB	Partial weight bearing
RBBB	Right bundle branch block
ROS	Removal of sutures
RTA	Road traffic accident
SCH	Sub conjuctival haemorrhage
SIJ	Sacro-iliac joint
SLR	Straight leg raising
UAP	Unstable angina pectoris
UTD	Up to date
VF	Ventricular fibrillation
VT	Ventricular tachycardia