# 7 Client Records Review Tool

### Guidance notes

Select a **minimum** sample of 20–25 client record files from all service sites using a randomised method. Systematic sampling uses every nth case (eg, every 10th case). Choose the starting point at random (eg, based on a random number between 1 and 10; use a calculator or computer to ascertain this starting number). It may also be important to specify certain conditions for the sample. For example, to represent Māori appropriately, you can separate the cases into two groups: Māori and non-Māori, and sample from each group at random. If the selection does not include at least one file from each staff member, then add files, using the same randomised process, from the list until you have the appropriate range.

You might also need to consider sampling records of:

* clients who are relatively new to OST
* medium and longer-term clients
* clients who have been discharged from treatment and/or transferred within the past two years
* clients who have been comprehensively assessed and have not been admitted to treatment due to exclusion criteria.

Under the terms of the Health Information Privacy Code 1994, clinical and quality audits are deemed to be a legitimate use of personal health information.

Good practice includes informing the clients of the audit and the purpose for reviewing client records. In addition, in each file reviewed, insert a note advising of the audit. At the next contact with the client concerned, a staff member will provide the client with information on the purpose of the audit.

In addition the audit team should observe the following:

* **No client files are to be taken from the service.**
* No personal health information obtained from a client’s record review is to be used for any purpose other than the audit.

(Use one sheet to record the audit results for each record.)

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| **Audit number:** |       |
| **Audit date:** |       |
| **Auditor:** |       |

| **Requirement** | **Attainment** | **Risk** | **Comment** |
| --- | --- | --- | --- |
| National Health Index (NHI) number |       |       |       |
| Demographic information |       |       |       |
| Consent forms (informed consent for treatment, disclosure of personal information, etc) |       |       |       |
| Comprehensive assessment |       |       |       |
| Diagnosis of opioid dependence |       |       |       |
| Initial treatment plan: recovery orientated and appropriateness to client aims; has realistic goals with timeframes, strengths and needs |       |       |       |
| Initial medication dose within recommended range |       |       |       |
| Family/support people involved |       |       |       |
| Information provided to client (and support people) |       |       |       |
| Nominated GP |       |       |       |
| Nominated key worker |       |       |       |
| Prescriber |       |       |       |
| Date treatment commenced |       |       |       |
| Medication dose |       |       |       |
| Dispensing arrangements |       |       |       |
| Pharmacy: name, address, telephone number and fax number and email address |       |       |       |
| Current treatment plan |       |       |       |
| Record of reviews by the prescriber |       |       |       |
| Record of regular monitoring of progress by the key worker in relation to short- and longer-term treatment plans and updated risk assessments |       |       |       |
| Progress notes record ongoing contact with the client and, where possible, significant others/whānau and other providers (including the GP and pharmacist) and interventions implemented in keeping with the current treatment plan |       |       |       |
| Evidence that the client and, where possible, significant others/whānau and other providers involved in the treatment plan (including the GP and pharmacist) reviews the treatment progress |       |       |       |
| Perceived risk, including criminal behaviour and forensic history |       |       |       |
| Summaries of treatment progress |       |       |       |
| Key worker and prescriber reviews at required frequency |       |       |       |
| GP authorisation forms, for those in GP shared care |       |       |       |
| Treatment review forms |       |       |       |
| Record of transfers or refusal of transfers and related factors |       |       |       |
| Any restriction notices under section 25 of the Misuse of Drugs Act 1975 or section 49 of the Medicines Act 1981 (or other relevant legislation) |       |       |       |
| Discharge date; factors involved in any involuntary discharge as appropriate |       |       |       |
| Client records organised in a clear, consistent and logical manner |       |       |       |
| Notes securely stored |       |       |       |
| Key information readily accessible |       |       |       |
| Staff members involved can be clearly identified |       |       |       |

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| **Summary** |
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