Youth School Based Health Services Documentation Audit Tool

Auditee: Auditor:

NHI/student ID							
Date on notes							
Presenting concern and history is documented thoroughly and accurately (including relevant medical/psychosocial history)							
Nursing assessment is documented thoroughly and accurately (including vital signs, findings of physical assessment, mental health assessment as appropriate)							
Evidence of red flags ruled out							
Nursing care planned, provided and offered is documented thoroughly and accurately (including mental health support provided and education)							
Correct documentation of any medication given (including name, dose, route, time, allergies)							
Evaluation of care provided clearly and accurately documented.							
Follow up and referrals clearly documented							
Designation of the nurse documented at the end of the notes							
Student nurse notes countersigned by RN							
If abbreviations used – only from approved list for School Based Health Service							

Comments:

Areas of strengths:

Areas identified for improvement:

Other areas which may require commenting on include:

- Use of generalisations
- Use of judgemental language
- Names used in clinical notes with no reference to the person's designation
- Acknowledgement of prior visits for same concern

Guide to documentation audit

Hx of presentation from student:

- What the student reports/says
- Hx of presenting compliant – how long/when started
- Mechanism of injury documented

Clinical assessment complete

- Clinical assessment of presenting issue documented
- Correct anatomical terminology used (spelt correctly)
- Location of injury and/or pain documented
- Pain score or type of pain documented (pain assessment)
- Vital signs documented and correctly recorded
- Red flags considered and assessed for common presentations – headache, abdominal pain, eye injuries, head injuries, UPSI, self-harm
- Vital signs recorded as appropriate

Plan of care

- Specific description of what care the nurse offered, provided or planned – no generalised statements

Evaluation of care

- If student remained is sick bay – documentation updating their condition