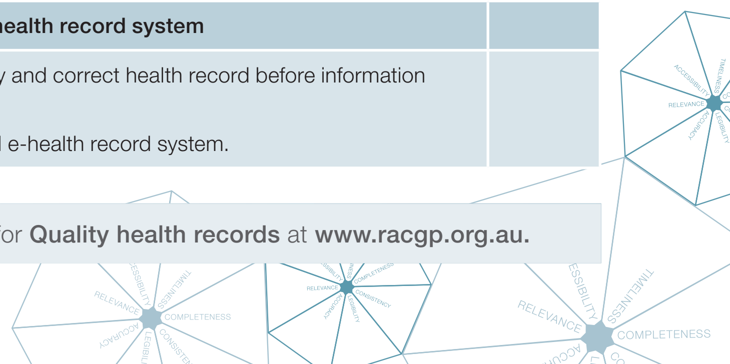
Sample compliance checklist for quality health records

This sample checklist provides some examples of simple ways practices can regularly assess the quality of health records against the Guide.

Principle		Sample compliance check	Status
Section 1		**Information quality and primary healthcare**	
1.1	**Information for multiple purposes**	Education session on the primary and secondary purposes of health records.	
1.2	**Main purpose of health records**	Education session on the importance of quality health records for safe and effective healthcare.	
1.3	**Expect to share**	Education session on the proper sharing of health information with other health professionals, patients and specified third parties, and what health professionals need to consider before passing health information on to others.	
1.4	**Governance**	Designated quality health record champion and responsibility for quality health records in the position descriptions of relevant team members.	
Section 2		**Essential attributes of quality health records**	
2.1	**Achieving the quality attributes**	Random audit of health records (using CCLARAT parameters) and quality improvement plans for health professionals who are not keeping quality health records.	
2.2	**Quality Improvement**	Reminders to help health professionals improve the quality of their health records.	
Section 3		**Capturing information in the consultation**	
3.1	**Recording consultations**	Health professionals have dedicated time to produce and maintain quality health records.	
3.2	**Recording problems**	Contemporaneous recordings of consultations which at least include the presenting problem, possible diagnosis and management plan.	
3.3	**Terminology and coding systems**	Standardised terminology and nationally recognised coding system that encompasses the full spectrum of diagnoses, clinical situations and observations.	
3.4	**Respectful language**	Education session on the optimal use of standardised terminology, a nationally recognised coding system, accepted acronyms, and respectful language.	
Section 4		**Capturing information from other sources**	
4.1	**Incorporating information from other sources**	Random audit of the system for follow up of tests and results and quality improvement plans to address near misses and mistakes.	
4.2	**Roles and responsibilities**	Position descriptions of team members who manage health information from other sources, clearly define their roles and responsibilities.	
Section 5		**System-specific issues**	
5.1	**Policies and procedures**	Policies and procedures that address strengths and weaknesses to optimise the operation of the health record system.	
5.2	**Managing risk**	Policies and procedures for managing risks in the health record system.	
5.3	**Education and training**	Initial and ongoing training sessions for clinical and administrative staff to make the most of the health record system.	
Section 6		**Information sharing and a national e-health record system**	
6.1	**Shared professional obligation**	Routine cross checking of patient identity and correct health record before information is shared. Staged plan for participating in a national e-health record system.	



The Guide is available from RACGP's website. Simply search for **Quality health records** at **www.racgp.org.au.**

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