ALLIED HEALTH PROFESSIONAL PRACTICE
DOCUMENTATION AUDIT GUIDELINES

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1. Allied Health Professional Practice Documentation Audits will be consistent with these guidelines and incorporate the minimum requirements for audit as outlined in these guidelines and in the audit form attached. The goal is to promote consistent audit processes and reporting across professions and clinical programs where possible. It is expected that the profession-specific documentation audit will include items beyond the minimum requirements outlined here to monitor compliance with professional standards of practice.

2. The purpose of the audit is to:

   - provide feedback to clinicians to improve documentation practices
   - to monitor compliance with the profession's Standards of Practice
   - to monitor compliance with Eastern Health Clinical Documentation Policy PRC-020
   - to promote excellence and development of learning

3. All practice areas within Eastern Health will conduct an audit at least once every 2 years on a schedule that allows an annual report to the VP for AHPP and clinical programs.

4. The Regional Professional Practice Consultant will develop the documentation audit process with the Council and clinical leaders and will be responsible to ensure the audit is completed and the results compiled, analyzed, and reported at the program and/or site level, where appropriate, and at the organizational level. This will include multi-year trending information.

5. The audit process must ensure the confidentiality of patient information. Audit tools will not record patient names or identifying patient information. The Personal Health Information Act allows access to patient records for audit purposes.

6. Names of the professionals who documented in the audited patients' records are not recorded. The purpose of the audit is to determine compliance with professional standards of practice within a program, not to assess the performance of individual professionals, which is reviewed during a Peer/Self Review process.

7. Access to electronic records for audit purposes can be flagged within CRMS, but not within Meditech. To ensure a list of records accessed electronically for audit purposes in Meditech is available, the list of patient records audited in Meditech within each profession will be placed in a sealed envelope and filed in the Allied Health Professional Practice office for 2 years.

8. Data gathered from individual patient records is rolled up into a report that reflects compliance at the team, division or program and for the profession as a whole within Eastern Health. The report is shared with program managers, with the professional group, and the VP responsible for professional practice.

9. If, during the course of the audit, significant issues with an individual's documentation are found, the auditor will contact the Regional Professional Practice Consultant for the

profession. The RPPC will contact the individual's manager, and carry out a review which may lead to a disciplinary process.

Audit Process:

1. The audit process must use the Allied Health Individual Documentation Audit Form and Summary forms, with appropriate additional profession-specific items.

2. The audit tool must be reliable as demonstrated through an inter-rater reliability check prior to the commencement of the audit, with a minimum of 80% reliability before the audit can proceed.

3. Records to be audited must be randomly chosen, with a sample size of 10% of eligible records within a practice area, as determined by the Council, with a minimum of 5 records and a maximum of 10 records per auditor.

4. Records to be audited will include documentation of the complete process of care, wherever possible, including referral, assessment, intervention, discharge and follow-up. These may be spread throughout the chart or be included in a single report.

5. Records to be audited may include paper records, electronic records, referral lists, wait lists, profession-specific charts and the central health record.

6. Documentation within the 12 months preceding the audit will be audited.

7. The audit process should involve all staff in the profession in the practice area/program being audited as auditors.

8. The audit tool must evaluate whether documentation occurred within timelines as outlined by the profession's Council.

9. Student documentation is included in the audit.

10. Documentation by support staff in the profession, where applicable, is included in the audit.

11. The staff person may document the work of an assistant who is working under their supervision, and this will be included in the audit.

12. No staff person will audit records containing their own documentation.

13. The standard for compliance with audit items is 80% unless otherwise indicated in the audit form by the individual professional council.

14. Areas below standard are noted and the RPPC and/or clinical leader ensures that an improvement plan is implemented, with a re-audit within 6 months, if required.

15. Individual and summary audit forms are to be sent to the RPPC and filed in the Allied Health Professional Practice office. Forms will be discarded when forms from a new audit are filed.

Report Process:

1. The RPPC will breakdown audit results by relevant clinical programs, and share the results, using the Allied Health Professional Practice - Documentation Audit Report, with relevant Program Directors, with a copy to the Director, AHPP.

2. Each audit report will include an analysis of the results with an action plan to address any areas of low compliance.

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