# **PART B: Clinical Audit Checklist**

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| **Date of Audits** | | **Cycle 1:** | **Cycle 2:** | | |
| **Name of participating GP** | |  | | | |
| **Patient Identifier** | |  | | | |
| **Criteria Assessed** | | | | **Initial Results compliance**  **(Cycle 1)** | **“Re-Audit” compliance (Cycle 2)** |
| **1.** | Is there evidence of a nutrition screening tool? | | |  |  |
| **2.** | Was the screening performed? | | |  |  |
| **3.** | If the person screened positive for risk of undernutrition were the recommendations followed through? if not, what was the barrier? | | |  |  |
| **4.** | If the screening was not performed, why was it not performed? | | |  |  |
| **5.** | Is there evidence of a depression screening tool such as K10, DASS or GDS? | | |  |  |
| **6.** | Was the screening performed (Y/N) ? | | |  |  |
| **7.** | If the person screened positive for risk of depression were the recommendations followed through? if not, what was the barrier? | | |  |  |
| **8.** | If the screening was not performed, why was it not performed? | | |  |  |
| **9.** | Is there evidence of a cognition assessment tool? (e.g., MMSE, GPCOG, RUDAS,) | | |  |  |
| **10.** | Was the assessment performed (Y/N)? | | |  |  |
| **11.** | If the person screened positive for risk of impaired cognition were the recommendations followed through? if not, what was the barrier? | | |  |  |
| **12.** | If the assessment was not performed, why was it not performed? | | |  |  |
| **13.** | Is there evidence of a frailty screening tool? (e.g., FRAIL, Edmonton, Kihon) | | |  |  |
| **14.** | Was the screening performed? | | |  |  |
| **15.** | If the person screened positive for risk of frailty were the recommendations followed through? if not, what was the barrier? | | |  |  |
| **16.** | If the screening was not performed, why was it not performed? | | |  |  |
| **17.** | Does the health assessment of the older person assess for risk of chronic kidney disease (CKD) by requesting a kidney health check (Urine ACR, BP and renal function test? | | |  |  |
| **18.** | Please list the date of last kidney health check. | | |  |  |
| **19.** | Please check patient eGFR and CKD staging. Has CKD been coded in health summary? | | |  |  |
| **20.** | Are there any potential medication interactions/contraindications with CKD for the patient? | | |  |  |
| **21.** | Does the Health assessment note when the last Bone Mineral Density performed to screen for osteoporosis if the diagnosis has not been made. (Current guidelines recommend very 5 years after age 70)? | | |  |  |
| **22.** | Does the health assessment state when it is next due? | | |  |  |
| **23.** | If the diagnosis of osteoporosis has been made, is the patient on osteoporosis therapy to prevent further bone loss? If not, why not? | | |  |  |
| **24.** | If the patient is taking 5 or more medications, is there evidence of a recommendation of a formal medication review (either HMR, or GP/geriatrician review) and any attempt at deprescribing documented? | | |  |  |
| **25.** | Has the patient's weight been recorded at least twice over the past 12 months? If not, why not? | | |  |  |
| **26.** | If the person is between 70-79, does the assessment state when they had a Zoster (shingles) vaccine? If not, why not? | | |  |  |
| **27.** | Does the health assessment state when the person had a a pneumococcal vaccine (either 23 or 13) vaccine? If not, why not? | | |  |  |
| **28.** | Does the health assessment state when the person had influenza vaccination in the past 15 months? if not, why not? | | |  |  |
| **29.** | Does the health assessment document the person’s COVID vaccination status? if not, why not? | | |  |  |
| **30.** | Does the Medication list in the health assessment only include current *active*  medications? (Current vs non-current prescription and over the counter) | | |  |  |
| **31.** | Does the health assessment include a review of documented social history, and is it accurate and up to date and including items such as:   * widowed * lives alone * carer * has aged care package * name and contact details of package provider has advanced care directive. | | |  |  |
| **32.** | Does the health assessment include evidence of current level of exercise (type and quantity) being documented? | | |  |  |
| **33.** | If the patient has been in hospital/attended an ED in the past 15 months, review the situation which surrounded the circumstances pre/post the admission/ED attendance if it occurred). Reflect on what could have been done differently to avoid the admission/ED attendance and write a few notes below: | | |  |  |
|  | **Cycle 1 (only) -** As a result of the review of the patient’s health assessment, document what the “care gaps” are and what is required to be completed for the patient. | | | | |
|  | **Cycle 2 (only) –** Following previous interventions and as a result of the 2nd review of the patient’s health assessment, document what the continued “care gaps” are and what is required to be completed. | | | | |