1. Month of audit:

2. Nutrition and Dietetics team:

3. Audited clinician:

4. Episode audited:

Inpatient Day case Outpatient Domiciliary visit

5. Type of record audited:

Medical note Electronic record Dietetic paper notes

Other, please state:

6. For all dietetic entries, have the following been documented for each entry:

 Yes No NA

Patient name at the top of page

Patient number at the top of page

Entry dated

Entry timed

Errors have a single line through, signed and dated

Has correction Fluid been used

Spaces before the dietetic entry have been scored through

Are all abbreviations recognised in policy

Name of clinician printed on first entry

 Yes No NA

Signature of clinician

Designation of clinician

Student / Junior grades have been countersigned

Bleep/contact number has been given

Patient records are contemporaneous

7. Please indicate level of legibility:

Electronic record

Legible (all words clear)

Less than 5 illegible words

Some words illegible (less than 50%)

Most words illegible (more than 50%)

Illegible (most or all words impossible to identify)

8. In the assessment; is there clear evidence of:

 Yes No NA

Referral reason

Referral source

Presenting complaint

Past medical History

Current medical treatment

Contradictions / precautions / allergies

Relevant investigations

Biochemistry / clinical observations

Clinical diagnosis

Assessment

Nutrition and Dietetic Diagnosis

Strategy

Implementing

Review date

9. Have goals or outcomes of dietetic intervention been clearly stated? E.g. prevent weight gain/meet full nutritional requirements via tube feed

Yes No

10. Is there clear evidence of a strategy delivered for this episode? E.g. advised on all aspects of low potassium diet / educated on low cholesterol diet / provided with samples of oral nutritional supplements or has it been documented that no intervention is required.

Yes No

a. Has the strategy been agreed with the patient / evidence of patients involvement with the plan or the care delivered:

Yes No Plan given in best interest

12. Is there clear evidence of the information shared for this episode? E.g. Healthcare professionals have discussed the patient’s care; to be referred to the speech and language therapist or other clinical team

Yes No Not required

13. Is there any evidence of written information (e.g. diet sheet, leaflet, booklets) given to the patient about their condition or treatment, at any point during their dietetic care?

Yes No Not required

14. Has review / discharge plan been documented?

Yes No