Process Map for Medical History Audit

1) Select audit topic and consider reasons for examining this area.
2) Sample size of 100 Medical Histories will show any problem areas
3) Set Standard. The standard to be achieved should ultimately be 100% of Medical History Forms fully completed and updated at last check up appt. As Clinical Audit is best used to identify areas for change and improvement it may sometimes be appropriate to set an initial standard for the Audit which is close to 100% and use the audit process of re-auditing to implement change and drive improvement.
4) Set Criteria. For example Patient Info correct, Form completed, Medications listed, ICE number present, Signed and dated by patient at last check up appt.
5) Make Data Capture table.
6) Collect Data.
7) Analyse Data and see what areas need to be improved.
8) Consider Re audit. This should be ongoing on an annual basis to ensure standards are being maintained. A small random sample should be enough to flag up any problems.
9) Write up report and complete CA2 form

Sample Data Capture For Medical History Audit

Pt details Correct	Form Completed	Updated at last check up appt	Medications accurately listed	ICE number present	Signed and dated by Patient