HEALTHCARE CLINICAL DOCUMENTATION AUDIT TEMPLATE

Clinical Documentation Audit Checklist

Audit patient identity, assessments, diagnoses, orders, medications, procedures, results, progress notes, handovers, discharge records, authentication, corrections, record integrity, and corrective-action closure.

FACILITY / LOCATION	AUDIT DATE	AUDITOR	APPROVER

Adapt required forms, completion timeframes, authentication rules, approved abbreviations, record-retention requirements, specialty documentation, audit samples, and escalation paths to current facility policy and applicable legal, regulatory, accreditation, payer, and professional requirements.

1. Audit setup, record scope, and documentation governance

1 **Confirm the facility, audit date, auditor, health-information or clinical-documentation owner, sampled departments, EHR systems, and escalation contacts.** METADATA + SIGN-OFF

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Record the people who can authorize immediate documentation corrections, access restrictions, and clinical escalation.

2 **Define the encounter types, services, units, practitioner groups, time period, sample size, and record-selection method included in the audit.** SCOPE + SAMPLE PLAN

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use a risk-based sample that covers high-risk services as well as routine care.

3 **Verify current policies for documentation content, timeliness, authentication, approved abbreviations, corrections, late entries, addenda, and downtime records are available.** CRITICAL DOCUMENT GOVERNANCE REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check version, approval date, ownership, staff access, and whether local rules are reflected in the current policy.

4 **Confirm the required clinical-record components for each sampled encounter type and role are defined in an approved documentation standard or matrix.** CRITICAL REQUIRED RECORD MATRIX

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Map mandatory forms and notes to the encounter, service, profession, and applicable facility requirement.

5 **Review previous documentation deficiencies, patient-safety events, coding or billing denials, complaints, legal issues, audit findings, and overdue actions.** PREVIOUS FINDINGS REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use repeat failures to target services, document types, authors, workflows, and system settings that need deeper sampling.

6 **Capture the audit start time, sample identifiers using approved privacy safeguards, record sources reviewed, and evidence needed to support each finding.** AUDIT EVIDENCE CAPTURE

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use only the minimum patient information needed for the audit and protect any exported or photographed evidence.

2. Patient identity, encounter details, consent, and foundational information

7 **Verify the sampled record uses the facility's required patient identifiers consistently across notes, orders, results, medication records, and forms.**

CRITICAL | PATIENT IDENTITY MATCH

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare identifiers across multiple record components and investigate any mismatch before continuing the audit.

8 **Confirm demographics, encounter date and type, service location, responsible clinician, and other required administrative details are accurate and consistent.**

ENCOUNTER DETAIL REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check for mismatched encounters, duplicate charts, incorrect locations, or copied details from another visit.

9 **Verify allergies, adverse reactions, and other critical alerts are documented, current, and reconciled where required before relevant care is provided.**

CRITICAL | CRITICAL ALERT DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare the allergy or alert field with medication, assessment, and handoff documentation for consistency.

10 **Confirm required consent, authorization, or refusal documentation is present, completed by the appropriate person, and linked to the correct procedure or treatment.**

CRITICAL | CONSENT VERIFICATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check identity, procedure, date, required signatures, interpreter support, and any facility-specific consent elements.

11 **Verify communication needs, interpreter use, decision-making capacity, surrogate decision-maker, advance-directive status, or other relevant patient preferences are documented where applicable.**

PATIENT PREFERENCE RECORD

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Only require elements that apply to the encounter and the facility's policy or legal framework.

12 **Check sensitive or confidential information is filed in the correct record location and there is no evidence of wrong-patient copy-forward or misplaced documentation.**

CRITICAL | CONFIDENTIALITY + RECORD MATCH

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Escalate suspected wrong-patient documentation immediately and preserve the audit trail during correction.

3. Clinical assessment, diagnoses, risks, and care planning

13 **Verify the initial history, physical examination, nursing assessment, or other required admission or encounter assessment is complete and documented within the approved timeframe.**

CRITICAL | INITIAL ASSESSMENT REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check the required assessment for the service rather than applying one universal form to every encounter.

14 **Confirm the presenting problem, relevant history, examination findings, current condition, and clinical reasoning are documented sufficiently to support the care provided.**

CLINICAL HISTORY + FINDINGS

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Look for evidence that the note explains the patient's current problem and why the planned care is appropriate.

15 **Verify diagnoses, active problems, and significant comorbidities are supported by the record and updated when the patient's condition changes.**

DIAGNOSIS + PROBLEM LIST

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare the problem list with assessments, results, treatment, and discharge documentation for unresolved contradictions.

16 **Confirm required risk assessments are completed and documented for applicable risks such as falls, pressure injury, deterioration, VTE, nutrition, suicide, or other service-specific hazards.**

CRITICAL | RISK ASSESSMENT DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use only risks relevant to the patient, setting, and approved clinical pathway.

17 **Verify the care plan includes current goals, interventions, responsible disciplines, review frequency, and updates based on the patient's response and changing needs.**

CARE PLAN REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check that the plan is active and individualized rather than a static template that no longer reflects the patient's condition.

18 **Confirm reassessment, changes in condition, escalation, clinical decisions, and the patient's response are documented when new risk or deterioration is identified.**

CRITICAL | REASSESSMENT + ESCALATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trace at least one significant change from first recognition through escalation, intervention, response, and follow-up.

4. Orders, medications, procedures, diagnostics, and results

19 **Verify sampled clinical orders are complete, attributable to an authorized practitioner, dated, timed, authenticated, and consistent with approved order-entry processes.**

CRITICAL | ORDER AUTHENTICATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check author, date, time, status, and whether modifications or discontinuations are traceable.

20 **Confirm verbal or telephone orders, where permitted, include the required read-back or verification and are authenticated within the applicable facility timeframe.**

CRITICAL | VERBAL ORDER CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Apply current law, regulation, medical-staff rules, and facility policy rather than assuming one universal authentication deadline.

21 **Review medication orders and administration records for drug, dose, route, time, omissions, holds, PRN indications, relevant monitoring, and documented response where required.**

CRITICAL | MEDICATION DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Investigate unexplained omissions, conflicting doses, undocumented holds, or administration that cannot be linked to a valid order.

22 **Verify procedure or operative documentation includes the indication, procedure performed, key findings, complications, devices or implants, specimens, and immediate outcome as applicable.**

CRITICAL | PROCEDURE NOTE REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Match the procedure note with consent, orders, implant records, specimens, recovery documentation, and discharge instructions.

23 **Confirm diagnostic, laboratory, imaging, pathology, and other relevant results are filed to the correct patient and reviewed or acknowledged according to policy, including critical-result communication.**

CRITICAL | RESULT REVIEW + ACKNOWLEDGMENT

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trace a critical or abnormal result to notification, clinician review, clinical decision, and follow-up action.

24 **Check outstanding orders, tests, referrals, procedures, and pending results have a documented owner and follow-up plan before transfer or discharge.**

PENDING ACTION CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Make responsibility for follow-up visible so unresolved work is not lost during transitions of care.

5. Progress notes, nursing records, monitoring, and response to care

25 **Verify progress notes reflect the patient's current condition, assessment, plan, clinical reasoning, and meaningful changes since the previous review.**

PROGRESS NOTE QUALITY

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Look for current clinical information rather than repeated text that does not explain today's condition or plan.

26 **Confirm nursing documentation records required assessments, interventions, care delivered, safety checks, escalation, and the patient's response.**

NURSING DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare nursing notes and flowsheets with orders, medication administration, risk assessments, and changes in condition.

27 **Verify vital signs, observations, device readings, intake/output, scores, and other required monitoring are recorded at the approved frequency and are clinically plausible.**

CRITICAL | MONITORING RECORD REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Investigate missing intervals, impossible values, duplicated entries, or deterioration without documented response.

28 **Confirm pain, symptoms, or other patient-reported concerns are assessed, treated or escalated as appropriate, and reassessed with the response documented.**

SYMPTOM + RESPONSE DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trace one significant symptom from assessment through intervention and reassessment.

29 **Verify adverse reactions, medication effects, incidents, complications, and unexpected outcomes are documented with the actions taken and subsequent patient response.**

CRITICAL | ADVERSE EVENT DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Ensure the clinical record contains care-related facts while separate incident-reporting requirements are handled according to policy.

30 **Check medical, nursing, allied-health, pharmacy, and other multidisciplinary entries are reasonably consistent and significant contradictions are reconciled.**

MULTIDISCIPLINARY CONSISTENCY

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare key facts such as diagnosis, precautions, mobility, diet, allergies, code status, and discharge plan across disciplines.

6. Consults, handovers, transfers, discharge, and follow-up

31 Verify consultation requests state the clinical question and the consultant's findings, recommendations, and required follow-up are documented and acted upon.

CONSULTATION DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trace recommendations that affect medication, procedures, monitoring, or discharge to evidence of follow-through.

32 Confirm handover documentation includes patient identity, current condition, major risks, medications, recent changes, pending tasks or results, and escalation needs as applicable.

CRITICAL | CLINICAL HANDOVER RECORD

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Audit transitions where responsibility changes between clinicians, shifts, departments, facilities, or transport teams.

33 Verify transfer records contain the information needed by the receiving team, including reason for transfer, current status, treatments, medications, risks, devices, and pending actions.

CRITICAL | TRANSFER DOCUMENTATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check that time-critical information is available before or at handoff rather than reconstructed later.

34 Confirm the discharge summary or equivalent final record includes principal problems, significant findings, treatment course, procedures, condition at discharge, medications, and follow-up plan as required.

DISCHARGE SUMMARY REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare the summary with the final medication list, pending results, referrals, and instructions given to the patient.

35 Verify patient or caregiver education, discharge instructions, warning signs, medication instructions, teach-back or understanding, and interpreter use are documented where required.

EDUCATION + INSTRUCTIONS

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check that documentation reflects what was actually taught and any barriers to understanding or adherence.

36 Confirm referrals, follow-up appointments, pending-result responsibilities, community services, and other continuity-of-care actions are documented with a clear owner.

FOLLOW-UP TRACEABILITY

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Identify who is responsible for each unresolved result, referral, or action after discharge or transfer.

7. Authorship, dates, times, authentication, corrections, and addenda

37 **Verify every sampled entry can be attributed to the person who created it through an approved electronic or written author-identification method.**

CRITICAL | AUTHOR IDENTIFICATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Shared credentials, generic logins, or unattributable documentation should be treated as record-integrity risks.

38 **Confirm entries are dated, timed, and completed promptly enough to support safe care and the facility's approved documentation timeframe.**

CRITICAL | TIMELINESS REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Compare entry time with the time of care and identify delayed documentation that could affect clinical decisions.

39 **Verify required signatures, electronic authentication, co-signatures, and approvals are complete and performed by the appropriate person.**

CRITICAL | AUTHENTICATION REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Apply role-specific, legal, regulatory, medical-staff, and facility requirements for authentication.

40 **Check late entries, addenda, amendments, and corrections preserve the original record, identify the author, show the date and time, and follow the approved correction process.**

CRITICAL | CORRECTION + ADDENDUM CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Do not obscure or overwrite the original entry; the audit trail should show what changed and who made the change.

41 **Review copied, cloned, templated, or carried-forward documentation for evidence it was verified and updated to reflect the current patient's condition and encounter.**

CRITICAL | COPY-FORWARD REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Investigate stale findings, contradictory dates, impossible values, or repeated text that could mislead care.

42 **Verify documentation by students, scribes, trainees, assistants, or other delegated contributors is reviewed, authenticated, or countersigned where required.**

DELEGATED DOCUMENTATION CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Match supervision and authentication requirements to the contributor's role and facility policy.

8. Completeness, legibility, terminology, and record standardization

43 **Confirm required fields, forms, sections, and mandatory data elements are complete with no unexplained blanks, placeholders, or unsigned draft content.** COMPLETENESS CHECK

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Distinguish truly not-applicable fields from missing documentation and require an approved notation where needed.

44 **Verify only approved abbreviations, symbols, terminology, and naming conventions are used where the organization restricts high-risk or ambiguous terms.** TERMINOLOGY REVIEW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use the facility's current approved or prohibited-abbreviation list and specialty-specific terminology rules.

45 **Check documentation is legible, objective, professional, clinically relevant, and free of ambiguous wording that could be misinterpreted by another care provider.** LEGIBILITY + CLARITY

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: For electronic records, review clarity and usability as well as literal text legibility.

46 **Confirm structured fields, flowsheets, narrative notes, medication records, orders, and problem lists do not contain unresolved contradictions about key clinical facts.** CRITICAL DATA CONSISTENCY CHECK

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Prioritize contradictions involving allergies, code status, precautions, medications, diagnoses, devices, or major risks.

47 **Verify required scores, scales, calculations, and assessment tools are completed correctly and the resulting level of risk or action is documented.** SCORE + SCALE VERIFICATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Recalculate a sample where feasible and trace the score to the expected clinical response.

48 **Review record-completion or deficiency reports and confirm incomplete or delinquent records are identified, assigned, escalated, and closed according to policy.** DELINQUENT RECORD CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trend missing signatures, incomplete summaries, unsigned orders, and other repeat deficiencies by service and author group.

9. Record integrity, privacy, scanning, downtime, access, and retention

49 Verify access to clinical documentation is role-appropriate and sampled audit logs or access reports show no obvious inappropriate access or shared-account activity.

CRITICAL | ACCESS + AUDIT TRAIL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Follow the organization's privacy and information-security process for any suspected inappropriate access.

50 Confirm sensitive records, confidential notes, privacy restrictions, and patient-authorized disclosures are handled according to the applicable policy and legal framework.

CRITICAL | PRIVACY DOCUMENTATION CONTROL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Apply local privacy law and facility policy to restricted or specially protected information.

51 Verify the EHR or record system preserves a reliable audit trail for creation, amendment, correction, authentication, and other material changes to clinical documentation.

CRITICAL | RECORD INTEGRITY AUDIT TRAIL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Check that amended content remains traceable and the responsible user, date, and time can be identified.

52 Review scanned, imported, faxed, or externally received documents for correct patient, encounter, document type, date, orientation, readability, and indexing.

CRITICAL | SCANNING + INDEXING CHECK

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Misfiled external documents can create wrong-patient risk even when the clinical content itself is accurate.

53 Confirm downtime or paper records are reconciled into the electronic record after system restoration without loss, duplication, conflicting entries, or missing authentication.

CRITICAL | DOWNTIME RECONCILIATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Trace one downtime encounter from paper capture through final EHR reconciliation and record completion.

54 Verify completed records are retained, retrievable, protected, and accessible to authorized users according to current facility policy and applicable legal or regulatory requirements.

RETENTION + RETRIEVAL

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Test retrieval of a representative record and confirm retention settings match the governing requirement for that record type.

10. Findings, corrective actions, verification, and sign-off

55 **Calculate the overall clinical-documentation compliance result and summarize critical gaps, repeat deficiencies, affected record types, services, and high-risk trends.** AUDIT SCORE + SUMMARY

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Separate isolated clerical issues from documentation failures that can affect patient safety, continuity, legal integrity, or compliance.

56 **Create immediate containment for wrong-patient entries, missing critical consent, uncommunicated critical results, unsafe medication or procedure documentation, and other high-risk failures.** CRITICAL | CRITICAL CONTAINMENT ACTION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Protect the patient first, preserve the record audit trail, and follow approved correction and escalation processes.

57 **Assign each finding an owner, priority, due date, root-cause requirement, corrective action, and objective closure-evidence rule.** CRITICAL | CORRECTIVE ACTION ASSIGNMENT

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Use short deadlines for immediate risk and realistic deadlines for process, training, template, or system changes.

58 **Escalate overdue, repeated, high-risk, privacy-sensitive, or patient-safety-related documentation issues to the required clinical, HIM, compliance, or leadership level.** CRITICAL | ESCALATION WORKFLOW

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Track acknowledgment, interim controls, revised due dates, and the responsible approver.

59 **Verify closure through corrected workflow, approved addendum or amendment where appropriate, training evidence, template or system changes, focused re-audit, and sustained improvement.** CRITICAL | CLOSURE VERIFICATION

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Do not close a finding based only on an owner's comment; use evidence that the documentation process is now controlled.

60 **Record the final audit decision, remaining restrictions or risks, next review date, auditor, clinical-documentation or HIM approval, date, time, and signature.** CRITICAL | APPROVAL + SIGNATURE

Compliant | Partially compliant | Non-compliant | N/A

Execution tip: Keep unresolved high-risk documentation failures visible until release criteria and follow-up requirements are met.