CHART AUDIT FORM

Name_____________ Apt. #______ Date of Admission____________
Facility________________________Audit Date______________

Abbreviations:

NSA-Negotiated Service Agreement
LOC-Level of Care
DOH-Director of Healthcare
ED-Executive Director

MAR-Medication Administration Record
POS-Physician Order Sheet
ADL-Activity of Daily Living
N/A-not applicable

Before beginning audit, have Office Manager run a copy of Resident's current Level of Care and a New Resident List. Use these to make sure all information is up to date.

Admission Records Tab	**Yes**	**No**	**N/A**
1. Admission Record/Face sheet is present (placed prior to first tab in sleeve)			
2. Chart Order/Admission Checklist Form (placed behind admission record, tool for ensuring chart is complete)			
3. Chart established within 5 working days from admittance date			
4. Is the Negotiated Service Agreement (NSA) dated and signed by DOH, ED, Resident, Case Manager,(when applicable)Social Service-(in IA)			
5. Is the NSA updated : ♦ Yearly ♦ When Change of Status or Level of Care (this needs to be done within one month)			
6. Is the NSA specific enough (does it state: what services, by whom, how often, specifics on how cares are done)			
7. Does the NSA match the current services being provided and the current Level of Care (if the state would compare this to the care actually being given would it match up)			
8. Is Managed Risk Agreement form present if appropriate			
9. Is Admission Agreement present- signed			

	Yes	No	N/A
10. Levels of Care form is present, current cares circled-matches what cares are currently being given, signed and dated (KS: FCS)			
11. Resident's Rights and Responsibilities form is present, signed and dated-Resident has copy also			
12. HIPAA Notice of Information Practices is present, signed and dated-Resident has copy also			
Advanced Directives Tab			
13. Advanced Directives Questionnaire signed (on or before admit)			
14. Copies of Advanced Directive –(POA, Guardianship) if it is noted if they have one			
History and Physicals Tab			
15. Release of Confidential Information form-original is signed and kept in chart (send copy out when need to)			
16. Recent (within 90 days) History and Physical from the doctor is present-make sure allergy and diagnosis from this matches information on the Chart and MAR-obtain at admission or prior to			
17. Discharge papers from hospital/previous facility-obtain at admit or prior to admit/readmit			
Physician Orders and Progress Notes Tab			
18. Initial Physician's Orders-for new residents-(sent before admission)–then sent to Pharmacy to receive MAR and any medication needing to be ordered			
19. Physician Order Sheets (POS) -reviewed and signed off by RN every month -sent to doctor for signature every 60-90 days-per policy/state regulation			
20. POS-has most recent medications-check current MAR with most recent POS(**make sure allergy and diagnosis match MAR)**			
21. Telephone orders, new orders, faxed orders, Physician Communication Sheets (are they kept in chronological order-is it easy to "follow" what was ordered by the doctor and if it was carried out)			
22. Are Physician Communication Sheets sent with the resident or faxed to the doctor when the resident goes to the doctor?			
23. Are doctor's orders "noted by________", dated and signed by nurse when they are taken off?			

Nursing Notes Tab	**Yes**	**No**	**N/A**
24. Is there a nursing signature sheet present and do staff sign names <u>and</u> titles?-(staff just need to sign this the first time they document in the chart or when there is a new signature sheet placed)			
25. Is there an initial assessment note in narrative nurses note? (may have been thinned from chart)-should include: orientation to code alert system, meal times, activities, and building)			
26. Completeness of Nurses Notes - Are they being used to document: ♦ All communication to families/doctors/outside agencies/etc… ♦ Unusual observances/signs or symptoms ♦ Changes in Status or Condition (all acute occurrences as well as reoccurring needs that may warrant a Change of Level or Discharge) ♦ C/o pain or change in alertness/level of consciousness ♦ Follow-up for 24 hours of Resident condition after a fall or incident (incident report should be filled out also) ♦ Unusual vital sign or weight change follow-up			
27. Proper documentation technique in narrative nurses notes: (see documentation policy for more guidelines) • Is the information objective and complete • No white out used			
Assessments Tab			
28. Resident Admission Assessment form filled out at: ♦ Admission or before at evaluation			
29. **For Kansas Facilities-**Resident Functional Capacity Screen filled out at: ♦ Admission ♦ Any time reassessment or NSA is done ♦ Change of Status/Level of Care ♦ Yearly			
30. Is there a Fall Risk form filled out if appropriate-filled out at admission or when fall risk is identified-(does not need to be filled out with every fall)			
31. Is there a Behavioral Assessment form filled out if appropriate/applicable-(see policy for guidelines)			

32. Resident Qualification to Self-Medicate is present	**Yes**	**No**	**N/A**
33. Resident Monthly Charting (filled out every month by staff-ADL's should reflect current LOC and NSA) (KS: Wellness Monitoring form)			
34. Resident Reassessment Form-to be done: • Change of Status/Level of Care • When return from stay at other facility • Yearly			
MAR/TX Tab			
35. Are there 3 months MAR's in chart			
36. Does the H & P allergy and diagnosis information match the NSA and MAR allergy information?			
37. Medication Self-Administration Sheet-done at admission (present if resident has requested to administer their own medication)			
Lab Results Tab			
38. Is there a 2-step TB doctor order and TB form present and completed?-done at admission within 7 days and q year after that(may be just a copy of form from previous facility)			
39. Are lab test results noted and signed by nurse?			
Consults Tab			
40. If there is an outside agency involved, do we have a copy of their care plan in consults section of chart? (outside agencies do not make charting entries in our chart)			
41. Is the pharmacist coming out every 3 months and reviewing MAR's, destroying DC'd Meds-consultant sheets on file			
Miscellaneous Tab			
42. Transfer/Discharge Sheet-may be kept at front of chart also-used when transferring or discharging residents			
43. Weight and Vital Sign Sheets-done at admission and monthly ♦ Is it present? ♦ Are sudden weight changes or loss or gain of 7.5 % in 3 months (5% in one month) assessed, doctor alerted and documented in nurses notes? ♦ Are unusual vital signs assessed, addressed and actions documented in nurses notes?			

44. If applicable-was a Pharmacy Authorization form filled out and sent to pharmacy?-(this is provided by your pharmacy if they need you to do this)	**Yes**	**No**	**N/A**
Chart/Binder			
45. Allergy Notification Sticker on front of the chart (at admission)			
46. Resident name and apartment number on outside of chart (at admission) Comments:			
Audit discharged Resident Charts - Is Transfer/Discharge sheet filled out? Is proper documentation of preparing Resident/Family for discharge as well as progression of decrease of functionality/condition that warrants discharge documented: Comments:			