Date:__/__/____ Time:_____

Setting:_____ Unique ID:_____ Entered By:_____

Reason for Audit:

** Indicates that an answer is required.*

Tracer - Inpatient

Advance Directives	Answer	Comments
1.* Documentation present on whether patient has an Advance Directive or not? Refer to EMR: Summary/Risk Legal (camera image), Care Activity/Advance Directive and/or paper AD chart tab *Standards:* ***RI.01.05.01***	___ Yes | ___ No | ___ NA	
2.* If patient has AD, documentation present of AD substance (N/A if patient does not have AD) Refer to EMR: Care Activity/Advance Directive *Standards:* ***RI.01.05.01, CMS 482.13.(b)***	___ Yes | ___ No | ___ NA	
Surrogate	**Answer**	**Comments**
3. Documentation of surrogate identity and surrogate assumption of authority form in chart (N/A if no surrogate identified) Refer to EMR: Summary/Risk Legal and paper chart *Standards:* ***RC.02.01.01, RI.01.02.01, 59A-3.254 .4***	___ Yes | ___ No | ___ NA	
Communication	**Answer**	**Comments**
4.* Oral and written communication needs identified, including preferred language, and implemented Refer to EMR: Summary/Indicators; Care Activity/ADM: General Admission Asmt; Teaching Record: General *Standards:* ***PC.02.01.21, RC.02.01.01***	___ Yes | ___ No | ___ NA	
5. Interpreter services documented if needed Refer to EMR: Care Activity/ADM: General Admission Asmt *Standards:* ***RI.01.01.03***	___ Yes | ___ No | ___ NA	
Learning Needs	**Answer**	**Comments**
6.* Learning needs assessment includes: • Patient's religious and cultural beliefs, • Emotional barriers, • Desire/motivation to learn, • Physical or cognitive limitations, and • Any barriers to communication • Education/training assessed daily Refer to EMR: Summary/Demographics, Care Activity/ADM: General Admission Asmt, Teaching Record: General *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
Admission Nursing Assessment	**Answer**	**Comments**
7.* Height, weight, allergies documented on admission Refer to EMR: Care Activity/Height and Weight Adult, Screening Assessment. For allergies: EMR header/click on "i" *Standards:* ***MM.01.01.01***	___ Yes | ___ No | ___ NA	

8.* Admission assessment completed within 24 hours of admission Refer to EMR: Care Activity/Height and Weight Adult, Screening Assessment *Standards:* ***PC.01.02.03, 59A-3.2085 .5***	___ Yes | ___ No | ___ NA	
9.* Admission medication reconciliation home list Refer to EMR: Care Activity/Home Medication Reconciliation *Standards:* ***NPSG.03.06.01***	___ Yes | ___ No | ___ NA	
10.* Admission skin/wound screen Refer to EMR: Care Activity/ADM Physical Assessment, Medical/Surgical Flowsheet *Standards:* ***PC.01.02.01***	___ Yes | ___ No | ___ NA	
11.* Admission nutritional screen Refer to EMR: Care Activity/Nutritional Assessment, Screening Assessment *Standards:* ***PC.01.02.01, PC.01.02.03, 59A-3.254 .1***	___ Yes | ___ No | ___ NA	
12.* Admission functional screen Refer to EMR: Care Activity/ADM Physical Assessment, Screening Assessment *Standards:* ***PC.01.02.01, PC.01.02.03, 59A-3.254 .1***	___ Yes | ___ No | ___ NA	
13.* Admission abuse/neglect screen Refer to EMR: Care Activity/ADM: General Admission Asmt *Standards:* ***PC.01.02.09***	___ Yes | ___ No | ___ NA	
14.* Admission suicide screen Refer to EMR: Care Activity/ADM: General Admission Asmt *Standards:* ***NPSG.15.01.01***	___ Yes | ___ No | ___ NA	
15.* Admission discharge planning needs Refer to EMR: Discharge *Standards:* ***PC.04.01.03, 59A-3.110.2, 59A-3.254 .1, CMS 482.43.(a)***	___ Yes | ___ No | ___ NA	
16.* Obstetric Hemorrhage Assessment completed	___ Yes | ___ No | ___ NA	
Referrals Triggered from Assessment	**Answer**	**Comments**
17. Order for referral for nutritional assessment within 24 hours (N/A if assessment not indicated) Refer to EMR: Care Activity/Screening Assessment, Dietician Assessment & Order History *Standards:* ***PC.01.02.03***	___ Yes | ___ No | ___ NA	
18. Order for referral for functional assessment within 24 hours (N/A if assessment not indicated) Refer to EMR: Care Activity/Screening Assessment, PT/OT/SLP Screening & Order History *Standards:* ***PC.01.02.03***	___ Yes | ___ No | ___ NA	

19. Order for referral for skin/Wound assessment within 24 hours (N/A if assessment not indicated) Refer to EMR: Care Activity/ADM Physical Assessment, Drain and Wound Assessment & Order History *Standards:* ***PC.01.02.01***	___ Yes | ___ No | ___ NA	
20. Order for referral for Case Management within 24 hours (N/A if referral not indicated) Refer to paper chart: documentation printed from ECIN and placed in chart *Standards:* ***PC.01.02.01***	___ Yes | ___ No | ___ NA	
History & Physical	**Answer**	**Comments**
21. H&P completed within last 30 days (N/A if patient is observation) Refer to EMR: Other Reports/History and Physical or External Records (camera if scanned) and/or paper H/P chart tab *Standards:* ***PC.01.02.03, RC.01.03.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
22. H&P update within 24 hours of admission (N/A if patient is observation) Refer to EMR: Other Reports/History and Physical or External Records (camera if scanned) and/or paper H/P chart tab *Standards:* ***PC.01.02.03, RC.01.03.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
23. H&P update includes review of H&P, patient examination, and changes/no changes in patient condition (N/A if patient is observation) Refer to EMR: Other Reports/History and Physical or External Records (camera if scanned) and/or paper H/P chart tab *Standards:* ***PC.01.02.03, RC.01.03.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
Fall Risk	**Answer**	**Comments**
24.* Fall risk assessment documented and fall prevention strategies implemented, if applicable Refer to EMR: Care Activity/Fall Risk Assessment *Standards:* ***PC.01.02.08***	___ Yes | ___ No | ___ NA	
25. Fall risk reassessed after change in level of care Refer to EMR: Care Activity/Fall Risk Assessment *Standards:* ***PC.01.02.03, 59A-3.254 .1***	___ Yes | ___ No | ___ NA	
26.* Patient education on fall reduction strategies Refer to EMR: Care Activity/Fall Risk Assessment *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
Pain Management	**Answer**	**Comments**
27.* Pain assessment performed per policy or appropriate to patient's condition Refer to EMR: Care Activity/Pain Assessment *Standards:* ***PC.01.02.07***	___ Yes | ___ No | ___ NA	
28. Pain scale appropriate Refer to EMR: Care Activity/Pain Assessment *Standards:* ***PC.01.02.07***	___ Yes | ___ No | ___ NA	

29. Action taken, adequate pain relief or further intervention Refer to EMR: Care Activity/Pain Assessment, Interventions, Medications *Standards:* ***PC.01.02.07, RI.01.01.01***	___ Yes | ___ No | ___ NA	
30. Pain reassessment after intervention Refer to EMR: Care Activity/Pain Assessment, Intervention, Medications *Standards:* ***PC.01.02.07***	___ Yes | ___ No | ___ NA	
31. Pain management reflected in plan of care Refer to EMR: Care Activity/Plan of Care *Standards:* ***PC.01.03.01***	___ Yes | ___ No | ___ NA	
Isolation	**Answer**	**Comments**
32. Identification of isolation patient in medical record (N/A for non-isolation patient) Refer to EMR: Care Activity/Med/Surg Flowsheet, Care Trends/Activity/Safety *Standards:* ***RC.01.01.01***	___ Yes | ___ No | ___ NA	
33. Isolation precautions appropriate to infection (N/A for non-isolation patient) Refer to EMR: Care Activity/Med/Surg Flowsheet *Standards:* ***IC.02.01.01***	___ Yes | ___ No | ___ NA	
Plan of Care	**Answer**	**Comments**
34.* Plan of Care completed on day of admission, updated daily and as needed Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.01.03.01, CMS 482.23.(b)***	___ Yes | ___ No | ___ NA	
35.* Issues/problems selected in Plan of Care appropriate to patient's reason for hospitalization and specific to patient Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.01.03.01***	___ Yes | ___ No | ___ NA	
36. Plan of Care includes appropriate precautions for patient (i.e. isolation) - (N/A if not applicable) Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.01.03.01***	___ Yes | ___ No | ___ NA	
37.* Plan of Care goals listed and measurable Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.01.03.01, 59A-3.110.2***	___ Yes | ___ No | ___ NA	
38. Evidence of issue/problem improvement or resolution documented on care plan, flow sheet or narrative note Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.01.03.01***	___ Yes | ___ No | ___ NA	

39. Plan of Care includes all disciplines as needed Refer to EMR: Care Activity/Evaluation Assessment for OT/PT/SLP and/or Respiratory Therapy *Standards:* ***PC.02.01.05***	___ Yes | ___ No | ___ NA	
40. Evidence of patient/family involvement in Plan of Care Refer to EMR: Care Activity/Plan of Care, Outcomes, Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
41.* Evidence of parent involvement in Plan of Care Refer to EMR: Care Activity/Plan of Care, Outcomes, Teaching Record: General, Care Trends/Education	___ Yes | ___ No | ___ NA	
Education	**Answer**	**Comments**
42.* Medication use and safety education documented Refer to EMR: Care Activity/Teach Medication *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
43. Medical equipment use and safety education documented Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
44. Coumadin/LMWH education documented: includes follow-up monitoring, dietary restrictions, administration technique, potential for adverse reactions (N/A if not applicable) Refer to EMR: Care Activity/Teach Medication *Standards:* ***NPSG.03.05.01***	___ Yes | ___ No | ___ NA	
45. Rehabilitation techniques education documented (N/A if not applicable) Refer to EMR: Care Activity/Evaluation Assessment for OT/PT/SLP, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
46. Interdisciplinary education documented (N/A if not applicable) Refer to EMR: Care Activity/Assessment for Dietician, Respiratory Therapy, OT/PT/SLP; Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
47.* Infection control measures education documented: includes hand hygiene, respiratory hygiene, contact precautions Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
48. MDRO, CLABSI, SSI education documented (N/A if not applicable) Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***NPSG.07.03.01, NPSG.07.04.01, NPSG.07.05.01***	___ Yes | ___ No | ___ NA	

49.* Education about reporting safety issues Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
50.* Patient's understanding of education evaluated Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
Record of Care	**Answer**	**Comments**
51. Entries in medical record legible Refer to paper chart *Standards:* ***RC.01.01.01***	___ Yes | ___ No | ___ NA	
52. Entries in medical record signed, dated and timed Refer to paper chart *Standards:* ***RC.01.01.01, RC.01.02.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
Critical Tests/Values	**Answer**	**Comments**
53. Documentation of critical values/results (N/A if not applicable) Refer to paper documentation *Standards:* ***NPSG.02.03.01, PC.02.01.03***	___ Yes | ___ No | ___ NA	
54. Documentation of read-back of critical values/results (N/A if not applicable) Refer to paper documentation *Standards:* ***PC.02.01.03***	___ Yes | ___ No | ___ NA	
Verbal Orders	**Answer**	**Comments**
55. Documentation of verbal order read-back Refer to EMR: Order History to view order, then audit order in paper chart *Standards:* ***PC.02.01.03***	___ Yes | ___ No | ___ NA	
56. Verbal orders signed, dated and timed Refer to EMR: Order History to view order, then audit order in paper chart *Standards:* ***RC.01.02.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
Orders	**Answer**	**Comments**
57. Orders signed, dated and timed Refer to EMR: Order History to view order, then audit order in paper chart *Standards:* ***RC.01.01.01, RC.01.02.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
58. Orders free of unapproved abbreviations Refer to EMR: Order History to view order, then audit order in paper chart *Standards:* ***IM.02.02.01, 59A-3.110.10***	___ Yes | ___ No | ___ NA	

59. Preprinted orders are initiated by an order Refer to EMR: Order History to view order, then audit order in paper chart *Standards:* ***MM.04.01.01, CMS 482.24.(c)***	___ Yes | ___ No | ___ NA	
60. STAT orders initiated within hospital defined time frame Refer to EMR: Order History *Standards:* ***PC.02.01.03***	___ Yes | ___ No | ___ NA	
Medication	**Answer**	**Comments**
61.* Allergies verified and listed as appropriate Refer to EMR header, click on "i" *Standards:* ***RC.02.01.01***	___ Yes | ___ No | ___ NA	
62. No do-not-use abbreviations in medications Refer to EMR: Order History *Standards:* ***IM.02.02.01, 59A-3.110.10***	___ Yes | ___ No | ___ NA	
63. Medication reconciliation completed upon transfer from one level of care to another Refer to EMR: Medications, active meds audit trail *Standards:* ***PC.02.02.01***	___ Yes | ___ No | ___ NA	
64.* Medication order present with indication for each medication Refer to EMR: Order History *Standards:* ***MM.04.01.01, CMS 482.25.(b)***	___ Yes | ___ No | ___ NA	
65. PRN medication orders have specific indications for use Refer to EMR: Order History *Standards:* ***MM.04.01.01***	___ Yes | ___ No | ___ NA	
66. No duplication of medications ordered for the same indication (for example, pain, nausea and vomiting, and constipation) Refer to EMR: Order History, Medications *Standards:* ***MM.05.01.01***	___ Yes | ___ No | ___ NA	
67. Documentation for missed medication doses in MAR Refer to EMR: Medications *Standards:* ***RC.02.01.01***	___ Yes | ___ No | ___ NA	
68. Documentation of patient's perception of effectiveness and side effects of medications Refer to EMR: Care Activity/Teach Medication *Standards:* ***PC.01.02.01***	___ Yes | ___ No | ___ NA	

Blood Transfusion	Answer	Comments
69. Authorization form for blood and blood component transfusion signed, dated, timed (N/A if not applicable) Refer to paper chart *Standards:* ***RC.02.01.01, RI.01.03.01, 59A-3.2085 .3***	___ Yes | ___ No | ___ NA	
70. Blood transfusion education provided to patient (N/A if not applicable) Refer to EMR: Care Activity/Teaching Record: General, Care Trends/Education *Standards:* ***PC.02.03.01***	___ Yes | ___ No | ___ NA	
71. Documentation of blood administration, including complications (N/A if not applicable) Refer to EMR: Blood Bank/Transfusion History *Standards:* ***PC.02.01.01, RC.02.01.03***	___ Yes | ___ No | ___ NA	
Handoff Communication	**Answer**	**Comments**
72. Process for handoff to or from next provider of care documented Refer to EMR: Care Activity/Transfer/Report In-Hospital or paper SBAR form *Standards:* ***PC.02.02.01***	___ Yes | ___ No | ___ NA	
Restraint - Behavioral	**Answer**	**Comments**
73. Individualized assessment performed for behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraints Violent Assessment *Standards:* ***PC.03.05.11, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
74. Physician order within 1 hour of initiation and Face to Face evaluation performed within 1 hour of initiation for behavioral restraint (N/A if not applicable) Refer to paper chart *Standards:* ***PC.03.05.05, PC.03.05.11, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
75. Behavioral restraint order is time limited (N/A if not applicable) Refer to paper chart *Standards:* ***PC.03.05.05***	___ Yes | ___ No | ___ NA	
76. PRN order not used for behavioral restraint (N/A if not applicable) Refer to paper chart *Standards:* ***PC.03.05.05, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
77. Renewal order obtained every 4 hours by Hub C3 or CC NM and by MD every 8 hours for behavioral restraint (N/A if not applicable) Refer to paper chart *Standards:* ***PC.03.05.05, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
78. In-person evaluation for continued behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraint Violent Assessment *Standards:* ***PC.03.05.05, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	

79. Monitoring and needs assessment documented every 15 minutes for behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraints Violent Assessment *Standards:* ***PC.03.05.07, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
80. Plan of care reviewed and modified for behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.03.05.03***	___ Yes | ___ No | ___ NA	
Restraint - Non-behavioral	**Answer**	**Comments**
81. Individualized assessment performed for non-behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraints Non-Violent Assessment *Standards:* ***PC.03.05.09***	___ Yes | ___ No | ___ NA	
82. Physician order within 12 hours of initiation of non-behavioral restraint (N/A if not applicable) Refer to EMR: Order History *Standards:* ***PC.03.05.05***	___ Yes | ___ No | ___ NA	
83. Physician examination within 24 hours of initiation of non-behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraints Non-Violent Assessment *Standards:* ***PC.03.05.05***	___ Yes | ___ No | ___ NA	
84. Non-behavioral restraint order is time limited (N/A if not applicable) Refer to EMR: Order History *Standards:* ***PC.03.05.05***	___ Yes | ___ No | ___ NA	
85. PRN order not used for non-behavioral restraint (N/A if not applicable) Refer to EMR: Order History *Standards:* ***PC.03.05.05, CMS 482.13.(e)***	___ Yes | ___ No | ___ NA	
86. Renewal order every 24 hours for non-behavioral restraint (N/A if not applicable) Refer to EMR: Order History *Standards:* ***PC.03.05.05***	___ Yes | ___ No | ___ NA	
87. Physician reassessment for continued non-behavioral restraint each calendar day (N/A if not applicable) Refer to EMR: Care Activity/Restraints Non-Violent Assessment *Standards:* ***PC.03.05.09***	___ Yes | ___ No | ___ NA	
88. Monitoring and reassessments documented every two hours for non-behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Restraints Non-Violent Assessment *Standards:* ***PC.03.05.07***	___ Yes | ___ No | ___ NA	
89. Plan of care reviewed and modified for non-behavioral restraint (N/A if not applicable) Refer to EMR: Care Activity/Plan of Care, Outcomes *Standards:* ***PC.03.05.03***	___ Yes | ___ No | ___ NA	

Discharge Planning	Answer	Comments
90. Written discharge instructions provided to patient Refer to EMR: Care Activity/Discharge Assessment *Standards:* ***PC.04.01.05, 59A-3.254 .3***	___ Yes | ___ No | ___ NA	
91. Other disciplines involved in discharge planning Refer to EMR: Discharge *Standards:* ***PC.04.01.03***	___ Yes | ___ No | ___ NA	
92. Home medications ordered and discrepancies reconciled Refer to EMR: Discharge *Standards:* ***NPSG.03.06.01***	___ Yes | ___ No | ___ NA	
93. Vaccine screen assessment documented Refer to EMR: Care Activity/Vaccine Screen Assessment *Standards:* ***PC.01.02.05***	___ Yes | ___ No | ___ NA	
94. Patient involved in selection of providers for post discharge Refer to paper chart: documentation printed from ECIN and placed in chart *Standards:* ***PC.04.01.01***	___ Yes | ___ No | ___ NA	
Patient Interview	**Answer**	**Comments**
95. Patient knows name of RN	___ Yes | ___ No | ___ NA	
96. Patient knows location of call light	___ Yes | ___ No | ___ NA	
97. Patient feels questions were answered by staff	___ Yes | ___ No | ___ NA	
98. Patient acknowledges hourly rounding performed	___ Yes | ___ No | ___ NA	
Patient Room Safety	**Answer**	**Comments**
99.* Patient bed locked	___ Yes | ___ No | ___ NA	
100.* Patient bed in low position	___ Yes | ___ No | ___ NA	