Quality of Care Audit

This guide was developed to assist nursing home staff with their quality improvement process.
This guide does not represent an all-inclusive list.
It is not intended to be part of the nursing home's permanent record.

Signature and Title	Sections	Date
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Quality of Care Audit References

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QUALITY OF CARE AUDIT

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

I. Outside grounds appearance

___1. Landscape neat and trimmed, trash picked up
___2. Building in good repair, I.e. roof, windows
___3. Walkways in good repair
___4. Garbage receptacles covered

II. Overall Resident Care Areas

___1. Nurses' station(s) (orderly, clean, no food, personal belongings stored appropriately)
___2. Bathing facilities (supplies labeled, supplies locked if unattended, cleaned up after use)
___3. Odors (no stale, pervasive odors)
___4. Linen carts handled correctly, clean stored away from soiled, containers no larger than 32 gallons
___5. Hand washing supplies available (Med. rooms, utility rooms, resident rooms)
___6. Hallways clear of equipment/wheelchairs etc
___7. Utility room doors locked if contain chemicals or chemicals stored in locked cabinets
___8. Door alarms functioning
___9. Lobby, common areas, entry way clean
___10. Resident equipment clean and in good repair (w/c, bedside table, etc)
___11. Preventative maintenance plan followed

III. Resident Rights

___1. Privacy - curtains pulled
___2. Privacy - residents covered
___3. Privacy - staff knocks before entering and waits for permission to enter
___4. Courteous treatment of residents, call by appropriate name and as careplanned
___5. Home atmosphere - resident rooms have pictures and appropriate appliances, etc.
___6. Grievance Policy/Procedure Logs - up to date
___7. Advanced Directives, informed of at admission, copy on chart, care plan reflective of directive
___8. Residents that refuse treatment - informed of risks vs benefits, treatment options, expected outcomes, resident concerns addressed and address on care plan
___9. Minutes from resident council, documentation to support follow-up of concerns

IV. Resident Rounds - Audit a minimum of 10% of residents
(Indicate # of residents observed in each category and # of exceptions observed.)

A. Personal hygiene

(Standards as below. Individualized hygiene needs to be addressed in each resident's care plan.)

___1. Mouth - free of debris, moist dentures in place _____ exceptions of _____ observations
___2. Hair - combed, clean_____exceptions of _____observations
___3. Facial Hair - not present as or as care planned
  a. Men _____ exceptions of _____ observations
  b. Women _____exceptions of _____ observations
___4. Nails trimmed and clean_____exceptions of _____ observations
___5. Bathing - Preferences for frequency and type in care plan
___6. Dressed - street clothes, socks, gown and robe _____ exceptions of _____ observations
___ a. Exceptions care planned and resident preference
___7. Clothes in good repair and free of food debris

B. Other Needs

___1. Overall skin condition (hydrated without bruises, skin tears, etc.) _____exceptions of _____observations
___2. Turning and positioning done as care planned _____exceptions of _____observations
___3. Incontinent resident, clean and dry _____exceptions of _____observations
___4. ADL charting and bowel monitoring documentation completed ____exceptions of ____observations
___5. Resident glucose/diabetic testing done and results followed up on as indicated____exceptions of ____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

C. Catheters (Worksheet attached)
___ 1. Medical reason documented on chart _____exceptions of _____observations (per regulations)
___ 2. Physician orders: state size, how often to change, irrigate, etc. _____exceptions of _____observations
___ 3. Fluid needs assessed and met _____exceptions of _____observations
___ 4. Proper positioning of drainage bag and tubing _____exceptions of _____observations
___ 5 Leg anchors and bag covers in place _____exceptions of _____observations
___ 6. Urine - color, odor, consistency _____exceptions of _____observations
___ 7. Catheter care & handling of drainage bag per policy _____ exceptions of _____ observations
___ 8. I & Os accurate and discrepancies reported _____exceptions of _____observations
___ 9. Competency skills checklist completed (Sample of checklist attached) _____exceptions of _____observations
___10. MDS reflects catheter usage _____exceptions of _____observations
___11. Care plan reflects catheter usage _____exceptions of _____observations

D. Tube Feeding (Worksheet attached)
___ 1. Mouth care moist, free of debris and odor, and per policy _____ exceptions of _____observations
___ 2. Stoma site clean, tx per orders/policy _____ exceptions of _____ observations
___ 3. Utensils clean, dated and stored properly _____exceptions of _____observations
___ 4. Head of bed elevated per care plan/physician order _____exceptions of _____observations
___ 5. Documentation of bowel sounds per policy _____exceptions of _____observations
___ 6. Documentation of quality of lung sounds per policy ___exceptions of ___observations
___ 7. Weighed per policy/changes addressed _____exceptions of _____observations
___ 8. Physician orders carried out accurately _____exceptions of _____observations
___ 9. I & Os complete/ accurate according to physician orders _____exceptions of _____observations
___10. Evidence of speech therapy evaluations _____exceptions of _____observations
___11. Monthly input by the Dietician _____exceptions of _____observations
___12. Dietician recommendations for fluids/calories/nutrients match current orders____exceptions of ____observations
___13. Documentation of need for tube feeding
___14. If NPO, water pitcher removed from room ____exceptions of ____observations
___15. Oral intake supervised and documented accurately ____exceptions of ____observations
___16. Competency skills checklist for continuous and bolus feeding completed (Sample of checklist attached)
_____exceptions of _____observations
___17. Competency skills checklist for meds per G-tube completed (Sample of checklist attached)
_____exceptions of _____observations
___18. MDS reflects usage of tube feeding _____exceptions of _____observations
___19. Care plan reflects usage of tube feeding _____exceptions of _____observations

E. Trachs (Worksheet attached)
___1. Mouth care given and charted every shift _____exceptions of _____observations
___2. Tie and/or dressing clean and intact at stoma site _____exceptions of _____observations
___3. Utensils clean, dated and stored properly _____exceptions of _____observations
___4. Head of bed elevated appropriately _____exceptions of _____observations
___5. Competency skills checklist completed (Sample of checklist attached) _____exceptions of _____observations
___6. MDS reflects the trach _____exceptions of _____observations
___7. Care plan reflects the trach _____exceptions of _____observations

F. Fluid Restrictions/Hydration Needs (Worksheet attached)
___1. For resident's with fluid restriction:
___ Physician orders clear on how much intake is allowed _____exceptions of _____observations
___ Clear division of amounts to be given by nursing/dietary per shift _____exceptions of _____observations
___ I & Os current and within acceptable ranges per physician orders_____exceptions of _____observations
___ Water pitcher at bedside removed or per care plan _____exceptions of _____observations
___2. For residents with hydration needs, there is evidence of lab values monitored and followed up on
_____exceptions of _____observations
___3. Residents without signs of dehydration, dry cracked lips, skin tenting_____exceptions of _____observations
___4. MDS reflects the fluid restrictions _____exceptions of _____observations
___5. Care plan reflects the fluid restrictions _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

G. Resident Unit

___1. Call light in reach
___2. Water within reach and fresh
___3. Water pitchers with lid and glass, changed per policy/protocol
___4. Bedside table neat and clean - toothbrushes, hair brushes, and personal items stored appropriately
___5. Bedpans clean and in proper place (labeled appropriately); bedside commodes clean; urinals with lids clean
___6. Dirty linens kept off the floor, trash in resident rooms empty
___7. Staff is responsive to resident requests and call lights
___8. Walkway free of cluster

H. Restraints (Worksheet attached)

___ 1. Physician orders current and include: medical symptom, when to use, type of device, length of time and frequency_____exceptions of _____observations
___ 2. Checked and released every 2 hours - 10 minutes for repositioning, toileting and exercised _____exceptions of _____observations
___ 3. Restraints in good condition; proper type used; and used as ordered _____exceptions of _____observations
___ 4. Restraints applied properly _____exceptions of _____observations
___ 5. Evidence of P.T. and/or O.T. input into restraint usage _____exceptions of _____observations
___ 6. Evidence of resident and/or legal representative consent and education for use of the restraint _____exceptions of _____observations
___ 7. Evidence of alternatives tried prior to restraint application_____exceptions of _____observations
___ 8. Documented evidence of prerestraining assessment prior to use and ongoing restraint reductions, including residents admitted with restraint order _____exceptions of _____observations
___ 9. Functional abilities evaluated, declines addressed, on restorative nursing program _____exceptions of _____observations
___10. MDS reflects restraint usage _____exceptions of _____observations
___11. Care plan reflects restraint usage _____exceptions of _____observations

I. Siderails (Worksheet attached)

___1. Evidence of a siderail assessment* (per Clinical Guidance of Bedrails) _____exceptions of _____observations
___2. If the siderail is indicated as a restraint on the assessment, evidence of alternatives prior to utilizing the siderail _____exceptions of _____observations
___3. Physician orders correct to include specific reason for usage _____exceptions of _____observations
___4. Evidence of P.T. and/or O.T. input into the siderail usage if it is considered a restraint _____exceptions of _____observations
___5. Care plan reflects the siderail usage_____exceptions of _____observations
___6. Evidence of resident/and legal representative consent and education for the use of the siderail _____exceptions of _____observations
___7. MDS reflects the siderail usage _____exceptions of _____observations

J. Bowel/Bladder Program (Worksheet attached)

___1. Bowel/Bladder Assessment completed per policy and appropriate actions taken _____ exceptions of _____observations
___2. Evidence of 1-3 day I & O/patterning, and progress notes per facility policy/procedure _____ exceptions of _____ observations
___3. Diagnosis to support type of incontinence _____ exceptions of _____ observations
___4. Appropriate incontinence program initiated (retraining, prompted voiding, scheduled toileting) _____exceptions of _____observations
___5. Staff aware of individualized toileting programs _____exceptions of _____observations
___6. All residents incontinent (coded as 2 or 3 on MDS) on toileting plan or documented why not _____exceptions of _____observations
___7. Documentation to support why residents coded as occasionally or frequently incontinent without a toileting plan from QM/QI _____exceptions of _____observations
___8. Competency skills checklist completed (Sample of checklist attached) _____ exceptions of _____ observations
___9. Bowel/bladder program addressed on MDS _____exceptions of _____observations
___10. Bowel/bladder programs addressed on care plan _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

K. Weights (Worksheet attached)
___1. All residents are weighed per physician orders or facility policy (i.e. monthly or weekly, etc.)
_____exceptions of _____observations
___2. Evidence of intervention by appropriate disciplines, (i.e. Physician notified, Dietitian, re-weighing, on gradual weight loss, fluctuation of weights)_____exceptions of _____observations
___3. Documented interventions prior to significant weight loss_____exceptions of _____observations
___4. Malnutrition assessment per policy and results followed up on _____exceptions of _____observations
___5. Residents reweighed when have 1-2 # difference _____exceptions of _____observations
___6. Weights monitored for 5% change monthly, 7 1/2% change in 3 months, or 10% change in 6 months
___ Significant MDS initiated as indicated _____exceptions of _____observations
___ Family and physician notified _____exceptions of _____observations
___7. Lab values monitored (albumin, prealbumin, electrolytes, etc) and hydration needs assessed
_____exceptions of _____observations
___8. Weight loss addressed on MDS _____exceptions of _____observations
___9. Weight loss addressed on care plan _____exceptions of _____observations

V. Meal Observations
A. Dining Room
___1. Meal service per facility policies _____exceptions of _____observations
___2. Residents assisted as needed. To include substitutions/choices as indicated, residents properly positioned, dentures in mouth, adaptive equipment as indicated _____exceptions of _____observations
___3. Food temperature within acceptable range:
___ Hot food when served should not be below 140 F _____exceptions of _____observations
___ Cold food when served should not be more than 41 F _____exceptions of _____observations
___4. Percentages (%) of food intake documented appropriately _____exceptions of _____observations
___5. 14 hours or less between evening meal and breakfast meal, or substantial snack offered
_____exceptions of _____observations
___6. Staff seated when assisting residents to eat _____ exceptions of _____ observations
___7. Staff talking with residents whil assisting to eat _____ exceptions of _____ observations
___8. Napkins, not utensils or cup, used to remove food debris from mouth _____ exceptions of _____ observations
___9. Room trays returned to dietary within one (1) hour after meal servied unless resident requires more time
_____ exceptions of _____ observations
___10. Residents requiring assistance beyond one hour - food is reheated or replaced
_____ exceptions of _____ observations

B. Nourishment Room/Kitchenette Areas
___1. Room clean and orderly
___2. Refrigerator temperature below 41 F
___3. Food items labeled with dates and resident's name
___4. No outdated food in refrigerator
___5. Only resident food in refrigerator
___6. Snacks available 24 hours/7days a week

C. Restorative Dining Programs (Worksheet attached)
___1. Dining program in place with appropriate referrals, and interventions are utilized ____ exceptions of ____observations
___2. Documentation completed per facility policy/procedures _____exceptions of _____observations
___3. Adaptive equipment being utilized and staff aware of how to use equipment _____exceptions of _____observations
___4. Program allow for privacy as indicated_____exceptions of _____observations
___5. No more than four residents/care provider. Documentation by licensed nurse evaluating resident staff trained to needed techniques to provide assistance with eating _____exceptions of _____observations
___6. MDS documentation supports appropriateness of restorative program (No independent or total assist)
___7. MDS reflects dining program _____exceptions of _____observations
___8. Care plan reflects dining program/adaptive equipment usage _____exceptions of _____observations

D. Snacks
___1. Served promptly and staff assisting resident as needed _____exceptions of _____observations
(Dietary date and label with resident's name)
___2. Percentages(%) of snacks intake documented appropriately _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

E. Thickened Liquids (Worksheet attached)

___1. Staff aware of thickened orders/consistency and liquids served per physician orders
_____exceptions of _____observations
___2. Staff have been trained on thickening procedure _____exceptions of _____observations
___3. Intake matches resident needs _____exceptions of _____observations
___4. Thickener at bedside or water pitcher removed _____exceptions of _____observations
___5. Evidence of speech therapy evaluation _____exceptions of _____observations
___6. MDS reflects swallowing problems _____exceptions of _____observations
___7. Care plan reflects thickened liquids/swallowing problems _____exceptions of _____observations

VI. Drug Room, Med Carts, and Treatment Carts

___A. Cleanliness: spills wiped up, contain appropriate supplies, no food items except those used in giving meds, drawers free of med debris
___B. Locks: med room and cart are locked if unattended (Scheduled IV meds double locked)
___C. Internals and Externals stored separately
___1. Proper temperature (36-44 F) in refrigerator
Nursing Station I _____
Nursing Station II_____
Other _____
___2. Meds are labeled and dated
___3. Multidose vials dated when opened and discarded after 30 days or as indicated
___4. Discontinued/outdated meds returned to pharmacy or destroyed per facility policy
___E. Evidence of recapped needles and sharps below fill line
___F. Emergency box locked and up-to-date with proper documentation
___G. Scheduled IV meds Count Sheet completed appropriately
___H. Outdated meds not on cart
___ I. Only staff authorized to give meds have keys
___J. All control medications counted every shift or per policy
___K. Competency skills checklist for all routes of med administration in staff files_____exceptions of _____observations

VII: Nursing Procedures

A. Skin Conditions (Worksheet attached)

___ 1. Admission assessment identifies pre-existing signs of skin breakdown and interventions added
_____exceptions of _____observations
___ 2. *Standardized pressure ulcer risk assessments current, (within 24 hrs of admit and then weekly x4, readmit, significant change and q MDS) _____exceptions of _____observations
___ 3. Interventions added based off of risk assessment score and identified risk factors including hx of ulcers
_____exceptions of _____observations
___ 4. For high risk residents, special mattresses/cushions (air, H2O, Gel) are utilized and care planned
_____exceptions of _____observations
___ 5. Daily monitoring of skin for high risk residents by direct care staff, staff aware of what to look for/report
_____exceptions of _____observations
___ 6. High risk skin audit done for at-risk residents (Audit sheet attached)_____exceptions of _____observations
___ 7. Weekly skin monitoring, documented on at-risk residents
_____exceptions of _____observations
___ 8. *Standardized skin ulcer documentation with each dressing change, change in skin ulcer status or at least weekly current and accurate in description of area _____exceptions of _____observations
___ 9. Daily monitoring of wound-surrounding tissue-dressing documented _____exceptions of _____observations
___10. Comptency skills checklist for dressing changes completed (Sample of checklist attached)
_____ exceptions of _____ observations
___11. Pressure ulcer care or other skin ulcers: treatment technique carried out appropriately
_____exceptions of _____observations
___12. Physician orders complete, include cleaning product and per clinical guidelines_____exceptions of _____observations
___13. Pictures per policy _____exceptions of _____observations
___14. Treatment changed/physician & responsible party notified immediately if wound worsening and if non-healing within 2-4 weeks (reassess overall clinical condition) _____exceptions of _____observations
___15. Family and physician notified initially and as skin ulcer changes _____exceptions of _____observations
___16. Medical Director notified in writing of skin ulcers _____exceptions of _____observations
___17. Actual breakdown audit done for all residents with skin breakdown (Audit sheet attached)
_____exceptions _____observations
___18. Weekly or QO week weights, followed on _____exceptions of _____observations
___19. Monthly input from dietician and followed up on _____exceptions of _____observations
___20. Lab monitored (albumin, H&H, WBC etc) as indicated_____exceptions of _____observations
___21. Medical Director approved and signed off on facility policy and protocol_____exceptions of _____observations
___22. MDS reflects presence of skin ulcer _____exceptions of _____observations
___23. Care plan reflects presence, interventions, and treatments of skin ulcer_____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

B. Infection Control Precaution

___ 1. Proper procedure to fit specific precautions_____exceptions of _____observations
___ 2. Supplies available to fit specific precautions_____exceptions of _____observations
___ 3. Biohazardous wastes stored properly_____exceptions of _____observations
___ 4. Infection control reporting reflective of facility infections_____exceptions of _____observations
___ 5. Evidence of Universal Precautions being carried out? i.e.: handwashing, proper use of gloves, etc.
_____exceptions of _____observations
___ 6. Infection Control reflected in the Q.A. minutes. Trends are identified. _____ exceptions of _____ observations
___ 7. Hepatitis B vaccine offered upon employment and given per recommended schedule
(initial, 30 days, 6 months from initial) _____ exceptions of _____ observations
___ 8. Employee TB testing completed as soon as employment begins using the two step method
_____exceptions of ____observations
___ 9. Resident TB testing completed as soon as residency begins using the two step method
_____exceptions of _____observations
___10. List of residents that received Influenza (reason documented in chart for those that did not receive injection)
_____exceptions of _____observations
___11. List of residents that received Pneumovac (reason documented in chart for those that did not receive injection)
_____exceptions of _____observations
___12. Clean linens transported and stored covered (hallways, closets, bathing areas)____exceptions of_____observations
___13. Soiled linens bagged at point of use_____exceptions of _____observations
___14. Comptency skills checklist for universal precautions completed (Sample of checklist attached)
_____exceptions of _____observations
___15. Active infection control program or process to track and trend (Sample of Infection Control log attached)
_____exceptions of _____observations

C. Urinary Tract Infections (Worksheet attached)

___1. Trend analysis to identify acute vs chronic UTI_____exceptions of _____observations
___2. Trend analysis done to identify cluster locations, staff trends_____exceptions of _____observations
___3. Intake matches hydration needs _____exceptions of _____observations
___4. Risk factors assessed and appropriate interventions added and care planned (increased fluids, cranberry, shower vs w/p, urology consult, prophylactic tx, etc)_____exceptions of _____observations
___5. Toileting schedule evaluated and adjusted as indicated for chronic UTIs_____exceptions of _____observations
___6. Post void residual done for chronic UTIs_____exceptions of _____observations
___7. Appropriate treatment* (symptoms and treatments per guidelines) _____exceptions of _____observations
___8. Comptency skills checklist completed (Sample of checklist attached) _____exceptions of _____observations
___9. Temporary care plan initiated
___10. MDS reflects presence of UTI

D. Incontinent Care

___1. Complete 2-3 staff from each work area/each shift for incontinence care competency skill checklist
___2. Incontinence care given matches policy (freq of cleansing, products used, moisture barrier)
_____exceptions of _____observations
___3. Incontinence care given matches care plan (freq of cleansing, products used, moisture barrier)
_____exceptions of _____observations
___4. Incontinence care products stored out of sight in resident rooms _____exceptions of _____observations

E. IVs (Worksheet attached)

___1. Physician orders are carried out accurately _____exceptions of _____observations
___2. I & Os accurate according to physician orders _____exceptions of _____observations
___3. MDS reflects IV usage _____exceptions of _____observations
___4. Care plan reflect IV usage _____exceptions of _____observations
___5. Competency skills checklist completed. (Sample of checklist attached) _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

F. Suctioning (Worksheet attached)
___1. Supplies available _____exceptions of _____observations
___2. Physician order for suctioning _____exceptions of _____observations
___3. MDS reflects suctioning _____exceptions of _____observations
___4. Care plan reflects reason for suctioning _____exceptions of _____observations
___5. Competency skills checklist completed. (Sample of checklist attached) _____exceptions of _____observations

G. Glucose Monitoring
___1. Evidence of training on glucose monitoring for appropriate personnel _____exceptions of _____observations
___2. Evidence of a CLIA waiver
___3. Competency skills checklist completed (Sample of checklist attached) _____exceptions of _____observations

H. Oxygen (Worksheet attached)
___1. Appropriate liters per physician orders _____exceptions of _____observations
___2. MDS reflects use of oxygen _____exceptions of _____observations
___3. Care plan reflects oxygen usage _____exceptions of _____observations
___4. Competency skills checklist completed (Sample of checklist attached) _____exceptions of _____observations

I. Pain Management (Worksheet attached)
___ 1. Staff regularly screen all residents for pain (with routine cares) and positive screen leads to comprehensive assessment and appropriate interventions _____ exceptions of _____ interventions
___ 2. Nonverbal indicator/scale used for cognitively impaired residents _____exceptions of _____observations
___ 3. *Standardized pain assessment completed per policy (within 24 hrs of admission, readmission, sig change, each MDS)_____exceptions of _____observations
___ 4. Diagnosis for pain meds _____exceptions of _____interventions
___ 5. Residents pain rated prior to and after PRN pain med given_____exceptions of _____observations
___ 6. Non-pharmacological approaches used as well as medications_____exceptions of _____observations
___ 7. Use pain chart audit on 5-10% of residents_____exceptions of _____observations
___ 8. Residents triggering QM/QI with moderate/severe pain - plan of care adjusted appropriately _____exceptions of _____observations
___ 9. MDS accurately reflects pain _____exceptions of _____observations
___10. Care plan reflects pain management _____exceptions of _____observations

VIII. Fire and Safety
___1. Residents/staff smoke in appropriate areas _____exceptions of _____observations
___ Protective clothing, I.e. smoking aprons, worn as appropriated
___ Staff supervision of resident who smoke, if appropriate
___2. Employee knowledgeable of safety threat procedures
___ Staff understand procedure on responding to Abuse, Neglect and Exploitation _____exceptions of _____observations
___ Staff understand procedure on responding to elopement _____exceptions of _____observations
___ Staff understand procedure on responding to tornados _____exceptions of _____observations
___ Staff understand procedure on responding to fire _____exceptions of _____observations
___3. Within the last 12 months, each shift has a quarterly fire drill (no more than 3 months between drill on each shift) _____exceptions of _____observations
___4. Staff aware of location of eye wash stations, MSDS books, pull stations and emergency exits, hazardous communications policy, general policies and procedures ____exceptions of _____observations
___5. Chemicals locked _____exceptions of _____observations

IX. Employee Files
___1. Evidence of registry check in CNAs' personnel files prior to working?_____exceptions of _____observations
___2. Up-to-date skills checklist in each employee personnel file_____exceptions of _____observations
___3. Screening/background check of all employees prior to hire _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

X. Inservice Education

___1. Employees in-service logs up-to-date and cover required inservices (Required in-services log attached)
_____exceptions of _____observations
___2. Staff needs assessed and inserviced on yearly
___3. Medical Director approved the facility yearly in-service calendar

XI. Poly Pharmacy/Psychotropic Medications/Depression Management

A. Poly Pharmacy (Worksheet attached)

___1. Documentation to support review/reduction attempts of residents with nine (9) or more meds
_____exceptions of _____observations
___2. Diagnosis listed for each medication _____exceptions of _____observations
___3. MARs, TARs, PRNs signed and followed up appropriately _____exceptions of _____observations
___4. No meds from the BEERS list ordered unless resident choice and risk/benefits education provided
_____exceptions of _____observations
___5. Monthly review of meds by pharmacist, followed up on pharmacist's recommendations, and physician notified
_____exceptions of _____observations

B. Psychotropic Medications (Worksheet attached)
(Antipsychotic, Hypnotic, Antianxiety)

___ 1. Physician orders complete to include an approved diagnosis/reason for usage_____exceptions of _____observations
___ 2. Documented behaviors and alternative interventions prior to medications initiated_____exceptions _____observations
___ 3. Evidence of consent prior to use by resident and/or legal representative _____exceptions of _____observations
___ 4. Evidence of a psychiatric evaluation, if applicable _____exceptions of _____observations
___ 5. AIMS/Discus test completed prior to use and q 6months _____exceptions of _____observations
___ 6. Documented evidence of monthly behavior observation _____exceptions of _____observations
___ 7. Evidence of monthly observations of side effects/adverse reactions from medications
_____exceptions of _____observations
___ 8. Hypnotic use no more than 10 consecutive days in a row _____exceptions of _____observations
___ 9. Review of residents with behaviors affecting others (from QM/QI report) and care plan updated
_____exceptions of _____observations
___10. Evidence of gradual dose reductions unless clinically contraindicated *(per regulations)
_____exceptions of _____observations
___11. Risk/benefit statement documented_____exceptions of _____observations
___12. Evidence of monthly review by pharmacist _____exceptions of _____observations
___13. MDS reflects psychotropic usage and behaviors _____exceptions of _____observations
___14. Care plan reflects psychotropic usage to include behavior modification _____exceptions of _____observations

C. Depression Management (Worksheet attached)

___1. All residents screened for depression using a validated screening tool (not the MDS) within seven days of admission readmission, significant change and q MDS _____exceptions of _____observations
___2. Positive screen leads to *standardized comprehensive assessment/interventions/diagnosis/reassessment in two weeks_____exceptions of _____observations
___3. All residents with symptoms of depression have treatment plan in place (per QM/QI report)
_____exceptions of _____observations
___4. Physician orders complete to include an approved diagnosis/reason for usage_____exceptions of _____observations
___5. If no prescription documentation as to reason, resident and family education provided to make informed decision
_____exceptions of _____observations
___6. Evidence of monthly observations of side effects/adverse reactions from medications
_____exceptions of _____observations
___7. Evidence of a psychiatric evaluation; if applicable _____exceptions of _____observations
___8. Evidence of monthly review by pharmacist _____exceptions of _____observations
___9. MDS reflects antidepressant usage _____exceptions of _____observations
___10. Care plan reflects antidepressant usage and non pharmacological interventions ____exceptions of ____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

XII. Quality Improvement Program

___1. Last year's annual survey and any complaint surveys reviewed and all citations corrected and monitored through QA until stable or resolved _____exceptions of _____observations
___2. Quarterly minutes up-to-date, Medical Director attends _____exceptions of _____observations
___3. Evidence of monitoring to ensure problems/concerns identified in minutes have been followed up and action is being taken to correct these problems/concerns
___4. Evidence of all disciplines involved in QI process/program
___5. Evidence of QMs/QIs being used/followed up monthly
___6. Activities and social services ensure that residents with little or no activity from QI report have social needs met and care planned
___7. Physical and mental evaluation done of residents that are newly coded with cognitive impairment on QI report
___8. QI review of new fractures, fecal impaction and appropriate follow up evident

XIII. Accident/Incidents

___1. Occurrence Reports - Last 3 months completed appropriately and signed by Administrator/DON/Medical Director
___2. Accidents/incidents reflected in Q.A. minutes
___3. Trend analysis are done
___4. Nurses Notes follow the facility policy/procedure _____exceptions of _____observations
___5. Fall Assessments are up-to-date _____exceptions of _____observations
___6. Staff aware of residents at-risk for falls and specific interventions _____exceptions of _____observations
___7. Report Abuse, Neglect, and Exploitation to State as appropriate
___8. Care plan reflective of risk and interventions, updated after each occurrence _____exceptions of _____observations

XIV. Minimum Date Set (MDS)

___1. MDS completed timely per regulations _____exceptions of _____observations
___2. Triggers and RAPs completed with each Comprehensive Assessment and indicate where information found in chart_____exceptions of _____observations
___3. MDS/Triggers/RAPs accurate to the resident's conditions and RAPs worked thoroughly (not just lists) _____exceptions of _____observations
___4. RN signed and dated MDS completion section R2a, R2b, VB2

XV. Restorative Nursing (Worksheet attached)

___1. Assessments done according to facility policy/procedure _____exceptions of _____observations
___2. Progress notes written according to facility policy/procedure and signed by Licensed Nurse _____exceptions of _____observations
___3. All residents on restorative nursing program or documentation in chart to support why not
___4. Residents that have decline in ADLs (per QMs/QIs) on restorative program _____exceptions of _____observations
___5. Residents that are bedfast (per QMs/QIs) have restorative program and activities needs met _____exceptions of _____observations
___6. Functional limitations of extremities assessed quarterly and addressed on care plan and MDS _____exceptions of _____observations
___7. Documentation - MDS section G
a. Documentation in clinical record matches coding of section G (or how is coding determined) _____exceptions of _____observations
b. How many days do staff document for section G or how is level of self performance determined _____exceptions of _____observations
___8. Documentation - MDS section P3
a. Is there documentation in the clinical record to support coding of MDS section P3 _____exceptions of _____observations
b. Are minutes documented for any programs coded on P3 of MDS _____exceptions of _____observations
c. Are there measurable objectives and interventions in care plan and clinical record (for direct care staff) _____exceptions of _____observations
d. Is there evidence of periodic evaluations by licensed nurse in the clinical record _____exceptions of _____observations
e. Is there documentation of training to staff of techniques that promote resident involvement in the program _____exceptions of _____observations
f. Activities are carried out by or under the supervision of nursing staff _____exceptions of _____observations
g. Programs do not include exercise groups with more than four residents per caregiver _____exceptions of _____observations
h. Programs do not include activities that are incidental to dressing etc. _____exceptions of _____observations
___9. Restorative programs addressed on care plan _____exceptions of _____observations

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

XVI. Hospice Services (Worksheet attached)

___1. Physician order for admission to Hospice _____exceptions of _____observations
___2. Documentation of collaboration between Hospice and facility on treatment plan and goals for the patient
_____exceptions of _____observations
___3. Evidence of communication between Hospice staff and facility staff
___4. MDS shows hospice services

XVII. Miscellaneous

___1. Hot water temperatures within acceptable ranges:
___ Resident bathing areas (98 F - 120 F) Area tested _____
___ Clinical (98 F - 120 F): Temperature _____ Area tested _____
___ Laundry (160 F): Temperature _____ *Must be at 160 F unless using special chemicals
Dietary Temperatures:
___ Dishwater rinse cycle (160 F): Temperature _____
___ Handwashing station (120F): Temperature_____
___2. Observe a med pass and treatment pass. Skills competency checklist for med pass completed.
(Sample of checklist attached)
___3. MDS/RAPs/Care plans individualized, current, accurately reflect resident and care received
___4. Most recent survey posted for public access
___5. 24 hour direct care staffing posted for public
___6. Medicare/Ombudsman/hotline numbers posted for residents and public
___7. Federal Labor Law poster posted for staff

***Bed Rail Safety Guidelines:**

1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped.
2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering
3. Care should by taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress.
4. Check for compression of the mattress' outside perimeter. Easily compressed perimeteres can increase the gaps. between the mattress and the bed rail
5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable.
6. The space between the bed rails and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails.
7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken.
8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment.
9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items should be ongoing.

***Incontinence/urinary tract symptoms and treatment:**

Post void residual of 150cc or greater may indicate finding is clinically significant.
No one lab test alone proves a urinary tract infection is present. Because many residents have chronic bacteriuria, the research-based literature suggests treating only symptomatic UTI's
Indications to treat a UTI: Symptomatic UTI's are based on the following criteria:

Residents without catheter present should have at least three of the following signs and symptoms:

fever (increase in temperature of >2 degrees F or rectal temperature >99.5 degrees F or single measurement of temperature >100 degrees F
new or increased burning pain on urination, frequency or urgency
new flank or suprapubic pain or tenderness
change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reproted by the laboratory new pyuria or microscopic hematuria)
worsening of mental or functional status (e.g., confusion, decreased appetite, unexplained falls, incontinence of recent onset, letha decreased activity)

Residents with a catheter should have at least two of the following signs and symptoms:

fever or chills
new flank pain or suprapubic pain or tenderness
change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reproted by the laboratory (new pyuria or microscopic hematuria)
worsening of mental or functional status. local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

*Validated depression screening tools include: Beck Depression Inventory (BDI), Center for Epidemiologic Studies Scale (CES-D), Cornell Scale for Depression in Dementia (CSDD), Geriatric Depression Scale (GDS), Hamilton Rating Scale for Depression (Ham-D), Patient Health Questionaire-9 (PHQ-9)

*Standardized pressure ulcer risk assessment forms: Braden, Norton or Norton Plus Scales, if use other form, ensure form includes impaired bed/chair mobility, bladder/bowel incontinence and/or moisture, impaired nutritional status.

*Comprehensive pressure ulcer assessment includes: location, stage, size (length x width x depth), presence/location/extent of any undermining/tunneling/sinus tracts, exudate (color, odor and amount), pain, wound bed and tissue type (necrotic, slough, eschar, granulation, epithelialization), description of wound edges and surrounding tissue.

*Comprehensive pain assessment includes: description of the pain, location, intensity/severity using accepted pain scale, frequency, current pain, pain at worst/least, aggravating/alleviating factors, effects of pain on life (sleep, appetite, physical activity, emotions, mood, nausea), current treatment, response to current treatment.

*Bowel and Bladder assessment guidelines to include: prior history of and previous tx, physical exam to identify structural disorders,, risk factors (cognitive impairment, mobility, visual problems, CHF, CVA, diabetes mellitus, Parkinson's, neurological disorders), functional impairments, impairments or alteration in patterns of intake/hydration status, constipation or fecal impaction, medications (anticholinergic properties), voiding patterns and classification of type of incontinence, post void residual/retention, UTIs, environmental factors (grab bars, raised toilet seats etc), assistance needed

***Dosage Reduction Guidelines:**
Antidepressant: Dosage reductions are not required by state and federal guidelines, but goal is effectiveness with minimal side effects.

Sedative/Hypnotic:
1. Daily use of hypnotic drug is less than 10 days consecutively.
2. Three dosage reduction attempts must be made within six months before it is considered clinically contraindicated to reduce the dosage.
3. Exceptions to dosages and continued usage are allowed when there is well documented improvement or maintenance of functional status (documentation must be both quantitative and qualitative).

Antianxiety:
1. Not to be used more than four months.
2. Dosage reduction should be attempted at least twice in one year before dosage reductions would be considered clinically contraindicated.
3. Exceptions to continuous usage includes:

A. Generalized Anxiety disorders
B. Anxiety associated with psychiatric disorder
C. Well documented maintenance or improvement of function status or maintenance dose
D. Organic mental syndromes with agitated features which constitutes distress or dysfunction to the resident or demonstrates a danger to self or others
E. Buspar is exempted from gradual dosage reduction requirements (documentation must be both quantitative and qualitative)

Nursing Home Name:_____ **Date** _____

Rank each item with a (S) for Satisfactory or a (U) for Unsatisfactory.

Antipsychotic:

1. Proceed gradually under close supervision
2. A four-month waiting period may be an appropriate waiting time before beginning a gradual dosage reduction.
3. Twice within one year of initiation of therapy for residents with organic mental syndromes.
4. Contraindications to dosage reduction include:

A. Residents with a specific diagnosis (schizophrenia, schizo-affective disorders, delusional disorder, psychotic mood disorder, including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, schizopheniform disorder, atypical psychosis, Toureette's disorder, Huntington's disease) and has a history of recurrence of psychotic symptoms (e.g. delusions, hallucinations) with a maintenance dose of an antipsychotic drug without incurring significant side effects.

B. Residents with organic mental syndromes (now called "Delirium, Dementia, and Amnestic and other Cognitive Disorders") and has had a gradual dose reduction attempted twice in one year and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction, or a return to previous dose reduction was necessary.

C. The resident's physician provides a justification why the continuous use of the drug and the dose of the drug is clinically appropriate. The justification should include diagnosis, not simply a label or code, but the description of the symptoms, a discussion of the differential psychiatric and medical diagnosis, description of the justification for the choice of a particular treatment, a discussion of why the present dose is necessary to manage the symptoms of the resident. This information need not necessarily be in the physician's progress notes, but must be a part of the clinical record.

COMMENTS:

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Catheters												
Room #	Resident Name	Medical reason documented on chart	Physician orders: state size, how often to change, irrigate, etc.	Fluid needs assessed and met	Proper positioning of drainage bag and tubing	Leg anchors and bag covers in place	Urine- color, odor, consistency	Catheter care & handling of drainage bag per policy	I & Os accurate and discrepancies reported	Competency skills checklist completed	MDS reflects catheter usage	Care plan reflects catheter usage

Notes

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Tube Feeding											
Room #	Resident Name	Mouth care moist, free of debris and odor	Stoma site clean, tx per orders/policy	Utensils clean, dated and stored properly	Head of bed elevated appropriately	Documentation of bowel sounds	Documentation of quality of lung sounds	Weighed per policy/changed addressed	Physician orders carried out accurately	I & Os complete/accurate according to physician's orders	Evidence of speech therapy evaluations

Notes

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Tube Feeding (continued)											
Room #	Resident Name	Monthly input by the Dietician	Dietician recommendations for fluids/calories/ nutrients match current orders	Documentation of need for tube feeding	If NPO, water pitcher removed from room	Oral intake supervised and documented accurately	Competency skills check list for continuous and bolus feeding completed	Competency skills checklist for meds per G-tube completed	MDS reflects usage of tube feeding	Care plan reflects usage of tube feeding	

Notes

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Trachs												
Room #	Resident Name	Mouth care given and charted every shift	Tie and/or dressing clean, dated and stored properly	Utensils clean, dated and stored properly	Head of bed elevated properly	Competency skills checklist completed	MDS reflects the trach	Care plan reflects the trach				

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Fluid Restriction/Hydration Needs											
Room #	Resident Name	Physician orders clear on how much intake is allowed	Clear division of amounts to be given by Nursing and Dietary per shift	I & Os current and within acceptable ranges per physician orders	Water pitcher at bedside removed or per care plan	For residents with hydration needs, there is evidence of lab values monitored and followed up on	Residents without signs of dehydration, dy cracked lips, skin tenting	MDS reflects the fluid restrictions	Care plan reflects fluid restrictions		

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Restraints												
Room #	Resident Name	Physician orders current and include: medical symptom, when to use, type of device, length of time and frequency	Checked and released every 2 hours - 10 minutes for repositioning, toileting and exercise	Restraints in good condition; proper type used; and used as ordered	Restraints applied properly	Evidence of P.T. and/or O.T. input into restraint usage	Evidence of resident and /or legal representative consent and education for use of the restraint	Evidence of alternatives tried prior to restraint application	Documented evidence of prerestraining assessment prior to use and ongoing restraint reductions, including residents admitted with restraint order	Functional abilities evaluated, declines addressed, on restorative nursing program	MDS reflects restraint usage	Care plan reflects catheter usage

Notes

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Siderails										
Room #	Resident Name	Evidence of a siderail assessment	If the siderail is indicated as a restraint on the assessment, evidence of alternatives prior to utilizing the siderail	Physician orders correct to include specific reason for usage	Evidence of P.T. and/or O.T. input into the siderail usage if it is considered a restraint	Care plan reflects the siderail usage	Evidence of resident/and legal representative consent and education for the use of the siderail	MDS reflects the siderail usage		

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Bowel/Bladder Program												
Room #	Resident Name	Bowel/Bladder Assessment completed per policy and appropriate actions taken	Evidence of 1-3-day I & O/patterning, and progress notes per facility policy/procedure	Diagnosis to support type of incontinence	Appropriate incontinence program initiated (retraining, prompted voiding, scheduled toileting)	Staff aware of individualized toileting programs	All residents incontinent (coded as 2 or 3 on MDS) on toileting plan or documented why not	Documentation to support why residents coded as occasionally or frequently incontinent without a toileting plan from QM/QI	Competency skills checklist completed	Competency skills checklist completed	Bowel/bladder program addressed on MDS	Bowel/bladder program addressed on care plan

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Weights										
Room #	Resident Name	All residents are weighed per physician orders or facility policy	Evidence of intervention by appropriate disciplines (i.e. Physician notified, Dietitian re-weighing, on gradual weight loss, fluctuations of weights)	Malnutrition assessment per policy and results followed up on	Residents reweighed when have 1-2 # difference	Weights monitored for 5% change monthly, 7 1/2% change in 3 months, or 10% change in 6 months	Lab values monitored (albumin, prealbumin, elctrolytes,etc) and hydration needs assessed	Weight loss addressed on MDS	Weight loss addressed on care plan	

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Restorative Dining Programs										
Room #	Resident Name	Dining program in place with appropriate referrals, and interventions are utilized	Documentation completed per facility policy/procedures	Adaptive equipment being utilized and staff aware of how to use equipment	Program allow for privacy as indicated	No more than four residents/car provider. Documentation by licensed nurse evaluating resdient staff trained to needed techniques to provide assistance with eating	MDS documentation supports appropriateness of restorative program	MDS reflects dining program	Care plan reflects dining program/adaptive equipment usage	

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Thickened Liquids											
Room #	Resident Name	Staff aware of thickened orders/consistency and liquids served per physician orders	Staff have been trained on thickening procedure	Intake matches resident needs	Thickener at bedside or water pitcher removed	Evidence of speech therapy evaluation	MDS reflects swallowing problems	Care plan reflects thickened liquids/swallowing problems			

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Skin Conditions									
Room #	Resident Name	Admission assessment identifies pre-existing signs of skin breakdown and interventions added	*Standardized pressure ulcer risk assessments current, (within 24 hrs of admit and then weekly x4, readmit, significant change and q MDS)	Interventions added based off of risk assessment score and identified risk factors including hx of ulcers	For high risk residents, special mattresses/cushions (air, H2O, Gel) are utilized and care planned	Daily monitoring of skin for high risk residents by direct care staff, staff aware of what to look for/report	High risk skin audit done for at-risk residents	Weekly skin assessment documented on at-risk residents	*Standardized skin ulcer documentation with each dressing change, change in skin ulcer status or at least weekly current and accurate in description of area

Notes

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Skin Conditions (continued)									
Room #	Resident Name	Daily monitoring of wound-surrounding tissue-dressing documented	Competency skills checklist for dressing changes completed	Pressure ulcer care or other skin wounds: treatment technique carried out appropriately	Physician orders complete, include cleaning product and per clinical guidelines	Pictures per policy	Treatment changed/physician & responsible party notified immediately if wound worsening and if non-healing within 2-4 weeks	Family and Physician notified initially and as skin ulcer changes	Medical Director notified in writing of skin ulcers

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Skin Conditions (continued)										
Room #	Resident Name	Actual breakdown audit done for all residents with skin breakdown	Weekly or QO week weights, followed on	Monthly input from dietician and followed up on	Lab monitored (albumin, H&H, WBC etc) as indicated	Medical Director approved and signed off on facility policy and protocol	MDS reflects presence of skin ulcer	Care plan reflects presence, interventions, and treatments of skin ulcer		

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Urinary Tract Infections											
Room #	Resident Name	Trend analysis to identify acute vs chronic UTI	Trend analysis done to identify cluster locations, staff trends	Intake matches hydration needs	Risk factors assessed and appropriate interventions added and care planned	Toileting schedule evaluated and adjusted as indicated for chronic UTIs	Post void residual done for chronic UTIs	Appropriate treatment	Competency skills checklist completed	Temporary care plan initiated	MDS reflects presence of UTI

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Ivs										
Room #	Resident Name	Physician orders are carried out accurately	I & Os accurate according to physician orders	MDS reflects IV usage	Care plan reflects IV usage	competency skills checklist completed				

Notes

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Suctioning										
Room #	Resident Name	Supplies available	Physician order for suctioning	MDS reflects suctioning	Care plan reflects reason for suctioning	Competency skills checklist completed				

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Oxygen										
Room #	Resident Name	Appropriate liters per physician orders	MDS reflects use of oxygen	Care plan reflects oxygen usage	Competency skills checklist in staff files					

Notes

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Pain Management											
Room #	Resident Name	Staff regularly screen for all residents for pain (with routine cares) and positive screen leads to comprehensive assessment and appropriate interventions	Nonverbal indicator/scale used for cognitively impaired residents	*Standardized pain assessment completed per policy (within 24 hrs of admission, readmission, sig change, each MDS)	Diagnosis for pain meds	Residents pain rated prior to and after PRN pain med given	Non-pharmacological approaches used as well as medications	Use pain chart audit on 5-10% of residents	Residents triggering QM/QI with moderate/severe pain - plan of care adjusted appropriately	MDS accurately reflects pain	Care plan reflects pain management

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Poly Pharmacy/Psychotropic Medications/Depression Management								
Room #	Resident Name	Documentation to support review/reduction attempts of residents with nine (9) or more meds	Diagnosis listed for each medication	MARs, TARs, PRNs signed and followed up appropriately	No meds from the BEERS list ordered unless resident choice and risk/benefits education provided	Monthly review of meds by pharmacist, followed up on pharmacist's recommendations, and physician notfified		

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Psychotropic Medications (Antipsychotic, Hypnotic, Antianxiety)											
Room #	Resident Name	Physician orders complete to include an approved diagnosis/reason for usage	Documented behaviors and alternative interventions prior to medications initiated	Evidence of consent prior to use by resident and/or legal representative	Evidence of a psychiatric evaluation, if applicable	AIMS/Discuss test completed prior to use and q 6 months	Documented evidence of monthly behavior observation	Evidence of monthly observations of side effect/adverse reactions from medications	Hypnotic use no more than 10 consecutive days in a row	Review of residents with behaviors affecting others (from QM/QI report) and care plan updated	Evidence of gradual dose reductions unless clinically contraindicated *(per regulations)

Notes

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Psychotropic Medications (continued)											
Room #	Resident Name	Risk/benefit statement documented	Evidence of monthly review by pharmacist	MDS reflects psychotropic usage and behaviors	Care plan reflects psychotropic usage to include behavior modification						

Notes

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Depression Management											
Room #	Resident Name	All residents screened for depression using a validated screening tool (not the MDS) within seven days of admission, readmission, significant change and q MDS	Positive screen leads to *standardized comprehensive assessment/interventions/diagnosis/reassessment in two weeks	All residents with symptoms of depression have treatment plan in place (per QM/QI report)	Physician orders complete to include an approved diagnosis/reason for usage	If no prescription documentation as to reason, resident and family education provided to make informed decision	Evidence of monthly observations of side effects/adverse reactions from medications	Evidence of a psychiatric evaluation; if applicable	Evidence of monthly review by pharmacist	MDS reflects antidepressant usage	Care plan reflects antidepressant usage and non pharmacological interventions

Notes

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Restorative Nursing										
Room #	Resident Name	Assessments done according to facility policy/procedure	Progress notes written according to facility policy/procedure and signed by Licensed Nurse	All residents on restorative nursing program or documentation in chart to support why not	Residents that have decline in ADL (per QM/QI) on restorative program	Residents that are bedfast (per QM/QIs) have restorative program and activities needs met	Functional limitations of extremities assessed quarterly and addressed on care plan and MDS	Documentation in clinical record matches coding of section G	How many days do staff document for section G or how is level of self performance determined	Is there documentation in the clinical record to support coding of MDS section P3

Notes

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Restorative Nursing (continued)											
Room #	Resident Name	Are minutes documented for any programs coded on P3 of MDS	Are there measurable objectives and interventions in care plan and clinical record	Is there evidence of periodic evaluations by licensed nurse in the clinical record	Is there documentation of training to staff of techniques that promote resident involvement in the program	Activities are carried out by or under the supervision of nursing staff	Programs do not include exercise groups with more than four resident per caregiver	Programs do not include activities that are incidental to dressing etc.	Restorative programs addressed on care plan		

Notes

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Hospice Services									
Room #	Resident Name	Physician order for admission to Hospice	Documentation of collaboration between Hospice and facility on treatment plan and goals for the patient	Evidence of communicaiton between Hospice staff anf facility staff	MDS shows hospice services				

Notes

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Staff Competency Evaluation
Emptying Urinary Drainage Bag

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Place paper towel or moisture proof pad on the floor and place measuring container on paper towel	☐	☐	_____
7. Open the clamp on the bottom of the drainage bag, don't touch it to the graduate	☐	☐	_____
8. Let all urine drain from bag and close the clamp on the catheter bag	☐	☐	_____
9. Cleanse the tip of the drainage port and replace in holder on catheter bag	☐	☐	_____
10. Observe urine for odor, color and consistency	☐	☐	_____
11. Measure urine, discard paper towel or moisture proof pad, and empty graduate	☐	☐	_____
12. Rinse and/or disinfect graduate and return to proper place	☐	☐	_____
13. Remove gloves and tie trach bag (touch outside of bag only)	☐	☐	_____
14. Wash hands	☐	☐	_____
15. Open curtains, privacy screens, door	☐	☐	_____
16. Remove trash from room	☐	☐	_____
17. Record amount and report any unusual odor, color and consistency	☐	☐	_____

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Staff Competency Evaluation
Female Catheter Care

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/position resident on their back with knees flexed (monitor for limitations)	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Already performed incontinence care	☐	☐	_____
8. Separate labia, check for any crust, abnormal drainage, or secretions	☐	☐	_____
9. Cleanse the catheter from the meatus down the catheter about 4 inches	☐	☐	_____
10. Avoid tugging or pulling on the catheter, repeat above steps at indicated	☐	☐	_____
11. Ensure the catheter is secured properly, coiled and leg anchor in place/tubing secured	☐	☐	_____
12. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able	☐	☐	_____
13. Adjust brief and clothes	☐	☐	_____
14. Position resident and adjust bedding as indicated	☐	☐	_____
15. If gloves on, remove gloves and tie trash bag (touch outside of bag only)	☐	☐	_____
16. Return supplies and wipe off bedside table as indicated	☐	☐	_____
17. Wash hands	☐	☐	_____
18. Open curtains, privacy screens, door	☐	☐	_____
19. Removed trash from room	☐	☐	_____
20. Report any skin conditions/concerns to charge nurse	☐	☐	_____

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Staff Competency Evaluation
Male Catheter Care

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/position resident on their back with knees flexed (monitor for limitations)	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Already performed incontinence care	☐	☐	_____
8. Retract foreskin, check for any crusts, abnormal drainage, or secretions	☐	☐	_____
9. Cleanse the catheter from the meatus down the catheter about 4 inches	☐	☐	_____
10. Avoid tugging or pulling on the catheter, repeat above steps at indicated	☐	☐	_____
11. Return foreskin to natural position	☐	☐	_____
12. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able	☐	☐	_____
13. Adjust brief and clothes	☐	☐	_____
14. Position resident and adjust bedding as indicated	☐	☐	_____
15. If gloves on, remove gloves and tie trash bag (touch outside of bag only)	☐	☐	_____
16. Return supplies and wipe off bedside table as indicated	☐	☐	_____
17. Wash hands	☐	☐	_____
18. Open curtains, privacy screens, door	☐	☐	_____
19. Remove trash from room	☐	☐	_____
20. Report any skin conditions/concerns to charge nurse	☐	☐	_____

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Staff Competency Evaluation
G-Tube Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician orders, specifying solution, amount rate, frequency (bolus or continual)	☐	☐	_____
2. Gather equipment and supplies	☐	☐	_____
3. Identify resident, explain procedure and provide privacy	☐	☐	_____
4. If not contraindicated, raise HOB 45 degrees or more for duration of feeding and 1 hour after	☐	☐	_____
5. Wash hands and apply gloves	☐	☐	_____
6. Prepare work area, feeding supplies	☐	☐	_____
7. Verify G-tube placement either:			
a. Place syringe tip in G-tube	☐	☐	_____
i. Aspirate stomach contents to determine placement and amount of residual	☐	☐	_____
ii. If residual greater than 50-100cc notify Dr. and hold feeding (or per individual order or policy)	☐	☐	_____
iii. Return aspirated contents to stomach	☐	☐	_____
b. Put 5-10cc air in syringe			
i. Place syringe tip in G-tube	☐	☐	_____
ii. Inject air and listen with stethoscope over stomach area	☐	☐	_____
iii. Pinch off and hold G-tube, remove syringe	☐	☐	_____
c. Per policy	☐	☐	_____
8. Flush tube with prescribed amount of water	☐	☐	_____
9. Administer feeding as ordered, (bolus, gravity, pump)	☐	☐	_____
10. Flush tube with prescribed amount of water	☐	☐	_____
11. Clamp and secure feeding tube unless continual feeding	☐	☐	_____
12. Give site care as ordered	☐	☐	_____
13. Clean work area, store equipment per policy	☐	☐	_____
14. Remove gloves and wash hands	☐	☐	_____
15. Maintain HOB elevated per orders	☐	☐	_____
16. Record administration of feeding and flush	☐	☐	_____

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Skills Checklist for Medication Administration per G-Tube

_____ _____

CMA Name **Date**

_____ _____

Mentor Name **Date**

PREPARATION	Satisfactory	Unsatisfactory	Notes
1. Read policy on Administration of Medications through a G-Tube	☐	☐	_____
2. Complete checklist for disconnecting/reconnecting G-tube feeding	☐	☐	_____
3. Prepare meds, crush or dissolve as indicated	☐	☐	_____
4. Wash hands	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Clamp formula tubing if on continuous feeding	☐	☐	_____
7. Pinch off and hold G-tube	☐	☐	_____
8. Disconnect formula tubing from G-tube	☐	☐	_____
9. Cap formula tubing end	☐	☐	_____
10. Verify G-tube replace either	☐	☐	_____
a. Place syringe tip in G-tube			
i. Aspirate stomach contents to determine placement and amount of residual	☐	☐	_____
ii. If residual greater than 50-100cc notify nurse and hold meds	☐	☐	_____
iii. Return aspirated contents to stomach	☐	☐	_____

	Satisfactory	Unsatisfactory	Notes
b. If unable to aspirate stomach contents			
i. Put 5-10cc air in syringe and place syringe tip In G-tube	☐	☐	_____
ii. Inject air and listen with stethoscope over stomach area	☐	☐	_____
iii. Pinch off and hold G-tube, remove syringe	☐	☐	_____

ADMINISTRATION

1. Place syringe tip in G-tube with plunger removed from syringe	☐	☐	_____
2. Give ordered amount of water flush per gravity flow	☐	☐	_____
3. Give meds per gravity flow	☐	☐	_____
4. Give ordered amount of water flush per gravity flow	☐	☐	_____
5. Pinch off and hold G-tube	☐	☐	_____
6. Remove syringe from G-tube	☐	☐	_____
7. Connect formula tubing with G-tube for continuous feeding or cap G-tube	☐	☐	_____
8. Release clamp from formula tubing	☐	☐	_____
9. Set pump rate and start feeding	☐	☐	_____
10. Rinse syringe	☐	☐	_____
11. Remove gloves and wash hands	☐	☐	_____
12. Record flush on intake/output record	☐	☐	_____

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Staff Competency Evaluation
Trach Care

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Gather equipment and supplies	☐	☐	_____
3. Identify resident, explain procedure and provide privacy	☐	☐	_____
4. Assist to position resident in fowlers position or as indicated	☐	☐	_____
5. Wash hands, apply gloves, suction mouth/or pharynx as indicated	☐	☐	_____
6. Discard gloves, wash hands	☐	☐	_____
7. Open tray kit or provide sterile or clean field per orders	☐	☐	_____
8. Apply gloves-sterile or clean	☐	☐	_____
9. Remove and clean trach as ordered	☐	☐	_____
10. Cleanse skin surrounding trach site as indicated	☐	☐	_____
11. Remove gloves, wash hands and re-glove	☐	☐	_____
12. Replace trach and apply dressing as ordered	☐	☐	_____
13. Remove gloves and reapply as indicated to clean up work area and equipment, store per policy	☐	☐	_____
14. Remove gloves and wash hands	☐	☐	_____
15. Position resident as indicated	☐	☐	_____
16. Remove waste from room	☐	☐	_____
17. Wash hands	☐	☐	_____
18. Record care provided	☐	☐	_____

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Staff Competency Evaluation
Medication Pass

	Satisfactory	Unsatisfactory	Notes
1. Demonstrates knowledge of medication			
a. Able to state action, side effect and implications for resident	☐	☐	_____
2. Prevents transfer of infection			
a. Cleanses hands before beginning to work with medications and between resident contact and between resident contact	☐	☐	_____
b. Maintains clean work area	☐	☐	_____
c. Maintains cleanliness of medication	☐	☐	_____
d. Pill crusher clean	☐	☐	_____
3. Prepared medication accurately			
a. Checks medication label to medication record	☐	☐	_____
b. Pours accurate amounts of liquid and solid medication	☐	☐	_____
c. Medication label, order and medication record match	☐	☐	_____
d. Medications given within time frame ordered (with meals, empty stomach etc.)	☐	☐	_____
e. Crushed meds suitable for crushing and order to crush	☐	☐	_____
4. Administers medication accurately and effectively			
a. Identifies resident accurately	☐	☐	_____
b. Administers the following types of medication effectively:			
i. Oral	☐	☐	_____
ii. Rectal	☐	☐	_____
iii. Eye drops or ointment	☐	☐	_____
iv. Inhaler or nebulizer therapy	☐	☐	_____
v. Vaginal	☐	☐	_____
vi. Ear	☐	☐	_____
vii. Topical	☐	☐	_____
viii. Transdermal	☐	☐	_____
ix. Parenteral	☐	☐	_____
c. Observes resident to see that medication is taken and retained – (swallowed, not under tongue, not squeezed out of eye, not not expelled from rectum, etc.)	☐	☐	_____

Medication Pass (continued)

	Satisfactory	Unsatisfactory	Notes
d. Sites of injections and topical patch sites rotated	☐	☐	_____
5. Provides for the safety of medication			
a. Keeps medications on cart or tray within control at all times	☐	☐	_____
b. Does not leave meds at bedside unattended	☐	☐	_____
c. Schedule C-II meds double locked and controlled drug records properly maintained	☐	☐	_____
d. Med cart and med room locked when not in sight	☐	☐	_____
6. Records medications and observations			
a. Recorded with set up or after administration	☐	☐	_____
b. PRN recorded after administration and followed up on	☐	☐	_____
c. Obtains and records vitals as indicated	☐	☐	_____

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Staff Competency Evaluation
Ear Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Position resident lying down with head turned to side	☐	☐	_____
a. If medicine is not at body temperature as it comes from bottle, it may be warmed by holding it in the hands for a few minutes, avoid heating it above body temperature to prevent loss of potency	☐	☐	_____
b. Clean and dry ear canal if needed	☐	☐	_____
c. Gently pull ear to straighten canal, up and back for adults, down and back for children	☐	☐	_____
d. Instill medication into ear without touching dropper to ear canal	☐	☐	_____
e. Wipe any spills around ear	☐	☐	_____
f. Have residents remain on side lying position for several minutes so the medication can be absorbed	☐	☐	_____
g. May put a cotton ball at ear canal opening to prevent excess medication from leaking	☐	☐	_____
6. Remove and dispose of gloves	☐	☐	_____
7. Wash hands	☐	☐	_____
8. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Eye Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Clean any secretions or debris from around eye	☐	☐	_____
6. Ask resident to look upward, assist to position	☐	☐	_____
7. Pull down lower lid	☐	☐	_____
a. Instill drop(s) inside lower lid	☐	☐	_____
b. Apply ointment in a thin string just inside lower lid	☐	☐	_____
c. Do not touch dropper or ointment tub to lashes or eye	☐	☐	_____
d. Wait the specified amount of time before applying multiple eye medications	☐	☐	_____
e. Provide resident with tissue or cotton ball	☐	☐	_____
f. Use different gloves for each eye	☐	☐	_____
8. Discard gloves and wash hands	☐	☐	_____
9. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Inhaler Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands	☐	☐	_____
5. Assist resident to upright position	☐	☐	_____
a. Shake medication as directed	☐	☐	_____
b. Instruct resident to breath out fully	☐	☐	_____
c. Place mouth piece of inhaler into mouth	☐	☐	_____
d. As resident begins to inhale around the mouthpiece, activate the inhaler	☐	☐	_____
e. Continue to inhale as deeply and for as long as possible	☐	☐	_____
f. Have resident hold their breathe for as long as comfortable to allow absorption of medication	☐	☐	_____
g. Repeat at one minute intervals or as directed if more than one puff ordered	☐	☐	_____
h. Wait 5-10 minutes between different inhaled medications	☐	☐	_____
6. Wash hands	☐	☐	_____
7. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Injections

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication, use safety syringes per policy	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Cleanse site and allow to dry	☐	☐	_____
6. Hold skin taunt, for subcutaneous may pinch skin and subcutaneous tissue between thumb and fingers	☐	☐	_____
7. Insert needle	☐	☐	_____
8. Aspirate for subcutaneous and intramuscular, **not** for intradermal or when giving anticoagulants	☐	☐	_____
9. Administer medication using steady push on the plunger, intradermal will produce a small bleb just under the skin of the resident	☐	☐	_____
10. Remove needle quickly at same angle inserted	☐	☐	_____
11. Do not break, bend or recap needle, place safety covering over needle	☐	☐	_____
12. Place syringe in sharps container	☐	☐	_____
13. Assist resident to comfortable position	☐	☐	_____
14. Remove gloves and discard	☐	☐	_____
15. Wash hands	☐	☐	_____
16. Record medication given and site any other pertinent information	☐	☐	_____

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Staff Competency Evaluation
Nebulizer Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands	☐	☐	_____
5. Assist resident to upright position	☐	☐	_____
a. Instruct resident to close lips tightly and keep mouthpiece between teeth	☐	☐	_____
b. Inhale slowly about 8-10 respirations per minute, pause and exhale freely	☐	☐	_____
c. Check pulse and respiration as indicated before, during and after treatment	☐	☐	_____
6. Clean nebulizer and return to designated area	☐	☐	_____
7. Wash hands	☐	☐	_____
8. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Oral Sublingual and Buccal

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Prepare medication, void touching meds with ungloved hands	☐	☐	_____
3. Explain procedure to resident	☐	☐	_____
4. Wash hands	☐	☐	_____
5. Assist to position resident, upright position if oral meds	☐	☐	_____
Oral			
a. Encourage to take a sip of liquid first if mouth dry	☐	☐	_____
b. Place medication in mouth	☐	☐	_____
c. Encourage to drink fluid to flush medication down	☐	☐	_____
d. Ensure medication swallowed	☐	☐	_____
Sublingual			
a. Apply gloves as indicated	☐	☐	_____
b. Enc to take sip of liquid if mouth dry	☐	☐	_____
c. Place medication under tongue	☐	☐	_____
d. Instruct resident to not swallow until the table is completely dissolved	☐	☐	_____
e. Do not give liquids until medication completely absorbed	☐	☐	_____
Buccal			
a. Apply gloves as indicated	☐	☐	_____
b. Place medication in the back of the cheek, between lower teeth and cheek	☐	☐	_____
c. Instruct resident to not swallow until the table is completely dissolved	☐	☐	_____
d. Do not give liquids until medication completely absorbed	☐	☐	_____
6. Remove gloves and wash hands	☐	☐	_____
7. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Rectal Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Position resident comfortably in left sims position or as tolerated	☐	☐	_____
a. Remove wrapper from medication	☐	☐	_____
b. Apply lubricant to suppository	☐	☐	_____
c. Gently insert pointed end of suppository the length of the index finger into the rectum	☐	☐	_____
d. Ensure the suppository is pressed against the wall of the rectum and not lodged in feces	☐	☐	_____
e. Have the resident breathe through mouth to relax the anal sphincter	☐	☐	_____
f. Ensure medication is not expelled from rectum	☐	☐	_____
g. Avoid having a bowel movement for 20 minutes so the medication can be absorbed	☐	☐	_____
6. Remove gloves and wash hands	☐	☐	_____
7. Record medication administration	☐	☐	_____

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Staff Competency Evaluation
Topical Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Prepare skin area to be treated	☐	☐	_____
6. Apply medication using clean or sterile technique	☐	☐	_____
7. Dispose of used supplies	☐	☐	_____
8. Remove gloves and wash hands	☐	☐	_____
9. Record treatment	☐	☐	_____

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Staff Competency Evaluation
Vaginal Administration

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment, prepare medication	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands, apply gloves	☐	☐	_____
5. Position resident comfortably on back with knees bent and legs apart	☐	☐	_____
a. Drape resident to minimize exposure	☐	☐	_____
b. Insert medication 2-3 inches along back of vagina	☐	☐	_____
c. Wipe vaginal opening if needed	☐	☐	_____
d. Provide sanitary pad as needed	☐	☐	_____
e. Avoid upright position for about 20 minutes	☐	☐	_____
6. Clean applicator	☐	☐	_____
7. Remove gloves and wash hands	☐	☐	_____
8. Record medication administration	☐	☐	_____

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(AT RISK) SKIN INTEGRITY AUDIT

Medical Review _____ Date of Review _____
Diagnosis _____

1.	Pressure Ulcer Assessment completed upon admit and weekly x 4 weeks, readmit, quarterly, annually and significant change	yes_____ no_____
2.	Were appropriate interventions added based off score of assessment (and risks identified from assessment)	yes_____ no_____
3.	Malnutrition assessment or dietary assessment completed	yes_____ no_____
4.	Prevention surface in place (bed and chair)	yes_____ no_____
5.	Repositioning and toileting program in place	yes_____ no_____
6.	Skin barrier/lotion used with pericare	yes_____ no_____
7.	Supplements or nourishments in use	yes_____ no_____
8.	Lab ordered (albumin, H&H, WBC, electrolytes, as indicated)	yes_____ no_____
9.	Dietary consult done and recommendations followed up on (protein needs per wt met)	yes_____ no_____
10.	Increase frequency of weights	yes_____ no_____
11.	Weight changes monitored, followed up on	yes_____ no_____
12.	Daily monitoring of skin	yes_____ no_____
13.	Weekly monitoring of skin documented	yes_____ no_____
14.	Staff aware of at risk residents	yes_____ no_____
15.	Staff aware of special needs/interventions for residents	yes_____ no_____
16.	If diabetic, blood sugar monitored and followed up on	yes_____ no_____
17.	MDS, RAPS and care plan identify risk factors and specific interventions	yes_____ no_____
18.	List all corrective action taken to address areas of concern identified through this audit _____	

_____

_____

_____

Signature _____ **Date Completed** _____

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IMPAIRED SKIN INTEGRITY AUDIT

Medical Review _____ Review date _____
Diagnosis _____

1. Physician notified, treatment & diagnosis obtained, description of ulcer documented within 24 hrs if stage II, immediately if stage III or IV — yes_____ no_____

2. Treatment and diagnosis appropriate for stage/type of wound per guidelines — yes_____ no_____

3. Responsible party notified within 24 hrs if stage II, immediately if stage III or IV — yes_____ no_____

4. Photos taken per policy — yes_____ no_____

5. Weekly progress report with wound description current per guidelines — yes_____ no_____

6. Healing monitored and treatment changed if non-healing after 2-4 weeks or if wound worsens Physician and responsible party notified immediately and treatment changed — yes_____ no_____

7. Dietary consult done and recommendations followed up on, protein needs per wt met — yes_____ no_____

8. If diabetic, blood sugars monitored and followed up on — yes_____ no_____

9. MDS person notified – status assessed for significant change, proceed as indicated — yes_____ no_____

10. Prevention measures in place and documented prior to skin breakdown — yes_____ no_____

11. Observe treatment procedure, universal precaution followed — yes_____ no_____

12. Medical Director notified — yes_____ no_____

13. MDS and RAPS identify wound — yes_____ no_____

14. Does the care plan address:
    - impaired mobility with interventions — yes_____ no_____
    - pressure relief surfaces — yes_____ no_____
    - nutritional interventions — yes_____ no_____
    - incontinence care — yes_____ no_____
    - frequency of skin checks — yes_____ no_____
    - treatment plan — yes_____ no_____
    - screen for pain r/t wound and treatment — yes_____ no_____
    - managing infection (dressing, assessment for) — yes_____ no_____

15. List all corrective actions taken to address areas of concern identified through this audit_____

_____

Signature_____ **Date Completed**_____

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Staff Competency Evaluation
Dressing Change Sterile Technique

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment and supplies needed	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands and apply non sterile gloves	☐	☐	_____
5. Remove old dressing, observe exudates, discard dressing per universal precautions	☐	☐	_____
6. Discard gloves, wash hands	☐	☐	_____
7. Provide sterile field and apply sterile gloves	☐	☐	_____
8. Cleanse wound area from inner to outer aspects using new gauze for each sweep	☐	☐	_____
9. Discard gloves, wash hands, apply sterile gloves	☐	☐	_____
10. Measure and assess wound	☐	☐	_____
11. Apply medication and dressing per sterile technique	☐	☐	_____
12. Remove gloves and clean up work area and equipment	☐	☐	_____
13. Label dressing appropriately	☐	☐	_____
14. Wash hands	☐	☐	_____
15. Follow above steps for each wound treatment	☐	☐	_____
16. Remove trash and equipment from room per universal precautions	☐	☐	_____
17. Wash hands	☐	☐	_____
18. Record treatment and wound assessment	☐	☐	_____

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Staff Competency Evaluation
Dressing Change Clean/Aseptic Technique

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment and supplies needed	☐	☐	_____
3. Explain procedure to resident, provide privacy	☐	☐	_____
4. Wash hands	☐	☐	_____
5. Provide clean field	☐	☐	_____
6. Apply gloves	☐	☐	_____
7. Assist to position resident and expose only area treating	☐	☐	_____
8. Remove old dressing, observe exudates, discard dressing per universal precautions	☐	☐	_____
9. Clean wound from inner to outer aspects using new gauze for each sweep	☐	☐	_____
10. Wash hands and apply gloves	☐	☐	_____
11. Measure and assess wound	☐	☐	_____
12. Complete treatment and apply dressing	☐	☐	_____
13. Remove gloves and clean up work area and equipment	☐	☐	_____
14. Label dressing appropriately	☐	☐	_____
15. Wash hands	☐	☐	_____
16. Follow above steps for each wound treatment	☐	☐	_____
17. Remove trash and equipment from room, per universal precautions	☐	☐	_____
18. Wash hands	☐	☐	_____
19. Record treatment and wound assessment	☐	☐	_____

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Staff Competency Evaluation
Universal Precautions

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Use protective barriers to prevent exposure of skin, eyes, nose and mucous membranes to blood and body fluids	☐	☐	_____
2. Type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated -protective barriers may require but not limited to:			
a. Wear gloves-when touching blood or body fluids	☐	☐	_____
b. Wear gloves, mask, eye wear- when procedure causes or risk of droplets in the air	☐	☐	_____
c. Wear gloves, mask, eye wear, gown-when splashing or contact of blood or body fluids	☐	☐	_____
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood and body fluids	☐	☐	_____
4. Report to nurse and complete exposure report for all known exposures to blood and body fluids	☐	☐	_____
5. Clean blood and body fluid spills immediately and according to policy	☐	☐	_____
6. Dispose of biohazard waste according to policy	☐	☐	_____
7. Specific isolation precautions for resident with infectious or communicable diseases followed and residents identified in a way to maintain confidentiality	☐	☐	_____

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Staff Competency Evaluation
Removing Gloves

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Grasp glove just below the cuff	☐	☐	_____
2. Pull the glove down over hand so that glove is inside out, without spattering any contents	☐	☐	_____
3. Hold removed glove in palm of gloved hand	☐	☐	_____
4. Slide first 1-2 fingers of ungloved hand inside cuff of gloved hand	☐	☐	_____
5. Pull glove down over hand and other glove turning glove inside out	☐	☐	_____
6. Discard gloves	☐	☐	_____
7. Wash hands	☐	☐	_____

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Staff Competency Evaluation
Hand Washing

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Stood away from sink	☐	☐	_____
Wash			
a. Wet hands and wrists, keep hands lower than elbows	☐	☐	_____
b. Apply soap	☐	☐	_____
c. Wash hands, use friction to work up lather for 10-30 seconds	☐	☐	_____
d. Wash hands, wrists, between fingers and under nails	☐	☐	_____
Rinse			
a. Do not touch inside of sink	☐	☐	_____
b. Water flows from wrist down off fingers	☐	☐	_____
c. Do not shake off excess water	☐	☐	_____
Dry			
a. Dry wrists and hands and discard paper towel	☐	☐	_____
b. Use clean paper towel to turn water off	☐	☐	_____
2. Times to wash hands:			
a. Before beginning work	☐	☐	_____
b. Before and after eating	☐	☐	_____
c. After using the restroom	☐	☐	_____
d. After any contact with a contaminated object	☐	☐	_____
e. Before and after resident care	☐	☐	_____
f. Before handling medication	☐	☐	_____
g. Before and after treatments	☐	☐	_____
h. Before handling or preparing food	☐	☐	_____

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INFECTION CONTROL
CASE REVIEW STUDY

Month/Year:_____**, 20**_____ **Facility:**_____

CASE REVIEWS

TYPE	ADMITTED WITH	NOSOCOMIALS	TOTALS
UTI			
UTI'S WITH CATHETER			
URI			
GI			
EYE			
EAR			
WOUND			
SKIN			
OTHER			
Totals			

List any significant changes from previous month, reasons why, actions taken to prevent future re-occurrence. _____
_____
_____

Any Methicillin Resistant Staphylococcus Aureus infections (MRSA)? If so, how many _____; what precautions were taken?_____
_____
_____
_____

This Case Review Study was presented at the Infection Control Committee Meeting on _____. Please refer to detailed minutes of the meeting regarding further discussion of the data presented here.

_____ _____
Infection Control Nurse Signature Date

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Infection Control Surveillance Log

Month/Year_____

Resident Name and Physician	Room	Diagnosis	Signs & Sypmtoms	Date of Onset	Infection									Culture Taken		Causitive Organism	Treatment	Date Initiated	Resident Progress	Foley	Trach	Control Techniques Utilized	Repeat Culture	Nosocomial		Resolved	Cluster &/or trends Identified		Reportable infections reported	
					UTI	Skin	Resp	Eye	Ear	GI	Blood	Genital	Temp	X/Ray	Yes	No									Yes	No		Yes	No	Yes	No

Staff Competency Evaluation
Female Incontinence Care in Bed

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/position resident on their back with knees flexed (monitor for limitations)	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Remove any stool, change gloves (wash hands/use alcohol gel if able	☐	☐	_____
8. Wipe front to back with one stroke, use new wipe/cloth with each stroke	☐	☐	_____
9. Observe perineal area for any signs of breakdown/chaffing/irritation	☐	☐	_____
10. Cleanse lower abdomen, inner thighs, vulva and inner labia, dry as indicated	☐	☐	_____
11. Assist resident to turn onto side	☐	☐	_____
12. Cleanse buttocks and rectal area, dry as indicated	☐	☐	_____
13. Change gloves and apply moisture barrier as indicated (wash hands/use alcohol gel if able)	☐	☐	_____
14. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able	☐	☐	_____
15. Adjust brief and clothes	☐	☐	_____
16. Position resident and adjust bedding as indicated	☐	☐	_____
17. If gloves on, remove gloves and tie trash bad (touch outside of bag only)	☐	☐	_____
18. Wash hands	☐	☐	_____
19. Return supplies and wipe off bedside table as indicated	☐	☐	_____
20. Open curtains, privacy screens, door	☐	☐	_____
21. Remove trash from room	☐	☐	_____
22. Report any skin conditions/concerns to charge nurse	☐	☐	_____

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Staff Competency Evaluation
Female Incontinence Care While Standing

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/assist to standing position, ensure resident safety while standing	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Remove any stool, change gloves (wash hands/use alcohol gel if able	☐	☐	_____
8. Wipe front to back with one stroke, use new wipe/cloth with each stroke	☐	☐	_____
9. Observe perineal area for any signs of breakdown/chaffing/irritation	☐	☐	_____
10. Cleanse lower abdomen, inner thighs, vulva and inner labia, dry as indicated	☐	☐	_____
11. Cleanse buttocks and rectal area, dry as indicated	☐	☐	_____
12. Change gloves and apply moisture barrier as indicated (wash hands/use alcohol gel if able)	☐	☐	_____ _____
13. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able	☐	☐	_____
14. Adjust brief and clothes	☐	☐	_____
16. If gloves on, remove gloves and tie trash bag (touch outside of bag only)	☐	☐	_____
17. Wash hands	☐	☐	_____
18. Return supplies	☐	☐	_____
19. Open curtains, privacy screens, door	☐	☐	_____
20. Remove trash from room	☐	☐	_____
21. Report any skin conditions/concerns to charge nurse	☐	☐	_____

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Staff Competency Evaluation
Male Incontinence Care While Standing

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/assist to standing position, ensure resident safety while standing	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Observe perineal area for any signs of breakdown/chaffing/irritation	☐	☐	_____
8. Remove any stool, change gloves (wash hands/use alcohol gel if able)	☐	☐	_____
9. Retract the foreskin if uncircumcised	☐	☐	_____
10. Cleanse the tip of the penis using a circular motion starting at the urethral opening and work outward	☐	☐	_____
11. Use a different wipe/cloth with each stroke	☐	☐	_____
12. Return the foreskin to its natural position	☐	☐	_____
13. Wipe down the shaft of the penis	☐	☐	_____
14. Cleanse lower abdomen, inner thighs, and scrotum, dry cleansed areas as indicated	☐	☐	_____
15. Cleanse buttocks and rectal area, dry as indicated	☐	☐	_____
16. Change gloves and apply moisture barrier as indicated (wash hands/use alcohol gel if able)	☐	☐	_____
17. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able)	☐	☐	_____
18. Adjust brief and clothes	☐	☐	_____
19. Assist resident to sitting position or as indicated	☐	☐	_____
20. If gloves on, remove gloves and tie trash bag (touch outside of bag only)	☐	☐	_____
21. Wash hands	☐	☐	_____
22. Return supplies	☐	☐	_____
23. Open curtains, privacy screens, door	☐	☐	_____
24. Remove trash from room	☐	☐	_____
25. Report any skin conditions/concerns to charge nurse	☐	☐	_____

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Staff Competency Evaluation
Male Incontinence Care in Bed

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Provide privacy to resident-close door, close drapes and pull privacy curtain	☐	☐	_____
2. Wash hands	☐	☐	_____
3. Gather all needed supplies	☐	☐	_____
4. Explain procedure/position resident on their back with knees flexed (monitor for limitations)	☐	☐	_____
5. Put on gloves	☐	☐	_____
6. Expose area you are cleansing, dispose of brief	☐	☐	_____
7. Observe perineal area for any signs of breakdown/chaffing/irritation	☐	☐	_____
8. Remove any stool, change gloves (wash hands/use alcohol gel if able)	☐	☐	_____
9. Retract the foreskin if uncircumcised	☐	☐	_____
10. Cleanse the tip of the penis using a circular motion starting at the urethral opening and work outward	☐	☐	_____
11. Use a different wipe/cloth with each stroke	☐	☐	_____
12. Return the foreskin to its natural position	☐	☐	_____
13. Wipe down the shaft of the penis	☐	☐	_____
14. Cleanse lower abdomen, inner thighs, and scrotum, dry cleansed areas as indicated	☐	☐	_____
15. Assist resident to turn onto side	☐	☐	_____
16. Cleanse buttocks and rectal area, dry as indicated	☐	☐	_____
17. Change gloves and apply moisture barrier as indicated (wash hands/use alcohol gel if able)	☐	☐	_____
18. Remove gloves (reapply gloves if indicated) wash hands/use alcohol gel if able)	☐	☐	_____
19. Adjust brief and clothes, position resident and adjust bedding as indicated	☐	☐	_____
20. If gloves on, remove gloves and tie trash bag (touch outside of bag only)	☐	☐	_____
21. Wash hands	☐	☐	_____
22. Return supplies	☐	☐	_____
23. Open curtains, privacy screens, door	☐	☐	
24. Remove trash from room	☐	☐	
25. Report any skin conditions/concerns to charge nurse	☐	☐	

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Staff Competency Evaluation
IV Existing Lines

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Monitor the flow rate of existing IV lines	☐	☐	_____
3. Regulate peripheral fluid infusion lines	☐	☐	_____
4. Observe sites frequently and document at least every 8 hours for local reactions or per policy and report results as indicated to physician	☐	☐	_____
5. Date tubing, lock and dressing	☐	☐	_____
6. Discontinuing IV therapy with an order	☐	☐	_____
7. Changing peripheral IV tubing and dressing every 72 hours or per policy	☐	☐	_____
8. Documenting IV procedures performed and observations made	☐	☐	_____
9. Aseptic technique used for all venipunctures and site care	☐	☐	_____

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Staff Competency Evaluation IV
Insertion of IV Line

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Wash hands, gather equipment and supplies, prepare IV fluids and tubing (needles or safety system per policy)	☐	☐	_____
3. Assist to position resident and explain procedure, provide privacy	☐	☐	_____
4. Wash hands and apply gloves	☐	☐	_____
5. Select vein site, place water proof pad under site	☐	☐	_____
6. Apply tourniquet above site	☐	☐	_____
7. Clean site	☐	☐	_____
8. Insert intercath until blood flows into needle hub	☐	☐	_____
9. Release tourniquet	☐	☐	_____
10. Remove needle, leaving catheter in place	☐	☐	_____
11. Attach IV fluids and open line, adjust rate	☐	☐	_____
12. Observe for any redness/swelling around site	☐	☐	_____
13. Secure intercath and apply dressing as indicated	☐	☐	_____
14. Remove gloves, date and initial dressing	☐	☐	_____
15. Clean work area and equipment	☐	☐	_____
16. Wash hands	☐	☐	_____
17. Remove waste from room	☐	☐	_____
18. Wash hands	☐	☐	_____
19. Record procedure	☐	☐	_____

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Staff Competency Evaluation
Oral Suction

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	
2. Gather equipment and supplies	☐	☐	
3. Explain procedure to resident and provide privacy	☐	☐	
4. Assist to position resident	☐	☐	
5. Wash hands, apply gloves	☐	☐	
6. Set up clean work field	☐	☐	
7. Attach catheter to connecting tube	☐	☐	
8. Turn suction machine on	☐	☐	
9. Test equipment by immersing catheter in glass of water to see if suction is adequate	☐	☐	
10. Tilt residents head back and open mouth	☐	☐	
11. With suction machine on, but without applying suction, insert tube	☐	☐	
12. Insert catheter and suction the upper throat and around the sides of the mouth	☐	☐	
13. Always suction gently	☐	☐	
14. Gently glide catheter back and forth while suctioning	☐	☐	
15. Suction intermittently, not more than 5-10 seconds at a time	☐	☐	
16. Pinch tube and remove slowly	☐	☐	
17. Turn suction machine off	☐	☐	
18. Discard or place tubing in plastic bag	☐	☐	
19. Empty or discard canister per policy	☐	☐	
20. Clean work area, cover machine if left in room	☐	☐	
21. Remove gloves and wash hands	☐	☐	
22. Remove waste from room, return equipment as indicated	☐	☐	
23. Wash hands	☐	☐	
24. Document procedure	☐	☐	

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Staff Competency Evaluation
Suction Nasopharyngeal

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	
2. Gather equipment and supplies	☐	☐	
3. Explain procedure to resident and provide privacy	☐	☐	
4. Assist to position resident	☐	☐	
5. Wash hands, apply gloves	☐	☐	
6. Set up clean work field	☐	☐	
7. Attach catheter to connecting tube	☐	☐	
8. Turn suction machine on	☐	☐	
9. Test equipment by immersing catheter in glass of water to see if suction is adequate	☐	☐	
10. Tilt residents head back	☐	☐	
11. Insert catheter approximately 3 inches into nostril, may use water base lubricant to nostril/tubing tip for insertion.	☐	☐	
12. With suction machine on but without applying suctions, insert tube into nostril	☐	☐	
13. Always suction gently, never force suction tube through nostril, watch for bleeding/trauma	☐	☐	
14. Gently glide catheter back and forth while suctioning	☐	☐	
15. Suction intermittently, not more than 5-10 seconds at a time	☐	☐	
16. Pinch tube and remove slowly	☐	☐	
17. Draw water through tubing to cleanse	☐	☐	
18. Turn suction machine off	☐	☐	
19. Discard or place tubing in plastic bag	☐	☐	
20. Empty or discard canister per policy	☐	☐	
21. Clean work area, cover machine if left in room	☐	☐	
22. Remove gloves and wash hands	☐	☐	
23. Remove waste from room, return equipment as indicated	☐	☐	
24. Wash hands	☐	☐	
25. Document procedure	☐	☐	

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Staff Competency Evaluation
Blood Glucose Testing

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Machine calibrated and logs current (corrections as indicated)	☐	☐	_____
2. Verify order	☐	☐	_____
3. Obtain equipment	☐	☐	_____
4. Identify resident and provide privacy	☐	☐	_____
5. Explain procedure	☐	☐	_____
6. Wash hands and apply gloves	☐	☐	_____
a. Cleanse site and allow to dry	☐	☐	_____
b. Handles strip properly	☐	☐	_____
c. Sterile lancet procedure	☐	☐	_____
d. Applies pressure to stop bleeding	☐	☐	_____
e. Discards disposables	☐	☐	_____
7. Remove gloves and wash hands	☐	☐	_____
8. Record results	☐	☐	_____

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Staff Competency Evaluation
Oxygen Initiation of O2 Therapy

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Verify physician order	☐	☐	_____
2. Obtain equipment	☐	☐	_____
3. Explain procedure to resident	☐	☐	_____
4. If using an E tank, crack/prepare tank for use	☐	☐	_____
5. If using concentrator, plug into wall outlet	☐	☐	_____
6. Ensure the flowmeter is in the off position	☐	☐	_____
7. Attach the flowmeter to the oxygen tank or concentrator	☐	☐	_____
8. If humidifier used, fill with distilled water	☐	☐	_____
9. Attach the humidifier to the flowmeter	☐	☐	_____
10. Attach the oxygen tubing (mask or nasal cannula) to the humidifier or flowmeter	☐	☐	_____
11. Turn concentrator on or open regulator valve on E tank	☐	☐	_____
12. Turn oxygen on to ordered liter flow, ensure no leaks and flowing through tubing unobstructed	☐	☐	_____
13. Place mask or cannula on resident	☐	☐	_____
14. Instruct resident on physicians orders, not to adjust O2 flow, keep tubing off floor	☐	☐	_____
15. Date tubing and canister	☐	☐	_____
16. No smoking allowed in room or with oxygen use, post no smoking signs as indicated	☐	☐	_____
17. Record administration of O2 therapy and resident response	☐	☐	_____

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Staff Competency Evaluation Oxygen
Maintain O2 Therapy

SKILL LEVEL-after reviewing policy	Satisfactory	Unsatisfactory	Notes
1. Distilled water should be kept at indicated level if humidifier used	☐	☐	_____
2. Maintain tubing free of kinks/obstructions	☐	☐	_____
3. Keep tubing off floor	☐	☐	_____
4. Change tubing per policy and date tubing	☐	☐	_____
5. Turn O2 on before placing mask or cannula and remove mask or cannula before turning off or adjusting flow rate	☐	☐	_____
6. No smoking allowed in room or with oxygen use, post no smoking signs as indicated	☐	☐	_____
6. Removed sources of static electricity	☐	☐	_____
7. Do not use oil based lubricants or solutions containing alcohol near oxygen administration	☐	☐	_____
8. Clean concentrator filter per policy	☐	☐	_____
9. E Tanks securely fastened to cart or wall and in upright position	☐	☐	_____
10. Change mask or cannula per policy	☐	☐	_____
11. Keep nose and mouth clean and moist	☐	☐	_____
12. Ensure that flow rate, orders and C.P. match	☐	☐	_____

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MDS/RAPs/Care Plan Audit

Name	Annual/Sig Change	Quarterly	RAPs	C.P

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Medicare MDS/RAPs/Care Plan Audit

Name	5 Day	14 Day	30 Day	RAPs	C.P

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