NURSING DOCUMENTATION AUDIT TOOL

- Use one form for each auditing event.
- The number of records to be audited can be determined by the Center. One percent of the total inpatient admissions may be a target.
- The clinical records should be randomly selected for audit.
- The following key can be used to evaluate the records:

Response:	Score:
Yes	1
Partly	2
No	3
Not applicable	4

- ***For those elements that score "2" or "3", state why in the comments section at the bottom of the audit form. Document the action plan to improve the record and the quality of staff documentation.***

	The record should be reviewed by the individual designated by the Center's Quality Assurance Committee.										
	Set 1	***Set 2***	***Set 3***	***Set 4***	***Set 5***	***Set 6***	***Set 7***	***Set 8***	***Set 9***	***Set 10***	***Set 11***
All Entries Legible											
All Entries written in black ink											
All entries identifiable with signature and discipline											
All entries dated											
All entries clearly timed											
All entries in chronological order											
All documents that belong to the chart are integrated into the chart (no loose filing)											
Patient name identifiable on each sheet											
Errors indicated by single line through ~~text~~											
Clinical history documented thoroughly and accurately											
Nursing Assessment documented thoroughly and accurately											
Care plan documented											
Communication with patients, family and physicians documented											

Change of condition is thoroughly documented.											
All labs ordered were carried out.											
All lab results are on the chart and the physician has been notified of pertinent results.											
Discharge note is complete and accurate.											
Height and weight are appropriately documented.											
Appropriate referrals to weight variance, wound committee or other appropriate multidisciplinary teams are accurately documented and followed-through.											
Medications are administered as ordered.											
Wound care is appropriately documented.											
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*											
Observations (see page 2 for Action Plan)											

Summary of Licensed Nurse's Documentation Audit and Action Plan

Date of Audit:		**Person performing audit:**	
Total No. of Notes Assessed:			
Identified Concern	**Action Plan**	**Date For Achievement of Action:**	**Person Responsible & Contact Number:**
▪			
▪			
▪			
▪			
▪			
Date of Next Audit:			
Overall Comments On Audit:			