

**Tsali Care  
Nursing Documentation**

<b>Element</b>	<b>Yes/No</b>	<b>Comments/Recommendations</b>
Every page has the patient's name and medical record number (when double-sided both sides must contain info)		
Month, date, year and time are recorded on all entries.		
Time blocks are used (i.e. 7-3) for narrative notes		
All notes are signed		
Are initials used for signatures? If so, is there a signature legend?		
Are faxed records found in the chart? If so have they been copied?		
Are entries in ink?		
Are entries legible?		
Are large spaces skipped in the record? If so are they crossed out?		
If entry is made out of order, is it documented as a late entry?		
On assessments, flow sheets, etc..., are all fields complete? Is n/a used as appropriate?		
Is language specific, rather than vague or generalized?		
Does the record have opinions rather than facts?		
Is the resident quoted?		
Are their abbreviations being used? If so, is there a dictionary of approved abbreviations?		
Are entries consistent?		
If there is contradictory notes, is there documentation explaining why?		
Is changes in the resident' condition documented?		
Do informed consent entries contain an explanation of the risks and benefits of a treatment/ procedure, alternatives to the treatment/procedure, and evidence that the resident or appropriate legal surrogate understands and consents.		
Is the resident's condition fully and accurately documented at times of		

admission and discharge?		
Upon discharge is patient education (ie.. self-care, etc.) documented?		
Do all notifications to family or physician include the time and method of communication and any orders received or responses, the implementation of such orders and the resident's response?		
Are incidents documented?		
Does charting include statements that blame, accuse, or compromise other caregivers, the resident, or his/her family?		
Does the admission note include the date and time of admission/readmission, how the resident was transported, the reason of admission and the resident's condition?		
Is a picture of the resident included in the chart?		
Do flow sheets or checklists used contain a space for narrative documentation?		
Does documentation justify the clinical reasons and medical necessity for Medicare Part A coverage, skilled services being delivered, and ongoing need for coverage?		
Does documentation justify ancillary services provided?		
Does the medical record prove that the resident needed and received skilled services on a daily basis?		
Addendums should have the current date and time, must be labeled addendum, and identify info to support addendum.		
Clarification notes must have the current date and time, labeled as clarification, and have sources to support.		
Is there a policy on late entries?		
Are their notes added for other caregivers?		
Are corrections handled appropriately?		