Admission Audit Tool

Instructions: Answer the following questions using the resident's admission medical record.

Audit Information

Audit Date: ____ Audit Period:__________ to __________

Resident Demographics

Resident's Name: ____

Resident's Admission Date: ______________________________

Resident's Admission Status:

- ☐ Admission
- ☐ Readmission

Resident's Date of Birth: ______________________________

Resident's Sex:

- ☐ Male
- ☐ Female
- ☐ Unable to determine

These questions are based on clinical best practices, not necessarily CMS regulatory requirements.

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Section I: Depression

1. **Was the resident screened for depression using a validated screening tool (not the MDS) within seven calendar days of admission?** *(This includes residents already diagnosed with depression.)*

   ☐ No *(skip to next clinical topic, page 3)* ☐ Yes

2. **Which tool was used to perform the screening?** *(Check one)*

   ☐ Beck Depression Inventory (BDI)
   ☐ Center for Epidemiologic Studies Depression Scale (CES-D)
   ☐ Cornell Scale for Depression in Dementia (CSDD)
   ☐ Geriatric Depression Scale (GDS)
   ☐ Hamilton Rating Scale for Depression (Ham-D)
   ☐ Patient Health Questionnaire-9 (PHQ-9)
   ☐ Other

3. **Did the resident screen positive for depression?**

   ☐ No *(skip to next clinical topic, page 3)* ☐ Yes

4. **What follow-up was initiated for the resident who screened positive for depression?** *(Check all that apply)*

   ☐ Clinical and diagnostic evaluation (beyond initial screen)
   ☐ On-going observation with formal re-evaluation in two weeks ("watchful waiting")
   ☐ Treatment (e.g., drug or non-drug)
   ☐ None
   ☐ Unable to determine from chart or medical record

5. **Was the resident diagnosed with depression or depressive symptoms?**

   ☐ No *(skip to next clinical topic, page 3)* ☐ Yes

6. **What actions were taken to treat the symptoms?** *(Check all that apply)*

   ☐ Group therapy
   ☐ Psychotherapeutic counseling (psychotherapy)
   ☐ Watchful waiting with clinical management
   ☐ Pharmacological intervention (medication)
   ☐ Transfer for inpatient psychiatric care or electroconvulsive therapy (ECT)
   ☐ None of the above

7. **What actions were taken to manage the symptoms?** *(Check all that apply)*

   ☐ Community connection (e.g., volunteer programs, program to "give back" to community)
   ☐ Environmental (e.g., room personalization, accommodations for sensory loss, massage, aromatherapy)
   ☐ Multidisciplinary consultation
   ☐ Reminiscence groups (e.g., life review)
   ☐ Recreation therapy
   ☐ Spiritual (e.g., hospice, pastor, rabbi, lay person)
   ☐ Watchful waiting with re-evaluation
   ☐ None of the above

8. **Is there evidence that the resident was re-evaluated within two weeks of the intervention to monitor the effects?**

   ☐ No ☐ Yes

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Section II: Pain

1. Was the resident screened for pain within 24 hours of admission?

- ☐ No *(skip to next clinical topic, page 4)* ☐ Yes

2. Did the screening within 24 hours of admission indicate the resident had pain?

- ☐ No *(skip to next clinical topic, page 4)* ☐ Yes

3. Indicate items included in resident pain and assessment within 24 hours of admission. *(Check all that apply)*

- ☐ Documentation of what improves (relieves) pain (past or present)
- ☐ Documentation of what worsens (increases) pain (past or present)
- ☐ Effects of medication (past or present) documented
- ☐ Effects of pain on activities of daily living, sleep, and mood documented
- ☐ Frequency of pain documented
- ☐ Intensity of pain documented
- ☐ Location of pain documented

4. Was a plan of care to address pain put into place within 48 hours of admission?

- ☐ No *(skip to #6)* ☐ Yes

5. Indicate non-drug therapies included in the resident's pain plan of care within 48 hours of admission.
(Check all that apply)

- ☐ Alternative medicine (e.g., aromatherapy, Reiki)
- ☐ Cutaneous stimulation/relaxation (e.g., deep breathing, massage therapy, TENS)
- ☐ Psycho/social (e.g., counseling, distraction)
- ☐ Therapy-related (e.g., heat treatment, cold treatment)
- ☐ Unspecified non-drug therapies
- ☐ None

6. Indicate orders for pain medication within 24 hours of identification of resident's pain.
(Check one of the following)

- ☐ Regularly scheduled pain medication ***and*** PRN medication for breakthrough pain
- ☐ Regularly scheduled pain medication ***only***
- ☐ PRN medication for breakthrough pain ***only***
- ☐ No pain medication prescribed

7. Did the resident have a diagnosis for the underlying cause(s) of pain within 30 calendar days of admission?

- ☐ No ☐ Yes

Section III: Physical Restraints

1. **Was the resident physically restrained any time within 48 hours of admission?**
   - ☐ No *(skip to next clinical topic, page 5)*
   - ☐ Yes
2. **Is there a physician's order *and* reason why a physical restraint was ordered?**
   - ☐ No
   - ☐ Yes
3. **What type of physical restraint was applied within 48 hours of admission?** *(Check all that apply)*
   - ☐ Chair that prevents rising
   - ☐ Vest
   - ☐ Limb (e.g., wrist, leg)
   - ☐ Waist
   - ☐ Side rails
   - ☐ Other
4. **Was there an assessment within 48 hours of admission to determine if the physical restraint used is the least restrictive device to treat the resident's medical symptoms?**
   - ☐ No
   - ☐ Yes
5. **In addition to the regular care-planinng meeting, does the resident's record document a plan to regularly re-evaluate this resident to reduce or eliminate the physical restraint?**
   - ☐ No
   - ☐ Yes

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Section IV: Pressure Ulcers

1. **Did the resident receive a skin assessment within 48 hours of admission?**

   ☐ No *(skip to #5)* ☐ Yes

2. **Indicate the highest staged pressure ulcer present at admission.** *(Check one)*

   ☐ No pressure ulcers present at admission (*skip to #5*) ☐ Stage I
   ☐ Stage II ☐ Stage III
   ☐ Stage IV ☐ Unable to stage (e.g., due to eschar)

3. **Was the resident's highest staged pressure ulcer evaluated within 24 hours of admission?**

   ☐ No *(skip to #5)* ☐ Yes

4. **Did the evaluation of the highest staged pressure ulcer include documentation of the following?**

   ☐ No ☐ Yes Staging
   ☐ No ☐ Yes Size
   ☐ No ☐ Yes Location
   ☐ No ☐ Yes ☐ N/A Epithelialization
   ☐ No ☐ Yes ☐ N/A Presence or absence of exudates
   ☐ No ☐ Yes ☐ N/A Presence or absence of granulation tissue
   ☐ No ☐ Yes ☐ N/A Presence or absence of necrotic tissue
   ☐ No ☐ Yes ☐ N/A Presence or absence of sinus tracts
   ☐ No ☐ Yes ☐ N/A Presence or absence of undermining
   ☐ No ☐ Yes ☐ N/A Presence or absence of tunneling

5. **Does the resident have a reported history of pressure ulcers?** *(History can be established from resident or family reports, or from medical record.)*

   ☐ No *(skip to #5)* ☐ Yes ☐ Not assessed

6. **Was the resident assessed for risk of developing pressure ulcers using a standardized risk assessment tool such as the Braden, Norton, or Norton Plus scale within 24 hours of admission?**

   ☐ No ☐ Yes *(skip to #8)*

7. **If the Braden, Norton, or Norton Plus Scales were not used within 24 hours of admission, was there a pressure ulcer risk assessment that included the following elements?** *(Check all that apply)*

   ☐ No ☐ Yes Documentation of bladder/bowel incontinence and/or moisture
   ☐ No ☐ Yes Documentation of cognitive impairment
   ☐ No ☐ Yes Documentation of impaired bed/chair mobility
   ☐ No ☐ Yes Documentation of impaired functional status
   ☐ No ☐ Yes Documentation of impaired nutritional status

8. **Based on the screening criteria, is the resident at risk for pressure ulcers?**

   ☐ No *(Stop abstraction)* ☐ Yes

Section IV: Pressure Ulcers *(continued)*

9. If the resident is at risk for pressure ulcers, was his/her skin inspected daily to detect new pressure ulcers?
(Inspection should include bony prominences and heels. May be performed by nurses or nursing assistants.)

☐ No ☐ Yes ☐ Unable to determine

10. If the resident is at risk for pressure ulcers, does the plan of care incorporate interventions that address each of the resident's specific risk factors?

☐ No ☐ Yes

11. Using visual inspection, determine which chair support surfaces are being used by the at-risk resident.
(You must observe the resident's chair support surface. Check all that apply.)

☐ Gel cushion
☐ High-density foam at least four inches thick
☐ Properly inflated static air or fluid cushion
☐ Other specially-designed cushion
☐ None of the above

12. Using visual inspection, determine which bed support surfaces are being used by the at-risk resident.
(You must observe the resident's bed. Check all that apply.)

☐ Air fluidized
☐ Dynamic air (air overlay)
☐ High-density foam overlay at least four inches thick
☐ High-density foam mattress
☐ Low air loss
☐ Properly inflated static air or fluid mattress
☐ None of the above

Instructions: Answer the following questions ONLY if the resident had a pressure ulcer(s) on admission. Otherwise, stop abstraction.

13. If the resident had a pressure ulcer(s) on admission, is there documentation of a weekly wound assessment for each pressure ulcer?

☐ No ☐ Yes

14. If the resident had a pressure ulcer(s) on admission, was a treatment plan consistent with current professional standards initiated for each pressure ulcer within 24 hours of admission?

☐ No ☐ Yes

15. If the resident had a pressure ulcer(s) on admission, is there documentation that the treatment plan for pressure ulcer(s) was consistently implemented as written?

☐ No ☐ Yes

16. If the resident had a pressure ulcer(s) on admission, is there evidence of improvement in the wound(s) by or before the end of the fourth week since admission?

☐ No ☐ Yes *(Stop abstraction)* ☐ Unable to determine from medical record

17. If there was no improvement in the wound by the end of the fourth week since admission, was the treatment plan modified or is there documentation indicating why the current treatment plan should continue?

☐ No ☐ Yes ☐ Unable to determine from medical record

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