# NCT Documentation Audit Tool

<table>
<thead>
<tr>
<th>Date of Audit:</th>
<th>Unit:</th>
<th>NCT audited</th>
<th>Audit completed by:</th>
<th>Patient initials/room number</th>
</tr>
</thead>
</table>

## Patient Profile

- Was admission height and weight documented?

## Patient Care Flowsheet

- Were vital signs documented as ordered?
- Was room air/supplemental oxygen documented with O2 sats?
- If patient on bedrest, were turns documented as ordered?
- If ordered, Was incentive spirometer use documented?
- Was ambu bag in room every shift?
- Was sleep/wake pattern documented hourly?
- Were finger sticks documented as ordered?
- If ordered, were daily weights recorded?

## Intake and Output

- Was I&O recorded per shift? (must have 0 if no intake or output)
- If applicable, were adult diapers checked every 1-2 hours and changed if needed? (should have 0 if diaper checked and was dry)
- Was meal consumption documented? (only applicable if has diet ordered…needs % documented)

## Assessment and Intervention

- If ordered, are SCDs documented as intervention?
- Was ROM or ambulation charted?
- Was hygiene care documented? (oral care, bath, linen change, foley care)

## Paper Items

- Personal Effect Sheet completed
- White Board Completed

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Developed by H. Wilson, revised 8/09