

Diabetes Adverse Outcome Audit Tool

Patient Name: _____ **Patient Number:** _____

SOC Date: _____ **D/C Date:** _____ **Site/County:** _____

Reason for Admission/ Documentation of Need: _____

Primary Dx/ICD9: _____

Visits: SN: _____ RD: _____ MSW: _____ PT/OT: _____ CDE: _____

Comorbid Conditions: HTN Obesity Heart Disease COPD ESRD PVD CVA
 Wound(s) Steroids Arthritis Orthopedic Terminal Illness Dementia
 Others: _____

Type of DM: _____ **Barriers to Learning:** _____

Lives with: Alone Spouse Family Member Friend Facility Other: _____

DM Management provided by: Pt CG/SO **Caregiver support:** Adeq Inadeq

Compliance w/ Plan of Care: Poor Fair Good Excellent

Reason For Emergent Care: _____

Legend: Y (Yes) N (No) N/A (Not Applicable) VA (Valid Exception): Pt/CG unable, unwilling, no available CG

	DOCUMENTATION	
	Instructed	Return Demo/Recall
Monitoring:		
a. Lancet use/blood testing	_____	_____
b. Meter maintenance	_____	_____
c. Target ranges	_____	_____
Meal Planning:		
a. Carbohydrate content	_____	_____
b. Portion/serving size	_____	_____
c. Meal/snack schedule	_____	_____
d. Sick Day Guidelines	_____	_____
Hypoglycemia:		
a. Signs/symptoms	_____	_____
b. Causes/contributing factors	_____	_____
c. Prevention	_____	_____
d. Use/carrying fast-acting CHO	_____	_____

DOCUMENTATION

Instructed Return Demo/Recall

Hyperglycemia:

- a. Signs/symptoms
- b. Causes/contributing factors
- c. Prevention
- d. Treatment

_____	_____
_____	_____
_____	_____
_____	_____

Insulin Therapy:

- a. Preparation/administration
- b. Onset/peak/duration
- c. Schedule
- d. Site selection and rotation
- e. Storage

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Anti-Diabetes Medications:

- a. Action/purpose
- b. Side effects
- c. Schedule

_____	_____
_____	_____
_____	_____

Medical Management (Y= yes; N= no; NA= not applicable).

May include comments:

- a. MD contacted re: altered BS's
- b. MD revision to plan of care/ medications
- c. Emergency plan inclusive for diagnosis
- d. Progression toward goals

_____	_____
_____	_____
_____	_____
_____	_____

Summary: Was the plan of care and goals applicable to patient's needs; note strengths and deficits of plan of care:

Satisfactory_____ Unsatisfactory_____

Audited By: _____ **Date:** _____