

Sample T-Log Guidelines:

High T-Logs:

- 1.ER visits
- 2.Critical events
- 3.Hospital admissions
- 4.Re admissions or initial admissions to a group home

Medium T-Logs

- 1.Medical appointments at which med changes/additions/discontinuations/new diagnoses were made
- 2.Nursing instructions
- 3.abnormal signs and symptoms or status change
- 4.Abnormal vitals related to a nursing instruction or illness/ follow up(routine vitals either wkly or monthly should be documented in vitals section on section of health tracking)
- 5.Med errors, falls, and head bans or injuries

Low T-logs

- 1.Normal vitals related to follow ups, shift checks, and or nursing instructions.
- 2.Routine doctor appointments at which no med changes, new orders, or diagnoses were made
- 3.All medical follow-ups as condition improves

Documents that need to be scanned into T-logs:

fall flows/head injury sheets

MD consultation forms

lab and test results

LOA medication forms when resident returned to CLA