

Charting / Documentation Guide

Nursing documentation should be clear, timely, accurate, reflective of observations, permanent and legible. This is a guide and not a complete list. Always follow policies in place at your facility.

Medicare Documentation	Anticoagulant Therapy Medicare Documentation	Fracture Hip Medicare Documentation
<ul style="list-style-type: none"> • Must reflect need/reason for skilled care • Must reflect Standard of Care • Describe intervention(s) • Describe resident's response to intervention(s) • Daily evaluation of progress or lack of progress • Resident response to skilled therapy • ADL function • Changes in condition • Change Care Plan ASAP after change in condition • Notification to MD and family 	<ul style="list-style-type: none"> • Must reflect need/reason for skilled care • Daily vital signs • Monitor for bleeding, bruises • Monitor lab values: Be sure PT/INR drawn per physician order and reported to MD • Monitor sudden dyspnea, chest pain, temp or color change in extremities 	<ul style="list-style-type: none"> • Must reflect need/reason for skilled care • Daily vital signs including pain • ADL ability/assistance needed (use MDS Language) • Monitor incision site • Indicate resident's response to therapy: pain, fatigues, etc.
Respiratory/Pneumonia Medicare Documentation	ADLs	Behavior Assessment/Documentation
<ul style="list-style-type: none"> • Must reflect need/reason for skilled care • Daily vital signs • Daily and PRN O₂ sat level • Daily and PRN lung sounds • SOB with exertion, when sitting at rest or when lying flat • Resident's response to interventions and skilled therapy • Progress or lack of progress • Change in condition • Change Care Plan ASAP after condition change • Notification to MD and family 	<ul style="list-style-type: none"> • How does resident perform? <ul style="list-style-type: none"> – Bed mobility – Transfers – Ambulation – Dressing – Eating – Toileting and personal hygiene • How much staff support is needed? <ul style="list-style-type: none"> – Independent – Set up help only – One person – Two + person physical assist – Activity does not occur • Document support needed for ADLs over all shifts • Which interventions used to compensate for ADL deficit: i.e., walker, w/c, cane? 	<ul style="list-style-type: none"> • Date/Time • Location • Specific behavior • Who is around? • Any triggering event (loud noises, new staff, providing care)? • How do symptoms interfere with ADLs? • How does it interfere with care? • Rule out: hunger, toileting needs, pain, boredom, medication changes • If has respiratory diagnosis – O₂ sat level • Non-medication intervention – resident response • Medication intervention if needed – document response • Medication changes if applicable and result of change
Bladder and Bowel	Change in Condition Requiring a New Intervention	Dialysis Assess/Documentation Prior to Leaving
<ul style="list-style-type: none"> • Indicate status: always continent, occasionally incontinent, frequently incontinent, always incontinent • Indicate if has catheter (indwelling or condom, intermittent), urinary ostomy, or no urine output • Toileting program in progress or attempted and outcome • Constipation? Which interventions used, and results? 	<ul style="list-style-type: none"> • Time/Date • Change that has occurred i.e., weight loss, pressure ulcer, cognition, overall deterioration • Which ADLs are affected? • Which intervention applied? • Response to intervention? • Was MD or family notified? 	<ul style="list-style-type: none"> • Date/Time • Observation of shunt • Assessment of skin • Meal consumption: Indicate if food sent with resident. • Fluid consumption • If edema noted, how much? (Write note for Dialysis team.)

Psychiatric Nursing Documentation Guidelines

M Carnoy



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