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 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, fatigue, etc.	
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	Must reflect need/reason for skilled care Daily vital signs Monitor for bleeding, bruises Monitor lab values: Be sure PT/ftNR drawn per physician order and reported to MD Monitor sudden dyspnea, chest pain, temp or color change in extremities		
Respiratory/Pneumonia Medicare Documentation	ADLs	Behavior Assessment/Documentation	
Must reflect need/reason for skilled care Daily vital signs Daily and PRN O ₂ 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	How does resident perform? Bed mobility Transfers Ambutation Dressing Eating Toileting and personal hygiene How much staff support is needed? 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.	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, pein, boredom, medication changes if has respiratory diagnosis — O, sat level Non-medication intervention — resident response Medication intervention if needed — document response Medication changes if applicable and result of change	
Bladder and Sowel	Change in Condition Requiring a New Intervention	Dialysis Assess/Documentation Prior to Leaving	
Indicate status: always continent, occasionally incontinent, frequently incontinent, always incontinent. Indicate if has catheter (indwelling or condom, intermittent), urinary ostomy, or no urine output. Tolleting program in progress or attempted and outcome. Constipation? Which interventions used, and results?	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?	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.)	

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