# Hospice Documentation Cheat Sheet

*This cheat sheet can be used as an informative resource for documentation creation or as an educational tool for what needs to be included to ensure adequate hospice documentation.*

*Be sure to comply with company guidelines and regulations.*

## Hospice Documentation Creation Cheat Sheet

☑ **Patient Admission:**

- Collect comprehensive medical history, demographics, and preferences.
- Document advance directives and goals of care.

☑ **Initial Assessment:**

- Conduct a thorough physical and psychosocial assessment.
- Record vital signs, pain levels, and emotional well-being.

☑ **Care Plan Development:**

- Create an individualized care plan based on assessments.
- Include interventions, medications, and goals aligned with patient preferences.

☑ **Interdisciplinary Collaboration:**

- Communicate with team members about patient status and care plan.
- Document contributions from nurses, social workers, chaplains, etc.

☑ **Ongoing Assessments:**

- Regularly assess and document changes in symptoms and patient condition.
- Update care plan as needed based on ongoing assessments.

☑ **Medication Management:**

- Document all medications administered, dosage, and effects.
- Monitor for side effects and document any adjustments made.

☑ **Symptom Management:**

- Document patient symptoms and effectiveness of interventions.
- Adjust care plan to address changes in symptomatology.

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