

# 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.

<b>Medicare Documentation</b> <ul style="list-style-type: none"> <li>• Must reflect need/reason for skilled care</li> <li>• Must reflect Standard of Care</li> <li>• Describe intervention(s)</li> <li>• Describe resident's response to intervention(s)</li> <li>• Daily evaluation of progress or lack of progress</li> <li>• Resident response to skilled therapy</li> <li>• ADL function</li> <li>• Changes in condition</li> <li>• Change Care Plan ASAP after change in condition</li> <li>• Notification to MD and family</li> </ul>	<b>Anticoagulant Therapy Medicare Documentation</b> <ul style="list-style-type: none"> <li>• Must reflect need/reason for skilled care</li> <li>• Daily vital signs</li> <li>• Monitor for bleeding, bruises</li> <li>• Monitor lab values: Be sure PT/INR drawn per physician order and reported to MD</li> <li>• Monitor sudden dyspnea, chest pain, temp or color change in extremities</li> </ul>	<b>Fracture Hip Medicare Documentation</b> <ul style="list-style-type: none"> <li>• Must reflect need/reason for skilled care</li> <li>• Daily vital signs including pain</li> <li>• ADL ability/assistance needed (use MDS Language)</li> <li>• Monitor incision site</li> <li>• Indicate resident's response to therapy: pain, fatigue, etc.</li> </ul>
<b>Respiratory/Pneumonia Medicare Documentation</b> <ul style="list-style-type: none"> <li>• Must reflect need/reason for skilled care</li> <li>• Daily vital signs</li> <li>• Daily and PRN O<sub>2</sub> sat level</li> <li>• Daily and PRN lung sounds</li> <li>• SOB with exertion, when sitting at rest or when lying flat</li> <li>• Resident's response to interventions and skilled therapy</li> <li>• Progress or lack of progress</li> <li>• Change in condition</li> <li>• Change Care Plan ASAP after condition change</li> <li>• Notification to MD and family</li> </ul>	<b>ADLs</b> <ul style="list-style-type: none"> <li>• How does resident perform? <ul style="list-style-type: none"> <li>– Bed mobility</li> <li>– Transfers</li> <li>– Ambulation</li> <li>– Dressing</li> <li>– Eating</li> <li>– Toileting and personal hygiene</li> </ul> </li> <li>• How much staff support is needed? <ul style="list-style-type: none"> <li>– Independent</li> <li>– Set up help only</li> <li>– One person</li> <li>– Two + person physical assist</li> <li>– Activity does not occur</li> </ul> </li> <li>• Document support needed for ADLs over all shifts</li> <li>• Which interventions used to compensate for ADL deficit: i.e., walker, w/c, cane?</li> </ul>	<b>Behavior Assessment/Documentation</b> <ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Location</li> <li>• Specific behavior</li> <li>• Who is around?</li> <li>• Any triggering event (loud noises, new staff, providing care)?</li> <li>• How do symptoms interfere with ADLs?</li> <li>• How does it interfere with care?</li> <li>• Rule out: hunger, toileting needs, pain, boredom, medication changes</li> <li>• If has respiratory diagnosis – O<sub>2</sub> sat level</li> <li>• Non-medication intervention – resident response</li> <li>• Medication intervention if needed – document response</li> <li>• Medication changes if applicable and result of change</li> </ul>
<b>Bladder and Bowel</b> <ul style="list-style-type: none"> <li>• Indicate status: always continent, occasionally incontinent, frequently incontinent, always incontinent</li> <li>• Indicate if has catheter (indwelling or condom, intermittent), urinary ostomy, or no urine output</li> <li>• Toileting program in progress or attempted and outcome</li> <li>• Constipation? Which interventions used, and results?</li> </ul>	<b>Change in Condition Requiring a New Intervention</b> <ul style="list-style-type: none"> <li>• Time/Date</li> <li>• Change that has occurred i.e., weight loss, pressure ulcer, cognition, overall deterioration</li> <li>• Which ADLs are affected?</li> <li>• Which intervention applied?</li> <li>• Response to intervention?</li> <li>• Was MD or family notified?</li> </ul>	<b>Dialysis Assess/Documentation Prior to Leaving</b> <ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Observation of shunt</li> <li>• Assessment of skin</li> <li>• Meal consumption: Indicate if food sent with resident.</li> <li>• Fluid consumption</li> <li>• If edema noted, how much? (Write note for Dialysis team.)</li> </ul>

# Quick Nursing Documentation Guide

**Daniela Niemeyer**



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