

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 • 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	Anticoagulant Therapy Medicare Documentation • 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	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.
Respiratory/Pneumonia Medicare Documentation • 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	ADLs • How does resident perform? – Bed mobility – Transfers – Ambulation – 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: i.e., walker, w/c, cane?	Behavior Assessment/Documentation • 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 • 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?	Change in Condition Requiring a New Intervention • 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?	Dialysis Assess/Documentation Prior to Leaving • 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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Nursing Documentation Made Incredibly Easy Kate Stout, 2018-06-05 Publisher's Note Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality authenticity or access to any online entitlements included with the product Feeling unsure about the ins and outs of charting Grasp the essential basics with the irreplaceable **Nursing Documentation Made Incredibly Easy 5th Edition** Packed with colorful images and clear as day guidance this friendly reference guides you through meeting documentation requirements working with electronic medical records systems complying with legal requirements following care planning guidelines and more Whether you are a nursing student or a new or experienced nurse this on the spot study and clinical guide is your ticket to ensuring your charting is timely accurate and watertight Let the experts walk you through up to date best practices for nursing documentation with NEW and updated fully illustrated content in quick read bulleted format NEW discussion of the necessary documentation process outside of charting informed consent advanced directives medication reconciliation Easy to retain guidance on using the electronic medical records electronic health records EMR EHR documentation systems and required charting and documentation practices Easy to read easy to remember content that provides helpful charting examples demonstrating what to document in different patient situations while addressing the different styles of charting Outlines the Do's and Don'ts of charting a common sense approach that addresses a wide range of topics including Documentation and the nursing process assessment nursing diagnosis planning care outcomes implementation evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings acute care home healthcare and long term care Documenting special situations release of patient information after death nonreleasable information searching for contraband documenting inappropriate behavior Special features include Just the facts a quick summary of each chapter's content Advice from the experts seasoned input on vital charting skills such as interviewing the patient writing outcome standards creating top notch care plans Nurse Joy and Jake expert insights on the nursing process and problem solving That's a wrap a review of the topics covered in that chapter About the Clinical Editor Kate Stout RN MSN is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport North Carolina [Complete Guide to Documentation](#) Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO

documentation standards and documenting outcomes and interventions for key nursing diagnoses Quick Review Series For B.Sc. Nursing: 1st Year - E-Book Annu Kaushik,2018-02-06 QRS for BSc Nursing 1st Year is an extremely exam oriented book The book contains a collection of the last 10 years solved questions of Anatomy Physiology Nutrition Bio chemistry Microbiology Psychology and Nursing Foundation in accordance with the new syllabus as per Indian Nursing Council The book will serve the requirements of BSc Nursing 1st year students to prepare for their examinations Collection of last 10 years solved questions asked in different university examinations across India Viva Voce questions Richly illustrated and lucid content presented with utmost simplicity Simple and easily reproducible diagrams Sample Papers for self practise Answers in point format Sample questions for non clinical subjects like English and Computers *Charting* Lippincott Williams & Wilkins,2006-11-01 Charting An Incredibly Easy Pocket Guide provides time starved nurses with essential documentation guidelines in a streamlined bulleted format with illustrations logos and other Incredibly Easy features The book is conveniently pocket sized for quick reference anytime and anywhere The first section reviews the basics of charting including types of records dos and dont s and current HIPAA and JCAHO regulations The second section alphabetically organized presents hundreds of examples and guidelines for accurately charting everyday occurrences Logos include Help Desk best practices tips Form Fitting completed forms that exemplify top notch documentation Making a Case documentation related court cases and Memory Jogger mnemonics *Rapid Mental Health Nursing* Grahame Smith,Rebecca Rylance,2016-02-03 A concise pocket sized A Z rapid reference handbook on all the essential areas of mental health nursing aimed at nursing students and newly qualified practitioners Covers a broad range of mental health disorders approaches interventions and conditions Easy to locate practical information quickly in a pocket sized rapid reference format The topics and structure are mapped on to the NMC s 2010 Standards for Pre registration Nursing Education and their required essential skills and knowledge *Taylor's Handbook of Clinical Nursing Skills* Pamela Lynn,2010-11-01 Taylor s Handbook of Clinical Nursing Skills is a step by step guide to basic and advanced nursing skills This book will be a quick reference tool for review of cognitive and technical knowledge and will assist students and practicing nurses to provide safe and effective healthcare It is an ideal companion to any nursing skills or nursing fundamentals text including Lynn Taylor s Clinical Nursing Skills and Taylor Fundamentals of Nursing The Art and Science of Nursing Care Quick Review Series: BSc Nursing, 4th Year E-BOOK Annu Kaushik,2022-09-22 Quick Review Series QRS for BSc Nursing 4th Year is an extremely exam oriented book The content has been developed and arranged in a manner so the entire INC syllabus has been covered The subject content has been divided unit wise and according to the weightage of marks in each unit It is well illustrated with simple reproducible diagrams and flowcharts To aid in quick learning before examinations memory aides have also been added The book will serve the requirements of BSc Nursing 4th year students to prepare for their examinations This book covers questions from all major universities across the country *Documentation in Action* Lippincott Williams &

Wilkins, 2006 Designed for rapid on the job reference Documentation in Action offers comprehensive authoritative practice oriented up to the minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties Need to know information is presented in bulleted lists charts flow sheets sidebars and boxes with icons and illustrative filled in samples Coverage includes documentation for care of patients with various diseases complications emergencies complex procedures and difficulties involving patients families and other health care professionals Suggestions are given for avoiding legal pitfalls involving telephone orders medication reactions patients who refuse care and much more A section addresses computerized documentation HIPAA confidentiality rules use of PDAs nursing informatics and electronic innovations that will soon be universal

Rapid Reference for Nurses Karren Kowalski, Patricia S. Yoder-Wise, 2005-07 This text equips nursing students with the facts and figures they need for early clinical experiences Contains a wealth of information ranging from CPR medical terminology and abbreviations to professional references organizations and licensure

Documentation, 2007 This full color handbook is a quick reference guide to all aspects of documentation for every nursing care situation It covers current documentation systems and formats including computerized documentation and features scores of sample filled in forms and in text narrative notes illustrating everything from everyday occurrences to emergency situations Coverage includes timesaving strategies for admission to discharge documentation in acute outpatient rehabilitation long term and home care environments and special documentation practices for selected clinical specialties critical care emergency perioperative maternal neonatal and psychiatric The book includes advice on legal safeguards dangerous abbreviations and compliance with HIPAA guidelines and JCAHO requirements

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