#### MEDICARE CHARTING GUIDELINES

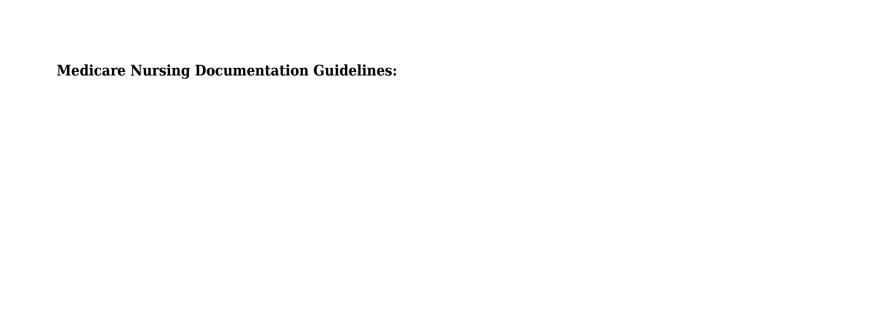
Resident Name:		Date of Admission://	
Adn	Admitting Dx (Main):		
Oth	er Dx:		
Guide 1. 2. 3.	fines: Chart Q Day: Use this guideline to focus your charting: Guideline to be completed by Medicare Nurse, Unit M.	anager, or other Nursing Supervisor.	

#### REASON FOR SKILLING ON MEDICARE:

- o Physical Thorapy: o Cocupational Thorapy: o Speech Thorapy: o Respiratory Thorapy: o Unstable IDDM: o Injections (IM only): o New G-Tube Fooding: o Decubina/Uceration [ o Stagell o Stage IV B Multi-Stage II ]: o Other Wounds (i.e. vip Surgical wicomplications): o Thorapy: o Straight Catheterication o Colombusy Elections/ Care: o Medication Adjustment o Debyslation/Malautrition o Indiation o Patient Teaching Planning Rehab
- o Modically Unstable Condition o Cardiovascular Compromise o Gastrointestinal Complications o Circulation Problems o Hernodialysis (w/ complications)
- TYPE OF SKILLED SERVICE TYPE OF SKILLED SERVICE TYPE OF SKILLED SERVICE o Physical, Occupational Therapy Respiratory Therapy / Impaired o Speech Therapy Describe exactly how the resident performs. Describe Exactly how the resident Respiratory Status communicates and makes needs known. Describe skilled trach care rendered Describe the amount of assistance provided Describe skilled nursing interventions used to Describe accurately breath sounds over all Describe how the resident accomplishes the compensate for speech deficits. lung aspects (i.e. wheepes, rales, ronchi). following: Describe residents ability to swallow foods: Describe respiratory rate, rhythm and quality. Bed Mobility \*\*\* and skilled nursing interventions used to Describe the effectiveness of any respiratory compensate for impaired swallowing abilities. treatments given (i.e. Nebulizers, Chest PT, Transferring \*\*\* Other Respiratory Medications, Oxygen, etc) Ambudates: o Umstable IDDM Describe residents comfort level as sit. Dresses Self respiratory status. Describe amount of order changes and Eats (Including G-Tubes)\*\* physician visits (Requires in the past 14 days) Describe any changes in LOC, anxiety or Toilet Use (Including Post-Use 2 order changes and 2 MD visits OR 4 order other mental status changes. Hygiene)\*\* Describe each incident of suctioning and any changes). Personal Hydiene and Bathing Describe any skilled nursing interventions. other invasive techniques. DESCRIBE SKILLED NURSING used to teach resident self administration. Describe resident's overall condition as rit. INTERVENTIONS USED TO COMPENSATE Describe outcome of resident teachings. respiratory status and any skilled nursing FOR ADL DEFICITS interventions used to aid in comfort and Describe any signs and symptoms associated " Indicates one of the 4 LATE LOSS ADLS with fluctuating blood sugar levels. improve overall status. which assign an ADL Index Score for RUG calculation. o I.M. or I.V. Medication Administration a New Gastrostomy Tube Feeding Decubitus Ulceration (Stage III or IV or MudS- If six Describe nature of medication used (include Describe amount of fluids/feedings delivered Describe condition of wound reason for use) and nursing skills and Describe resident's ability to communicate observations used in administration of and make needs known to staff. Describe response to current treatments medication. Describe how resident tolerated tube feeding Describe nursing interventions used to Describe effectiveness of medication and any - specifically any adverse effects to feeding prevent further ulcer development. side effects observed. such as diamhea, abdominal distension. Describe skilled nursing interventions used to Describe how resident tolerated such therapy Cardiac symptoms, abnormal lung sounds. gridlend begins in big 6.e. IV infiltration, fluid volume overload, pain, Describe type of ostomy care rendered Describe consumption amounts of meals and priniebilitis, etch around G-Tube site and condition of site. fluids provided. Describe clinical necessity for G-Tube/J-Tube Describe overall skin condition including poor Surgical Wounds or Open Lesions (does Straight Catheterization / GU skin turgor, bruises, rashes, cyanosis, Complications not include rashes, ulcers and cuts) redness, edema or other abnormality. Describe location and nature of wound. Describe nature of resident's condition that Document any interventions implemented sit warrants the use of straight catheterization abnormal lab values (i.e. low H&H, low serum. Describe any pain rit to surgical wound and albumin, low Fe+ levels, etc) interventions used to combat pain. Marc Promises were. Describe use of sterile technique during Describe dietary interventions implemented Describe nursing interventions and such as increased vitamin C and protein observations of surgical wound healing catheter administration. floods offered. Describe any resident teaching rit catheter At least q week, describe in detail wound Describe any drainage, areas of increased measurements, locations and response to Describe any clinical conditions present that errytherma, or warmth. breadments. require skilled nursing observation (such as Describe response to any treatments ordered. frequency, dysuria, indicators of UTIL etc) At least a week describe in detail wound healing process and response to tx.

# **Medicare Nursing Documentation Guidelines**

**B** Lingard



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