

MEDICARE CHARTING GUIDELINES

Resident Name: _____ **Date of Admission:** ____/____/____

Admitting Dx (Main): _____

Other Dx: _____

Guidelines:

1. Chart Q Day.
2. Use this guideline to focus your charting.
3. Guideline to be completed by Medicare Nurse, Unit Manager, or other Nursing Supervisor.

REASON FOR SKILLING ON MEDICARE:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Respiratory Therapy ☐ Unstable IDDM ☐ Injections (IM only) ☐ New G-Tube Feeding
☐ Decubitus/Ulceration [☐ Stage III ☐ Stage IV B Multi-Stage II] ☐ Other Wounds (i.e. v/v Surgical w/complications) ☐ I.V. Therapy ☐ Straight Catheterization
☐ Colostomy/Ileostomy Care ☐ Medication Adjustment ☐ Dehydration/Malnutrition ☐ Isolation ☐ Patient Teaching/Nursing Rehab
☐ Medically Unstable Condition ☐ Cardiovascular Compromise ☐ Gastrointestinal Complications ☐ Circulation Problems ☐ Hemodialysis (w/ complications)
☐

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

Medicare Nursing Documentation Guidelines

DJ Losen



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Table of Contents Medicare Nursing Documentation Guidelines

1. Understanding the eBook Medicare Nursing Documentation Guidelines
 - The Rise of Digital Reading Medicare Nursing Documentation Guidelines
 - Advantages of eBooks Over Traditional Books
2. Identifying Medicare Nursing Documentation Guidelines
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Medicare Nursing Documentation Guidelines
 - User-Friendly Interface
4. Exploring eBook Recommendations from Medicare Nursing Documentation Guidelines
 - Personalized Recommendations
 - Medicare Nursing Documentation Guidelines User Reviews and Ratings
 - Medicare Nursing Documentation Guidelines and Bestseller Lists
5. Accessing Medicare Nursing Documentation Guidelines Free and Paid eBooks
 - Medicare Nursing Documentation Guidelines Public Domain eBooks
 - Medicare Nursing Documentation Guidelines eBook Subscription Services
 - Medicare Nursing Documentation Guidelines Budget-Friendly Options

6. Navigating Medicare Nursing Documentation Guidelines eBook Formats
 - ePub, PDF, MOBI, and More
 - Medicare Nursing Documentation Guidelines Compatibility with Devices
 - Medicare Nursing Documentation Guidelines Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Medicare Nursing Documentation Guidelines
 - Highlighting and Note-Taking Medicare Nursing Documentation Guidelines
 - Interactive Elements Medicare Nursing Documentation Guidelines
8. Staying Engaged with Medicare Nursing Documentation Guidelines
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Medicare Nursing Documentation Guidelines
9. Balancing eBooks and Physical Books Medicare Nursing Documentation Guidelines
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Medicare Nursing Documentation Guidelines
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Medicare Nursing Documentation Guidelines
 - Setting Reading Goals Medicare Nursing Documentation Guidelines
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Medicare Nursing Documentation Guidelines
 - Fact-Checking eBook Content of Medicare Nursing Documentation Guidelines
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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