

# 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>

# Long Term Care Charting Guidelines

**JA Banks**



## **Long Term Care Charting Guidelines:**

## Unveiling the Energy of Verbal Art: An Psychological Sojourn through **Long Term Care Charting Guidelines**

In some sort of inundated with displays and the cacophony of fast conversation, the profound energy and emotional resonance of verbal art usually diminish in to obscurity, eclipsed by the regular onslaught of noise and distractions. However, nestled within the lyrical pages of **Long Term Care Charting Guidelines**, a fascinating work of fictional elegance that pulses with fresh thoughts, lies an wonderful journey waiting to be embarked upon. Composed with a virtuoso wordsmith, this enchanting opus manuals viewers on a psychological odyssey, delicately revealing the latent possible and profound affect embedded within the complex web of language. Within the heart-wrenching expanse of this evocative evaluation, we can embark upon an introspective exploration of the book is main styles, dissect its interesting publishing style, and immerse ourselves in the indelible impact it leaves upon the depths of readers souls.

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