

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

T. M. Marrelli



Medicare Nursing Documentation Guidelines:

The book delves into Medicare Nursing Documentation Guidelines. Medicare Nursing Documentation Guidelines is an essential topic that needs to be grasped by everyone, ranging from students and scholars to the general public. This book will furnish comprehensive and in-depth insights into Medicare Nursing Documentation Guidelines, encompassing both the fundamentals and more intricate discussions.

1. This book is structured into several chapters, namely:
 - Chapter 1: Introduction to Medicare Nursing Documentation Guidelines
 - Chapter 2: Essential Elements of Medicare Nursing Documentation Guidelines
 - Chapter 3: Medicare Nursing Documentation Guidelines in Everyday Life
 - Chapter 4: Medicare Nursing Documentation Guidelines in Specific Contexts
 - Chapter 5: Conclusion
 2. In chapter 1, this book will provide an overview of Medicare Nursing Documentation Guidelines. This chapter will explore what Medicare Nursing Documentation Guidelines is, why Medicare Nursing Documentation Guidelines is vital, and how to effectively learn about Medicare Nursing Documentation Guidelines.
 3. In chapter 2, the author will delve into the foundational concepts of Medicare Nursing Documentation Guidelines. The second chapter will elucidate the essential principles that must be understood to grasp Medicare Nursing Documentation Guidelines in its entirety.
 4. In chapter 3, the author will examine the practical applications of Medicare Nursing Documentation Guidelines in daily life. This chapter will showcase real-world examples of how Medicare Nursing Documentation Guidelines can be effectively utilized in everyday scenarios.
 5. In chapter 4, the author will scrutinize the relevance of Medicare Nursing Documentation Guidelines in specific contexts. This chapter will explore how Medicare Nursing Documentation Guidelines is applied in specialized fields, such as education, business, and technology.
 6. In chapter 5, this book will draw a conclusion about Medicare Nursing Documentation Guidelines. This chapter will summarize the key points that have been discussed throughout the book.
- This book is crafted in an easy-to-understand language and is complemented by engaging illustrations. It is highly recommended for anyone seeking to gain a comprehensive understanding of Medicare Nursing Documentation Guidelines.

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