

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

Robert R. Redfield



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