

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 • Multi-Stage II] • Other Wounds (i.e. v/p Surgical w/complications) • I.V. Therapy • Straight Catheterization
 • Colostomy/Ileostomy Care • Medication Adjustment • Dehydration/Malnutrition • Isolation • Patient Teaching/Nursing Rationale
 • Medically Unstable Condition • Cardiovascular Compromise • Gastrointestinal Complications • Circulation Problems • Hemodialysis (w/ complications)
 •

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE
<p>• Physical, Occupational Therapy</p> <ul style="list-style-type: none"> Describe exactly how the resident performs ADLS. Describe the amount of assistance provided. Describe how the resident accomplishes the following: <ul style="list-style-type: none"> 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. <p>** Indicates one of the 4 LATE LOSS ADLS which assign an ADL Index Score for RUG calculation.</p> <p>• IM, or I.V. Medication Administration</p> <ul style="list-style-type: none"> 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) <p>• Surgical Wounds or Open Lesions (does not include rashes, ulcers and cuts)</p> <ul style="list-style-type: none"> Describe location and nature of wound. Describe any pain rt to surgical wound and interventions used to combat pain. Describe nursing interventions and observations rt 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. 	<p>• Speech Therapy</p> <ul style="list-style-type: none"> 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. <p>• Unstable IDDM</p> <ul style="list-style-type: none"> 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. <p>• New Gastrostomy Tube Feeding</p> <ul style="list-style-type: none"> 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 <p>• Straight Catheterization / GU Complications</p> <ul style="list-style-type: none"> 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 rt catheter use. Describe any clinical conditions present that require skilled nursing observation (such as frequency, dysuria, indicators of UTI, etc) 	<p>• Respiratory Therapy / Impaired Respiratory Status</p> <ul style="list-style-type: none"> 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 rt 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 rt respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status. <p>• Decubitus Ulceration (Stage III or IV or Multi- II's)</p> <ul style="list-style-type: none"> 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 rt 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.

Medicare Skilled Nursing Documentation Guidelines

Valentine Korah



Medicare Skilled Nursing Documentation Guidelines:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

Home Care Nursing Practice Robyn Rice, 2006-01-01 This text covers conceptual information leadership skills and current issues and trends It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care Cover

Manual of Nursing Home Practice for Psychiatrists American Psychiatric Association, 2008-11-01 The shifting demographic toward a graying population coupled with today's reality of managed care makes the need for high quality cost effective psychiatric services within the nursing care setting more urgent than ever As we increase the number of our years it is also imperative that we enhance the quality of those years The product of the American Psychiatric Association's APA's Council on Aging and its Committee on Long Term Care and of the Elderly the Manual of Nursing Home Practice for Psychiatrists stands out because it focuses on the how not the why of nursing home care Of exceptional importance is its detailed discussion of the Minimum Data Set MDS a structured assessment required by both Medicare and Medicaid for all residents of skilled nursing facilities Divided into six sections this how to volume contains practical information readers can use right away from getting reimbursed by insurance companies to handling nursing facility politics Clinical History evaluation and management of psychiatric problems in long term care patients an overview of the MDS sexuality within the nursing home care setting Regulatory Introduction to the Nursing Home Reform Act of 1987 part of OBRA 87 and its implications for psychiatric care details about the Resident Assessment Instrument RAI which includes the MDS the Resident Assessment Protocols RAPs and Utilization Guides specified in the State Operations Manual SOP Financial Documentation reimbursement and coding what to look for when contracting with nursing homes Legal and ethical The dehumanizing effect of diagnostic labels and the ethical issues inherent in regulating daily schedules e g bed meal and bath times nursing home placement competence and decision making ability comfort care for end stage dementia coping with Alzheimer's disease and the role of caregivers Summary and Future Perspectives A detailed vision about how psychiatrists can improve the diagnosis and treatment of nursing home patients Appendixes and bibliography Staffing recommendations and assessment instruments Edited by a distinguished authority and former chair of the APA's Committee on Long Term Care and Treatment of the Elderly this comprehensive volume will appeal to a wide

audience of professionals from general psychiatrists nurse practitioners and clinical nurse specialists to primary care physicians and residents *Current Catalog* National Library of Medicine (U.S.),1993 First multi year cumulation covers six years 1965 70 *Documenting Care* Frances Talaska Fischbach,1991 University of Wisconsin Milwaukee School of Nursing s comprehensive charting and documentation manual for students and practitioners **Management of Adult Neurogenic Dysphagia** Maggie Lee Huckabee,Cathy A. Pelletier,1999 Clearly delineates the terminology and practices associated with compensatory versus rehabilitative treatment technique in neurogenic dysphagia Includes comprehensive treatment planning and selection of techniques based on physiologic abnormalities rather than symptomatology Provides in depth discussion of various biofeedback modalities and reviews the challenge of diet modification terminology and standard practices Reviews surgical and pharmacological management of the dysphagia patient TEXTBOOK An Introductory Guide to EC Competition Law and Practice Valentine Korah,1994 *Risk Management Handbook for Health Care Organizations* Peggy Nakamura,Roberta Carroll,2006 This is the most current edition of the book that has become a standard in the field The three volume set covers the enterprise wide continuum of care and associated risk and has been thoroughly revised and updated to reflect the current changes in the health care environment The Risk Management Handbook for Health Care Organizations offers current information regulatory and legal updates and assessment tools that will prove invaluable to both new and seasoned risk managers **Nursing Documentation** Ellen Thomas Egglund,Denise Skelly Heinemann,1994 Focuses on the communication skills that are the key to good documentation **Effective Documentation for Occupational Therapy** Jane D. Acquaviva,1998 **Straight to the Point Documentation Guide for LTC/SNF Nurses** Kik Nursing Strategies,2020-11-23 Tired Of Being Hassled for Documentation as a Nurse in a LTC SNF A Straight To The Point Guide From MDS Coordinators What Exactly It Is We Need From Your Medicare Documentation An easy to use reference made for Nurses in the long term care setting We have gathered that in Nursing school we re taught to document or it didn t happen and on the job tells you to document but you re never given the specifics of what exactly is needed This is why this reference guide was created by MDS Coordinators for LTC SNF Nurses Who better to hear it from than MDS Nurses themselves Bridging the knowledge gap 1 Nurse at a time **The Complete Nursing Home Guide** Mary Brumby Forrest,Christopher B. Forrest,Richard Forrest,1993 Ryan's Occupational Therapy Assistant Karen Sladyk,Sally E. Ryan,2001 The classic foundation work developed by Sally Ryan COTA ROH has been completely revised and updated to reflect current healthcare trends The reformulation of Ryan s Occupational Therapy Assistant Principles Practice Issues and Techniques Third Edition includes occupation based case studies that highlight the didactic material presented in each chapter along with an updated style of information Four sections make up the new integrated text The first section looks at important foundation concepts such as history uniform technology and the occupational therapy process The second section introduces readers to people who are experiencing the challenges of disabilities The chapters provide general information

about the disabilities as well as essential vocabulary and key concepts The third section provides information on the doing of occupational therapy Foundation treatment techniques are introduced so readers can master basic skills and continue to research current practice Lastly the fourth section focuses on the management aspects of an OTA s professional life How to information as well as professional development is the focus of this section

CURRENT Geriatric Diagnosis and Treatment C. Seth Landefeld,Robert Palmer,Mary Anne Johnson,Catherine Bree Johnston,William Lyons,2012-09-01 The most up to date source of clinically focused information on the medical care of the increasing elderly population This text features relevant diagnostic and treatment content needed by every provider of healthcare to older adults The text covers the major diseases and disorders of the elderly with particular attention to the care of the elderly

Documenting Physical Therapy Angela Marie Baeten,Michael L. Moran,Lynn M. Phillippi,1999 Documenting Physical Therapy provides practitioners with the tools necessary to make documentation a successful and beneficial part of clinical practice Using the reviewer s perspective emphasis is placed on documenting components that are essential for coverage determinations

Physicians Fee & Coding Guide ,2011

A Guide to Management and Supervision in Nursing Homes Sarah Burger,Brenda H. Sullivan Miller,Brenda Fay Mauney,1986

Documentation for Rehabilitation Lori Quinn,James Gordon (Ed.D.),2010 In this textbook Quinn and Gordon provide a general approach to documentation that can be adapted to different settings for physical therapy students and professionals They emphasize the concept that clinical reasoning is reflected in documentation and vice versa and that documentation is a framework for clinical decision making They cover each documentation component and examples and exercises that relate to areas such as rehabilitation women s health health and wellness orthopedics and acute care This edition has been revised and expanded and includes new chapters on payment policy and coding legal aspects pediatrics and computerized documentation and incorporates the International Classification of Functioning Disability and Health model

Principles and Practice of Hospital Medicine Sylvia C.

McKean,2012-04-19 The definitive guide to the knowledge and skills necessary to practice Hospital Medicine Presented in full color and enhanced by more than 700 illustrations this authoritative text provides a background in all the important clinical organizational and administrative areas now required for the practice of hospital medicine The goal of the book is provide trainees junior and senior clinicians and other professionals with a comprehensive resource that they can use to improve care processes and performance in the hospitals that serve their communities Each chapter opens with boxed Key Clinical Questions that are addressed in the text and hundreds of tables encapsulate important information Case studies demonstrate how to apply the concepts covered in the text directly to the hospitalized patient Principles and Practice of Hospital Medicine is divided into six parts Systems of Care Introduces key issues in Hospital Medicine patient safety quality improvement leadership and practice management professionalism and medical ethics medical legal issues and risk management teaching and development Medical Consultation and Co Management Reviews core tenets of medical

consultation preoperative assessment and management of post operative medical problems Clinical Problem Solving in Hospital Medicine Introduces principles of evidence based medicine quality of evidence interpretation of diagnostic tests systemic reviews and meta analysis and knowledge translations to clinical practice Approach to the Patient at the Bedside Details the diagnosis testing and initial management of common complaints that may either precipitate admission or arise during hospitalization Hospitalist Skills Covers the interpretation of common low tech tests that are routinely accessible on admission how to optimize the use of radiology services and the standardization of the execution of procedures routinely performed by some hospitalists Clinical Conditions Reflects the expanding scope of Hospital Medicine by including sections of Emergency Medicine Critical Care Geriatrics Neurology Palliative Care Pregnancy Psychiatry and Addiction and Wartime Medicine

Community-based Nursing Melanie McEwen, 1998 This straightforward practical resource focuses on health promotion and illness prevention while also addressing the nursing care of persons with routine and chronic conditions discusses the factors that affect health and health care delivery including epidemiology environmental health issues and cultural influences examines the unique community based nursing needs of specific client populations such as women infants and children and the elderly clients with HIV Infection and AIDS and clients with mental health conditions provides practical tools for use in all areas of community health from assessment and screening recommendations to detailed information on health teaching and suggestions for improving nursing care emphasizes Healthy People 2000 objectives and strategies throughout and lists resources within each chapter that provide contact information for important agencies and institutions

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