CHARTING CHEATSHEET

ASSESSMENT:

VITAL SIGNS, PHYSICAL AND MENTAL HEALTH STATUS, ANY SIGNS AND SYMPTOMS OF ILLNESSES OR CONDITIONS, AND ANY CHANGES OBSERVED SINCE THE LAST VISIT.

MEDICATIONS:

ANY MEDICATIONS THE PATIENT IS TAKING, INCLUDING DOSAGE, FREQUENCY, AND ANY CHANGES TO THE MEDICATION REGIMEN.

CARE PLAN:

DOCUMENT THE PATIENT'S CARE PLAN, INCLUDING ANY INTERVENTIONS PERFORMED, ANY CHANGES TO THE CARE PLAN, AND THE PATIENT'S RESPONSE TO THE PLAN.

WOUND CARE:

NURSES SHOULD DOCUMENT ANY WOUNDS THE PATIENT HAS, INCLUDING THE LOCATION, SIZE, DEPTH, AND TYPE OF WOUND, AND ANY TREATMENTS PERFORMED.

EDUCATION:

DOCUMENT ANY EDUCATION PROVIDED TO THE PATIENT OR THEIR CAREGIVERS, INCLUDING INFORMATION ON MANAGING THEIR CONDITION, MEDICATIONS, AND ANY LIFESTYLE CHANGES RECOMMENDED.

COMMUNICATION:

DOCUMENT ANY COMMUNICATION WITH THE PATIENT'S PHYSICIAN OR OTHER HEALTHCARE PROVIDERS, INCLUDING ANY CHANGES TO THE PATIENT'S CONDITION OR CARE PLAN.

. SAFETY:

DOCUMENT ANY SAFETY CONCERNS OR HAZARDS OBSERVED IN THE PATIENT'S HOME AND ANY ACTIONS TAKEN TO ADDRESS THEM.

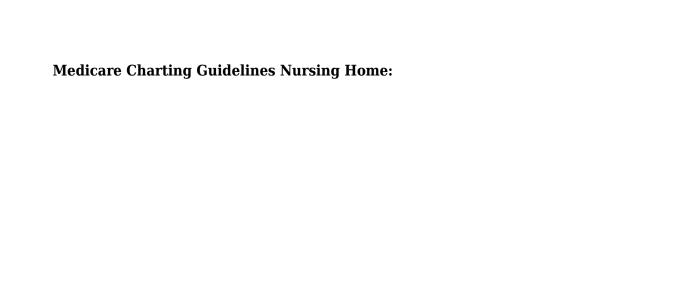
DISCHARGE PLANNING:

DOCUMENT ANY DISCHARGE PLANNING ACTIVITIES, INCLUDING ANY REFERRALS MADE TO OTHER HEALTHCARE PROVIDERS OR SERVICES AND ANY FOLLOW-UP APPOINTMENTS SCHEDULED.

DOCUMENTATION IS CRITICAL FOR TRACKING THE PATIENT'S PROGRESS, ENSURING CONTINUITY OF CARE, AND COMMUNICATING WITH OTHER HEALTHCARE PROVIDERS INVOLVED IN THE PATIENT'S CARE.

Medicare Charting Guidelines Nursing Home

Kathleen Armour



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