

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. w/p 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.
☐ IM, 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 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)	

2013 Daily Skilled Charting Guide

Liyong Dong



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