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Therapy that exceeds expectations.

Skilled Nursing Documentation Recommendations

Respiratory	Urinary/Bowel	Integumentary	Diabetic Care	Pain Control	Orthopedic
Respiratory rate, rhythm, quality, pattern	Document S/S of infection	□ Wound location and type □ Condition/appearance of wound □ Wound measurements □ Wound stage □ Presence of drainage, erythema, or warmth □ S/S infection	Performing/reading blood sugars	Type Location Severity Frequency Time of day Activity related to pain	ADLs affected and amount of assist needed for ADLs
Describe any changes in level of consciousness, anxiety, or other mental status changes	Burning, pain, bloody, cloudy, pus in urine, odor		Describe number of order changes and MD visits		Assist with transfers
Lung sounds: wheezes, rales, ronchi	Dysuria description		Determining/drawing insulin		Assist with ambulation Positioning/safety devices
SOB cause; SOB while lying flat; Nursing care to decrease SOB	Urgency Fever Confusion Behavior	Surgical wound: □ Describe pain and interventions to decrease pain	Self-injections: □ Rotating sites; □ Describe skilled nursing care to teach resident self-administration □ Describe effectiveness of resident teaching □ Resident return demonstration	Medications and response Pain rate before and after medication	Pain: (see pain control section) Surgical Incision appearance/care □ Describe pain and interventions to decrease pain
Describe the presence of Cough/congestion	Medications ordered and response	Dressing type and change orders		Non-therapeutic interventions: turning down lights, quiet environment, position change, massage, therapy, etc.	Precautions/contraindications
Oxygen use/O2 sats and interventions provided	Change in S/S	Pain with dressing changes			Weight Bearing Status; affected extremity
Fever present and interventions provided	Straight catheterization □ Describe condition that requires straight catheterization; □ Describe sterile technique used; □ Describe any teaching regarding catheter use;	Skin integrity nursing care	Diabetic diet		
Respiratory treatment effectiveness		Describe outcome and resident's understanding from self-wound care training	Describe S/S associated with blood sugar fluctuations		
Meds and response			Diabetic foot care		
Activity tolerance	Describe outcome and resident's understanding from colostomy/ileostomy/ supra-public care training.	Nutritional intake; include meal & fluid consumption; dietary interventions (protein shakes/food; vitamin C; etc.)			
Comfort level relating to respiratory status					
Sore throat					
Description of trach care/suctioning provided	Describe outcome and resident's understanding from bowel and bladder training	Current treatment and response Describe wound healing process			**I.V. or I.M. Medication**
Skilled nursing interventions used to improve comfort & overall functional status	**Dialysis:** describe nursing care used to maintain homeostasis & skilled observations related to signs of hyperkalemia (monitor K+ levels), intake/output; monitor edema/respiratory issues, H&H, & signs of infection	Pressure Ulcers: also include: □ Description of nursing care to prevent further ulcers; □ Description of nursing care to improve wound healing; □ Description of overall skin condition (skin turgor/ bruises/ rashes/ cyanosis/ redness/ edema, other abnormality □ Abnormal labs & interventions (low H&H, serum albumin, Fe+ levels)			Describe medication used, reason for use and nursing skills & observations used when administering the medication. Describe effectiveness of medication and any side effects reported or observed. Describe dose, frequency, and how resident tolerated (IV infiltration, fluid volume overload, pain, phlebitis, etc.)
	Ostomy Teaching				
	Emptying bag; applying new bag				
	Unclamping/clamping bag				
	Checking/treating skin				

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Cerebrovascular	Rehabilitation	Mood/Behavior		Cardiac	Tube Feedings
ADL status and assist level	**PT & OT**	Type of behavior; sadness; wandering; acting out toward others	Increased fidgety or restless movements	Vital signs, B/P and Apical pulse	Reason for tube feeding; clinical necessity
Paralysis or weakness of specific extremity	ADL ability Amount of assistance	Medication change in orders and response or effectiveness	Thoughts that they would be better off dead/hurting themselves	Chest pain and type; nursing care to improve comfort	Other sources of nutrition
Neurochecks; pupil response to light	□ Bed Mobility Assistance □ Transferring Assistance	Redirectable or not; social inappropriateness	Moving/speaking slowly that others noticed	SOB lying/sitting/exertion	Amount of feeding / response. □ Include any adverse effects (diarrhea, abdominal distension, cardiac symptoms, abnormal lung sounds, etc.)
Vital signs	□ Ambulation Assistance; include assistive device used	Response to meds Response to distractions	Feeling bad about themselves or that they are a failure or have let themselves/family down	Edema /Weight gain (measurements)	
Ability to communicate	□ Dressing abilities & amount of assistance □ Eating abilities & amount of assistance	Describe any persistent anger, self-depreciation, sleeping problems	Concentrating on reading newspaper/watching T.V.	Cardiac meds/diuretics; response to medications; effectiveness	
Coordination and nursing care to compensate	□ Toilet Use including toileting hygiene abilities & amount of assistance	Responses to other residents and staff and Changes to environment such as removing the trigger or removing the resident having the behavior	**Cognition**	Anticoagulation meds type/response	Weight and bowel patterns
Cognition: describe the severity of the cognitive impairment and nursing interventions to compensate for deficits			Type of severity of cognitive impairment Problem solving Safety awareness	Skin color; Skin warmth; Skin dryness Type and response from chest pain relieving medication	Flushes and results Check residual Check placement
Describe nursing care used to maintain homeostasis and skilled observation as well as skilled interventions to assist resident cope with ADL dependence.	Therapy response / progress Pain related to therapy Improvement in mobility	Little Interest or pleasure in doing things Feeling down, depressed, or hopeless Trouble falling or staying asleep or sleeping too much	Sequencing issues; difficulty communicating ADL decline with nursing care Ability to follow directions & nursing care to compensate	Oxygen use/O2 sats	Skin around stoma: □ Describe type of ostomy care □ Describe condition of site □ Location
Therapy involvement: type of therapy, functional abilities	Describe nursing care provided to compensate for ADL deficits	Feeling tired or having little energy, poor appetite/overeating	Redirection cues		Describe resident's ability to communicate wants & needs
Swallowing; mechanically altered diet		Describe any negative statements made; repetitive questions.	Ability to stay on task; responsiveness to interactions		**Dehydration:** Describe nursing care used to maintain homeostasis & skilled observation & measures to correct dehydration
Anticoagulation meds type/response	**ST**		Describe the severity of cognitive loss and describe current level of orientation (person, place, time)		
	Describe resident's ability to communicate; describe how resident makes wants and needs known				
	Describe nursing care provided to compensate for speech deficits				
	Describe resident's ability to swallow foods		Describe area of deficit: short term/long term memory affected		
	Describe diet type / textures & resident response to diet				
	Describe resident's ability to swallow foods				
	Describe nursing care provided to compensate for swallowing deficits				
	Describe swallowing compensatory strategies				
Observation/Assessment/Care Plan					
I & O Appetite/nutrition; skin integrity	Refusals; fall risk; pain control	Assistance needed with care/mobility	LOC, responsiveness	Specific resident requests; fall risk	Any change/decline

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