SNF Documentation Guidelines

Assessment / Findings: Document in clinical record
Skilled Analysis / Adjustment: Narrative documentation
Why Me – Why does resident require skills of a nurse or therapist?
Why Here – Why does the resident require SNF setting versus AL or HH?
Why Now – Why does the resident's clinical condition require skilled services at this time?

IV Medications / Fluids

- Reason
- Type of fluid
- Response to interventions
- Vital signs and nursing note Q shift
- Description of IV site
- Rate of flow

Suctioning (Nasopharyngeal)

- Need
- Quantity and description of secretions
- Chart on shift it was done and shift following
- Frequency
- Vital signs
- Lung sounds

Pressure Ulcer

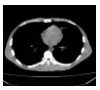
- Location of ulcers(s), stage
- Drainage:
  - Type
  - Odor
  - Color
  - Amount
- Response to treatment
- Interventions (including special mattress)
- Utilize wound flow sheet

Skin Tear / Excoriation

- Location and description of wound(s)
- Dressing / treatment
- Utilize wound flow sheet
- Pain
- Color
- Rash

Pneumonia / Respiratory

- Results of chest x-ray, labs, etc. as completed
- Treatment
- Vital signs to include O2 sats and lung sounds Q shift
- Headache, disorientation
- Cough (painful, hacking, productive, non-productive)
- I & O and weight
- Sputum (describe)
- Anxiety / apprehension



Feeding Tubes

- Utilize tube feeding flow sheet and include documentation of:
  - Formula
  - Check tube placement
  - Flushes
  - HOB elevated, etc.
- Description of g-tube site
- Tolerance to feeding
- Mouth care

Diabetes

- S/S Hypo/Hyperglycemia
- Appetite
- Vital signs
- Skin problems
- Adherence to diet
- Podiatry care
- Weight
- Insulin type / response
- Visual difficulties
- Extremities (condition, color, edema, sensation)
- Physician notification for blood sugars outside ordered range

Mobility / Therapy

- Document according to tx plan (i.e., if for ambulation, note how well the resident ambulates, etc.)
- Safety concerns / risks
- For PT/OT assistance needed for bed mobility, transfer, toilet, ambulation
- For ST, assistance needed with eating, thickened liquids, etc.
- Weight bearing status
- Tolerance

Post Surgery

- Presenting symptoms (i.e., surgical wound, appearance of eye for cataract removal, etc.)
- Level of consciousness
- Pain management
- Blood clots / DVT risk
- Nutrition for healing
- Tolerance
- Vital signs

Oxygen Use

- Vital signs to include lung sounds
- Reason
- Amount
- Route
- Frequency
- O2 sats

UTI

- Frequency of urination
- Color, odor, amount of voids
- Vital signs Q shift until resolved
- Antibiotic treatment ordered
- Labs as ordered
- I & O

Falls

- Complete post fall assessment
- Injuries sustained
- Document Q shift x 72 hours to include neuro assessment
- Document noncompliance with fall interventions
- Document neuro assessment on flow sheet for head injury
- Document interventions

Created by The Evangelical Lutheran Good Samaritan Society – Revised April 2017

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In Christ's Love, Everyone Is Someone.

Behaviors

- Precipitating factors if known
- Interventions and resident response
- Administration of PRN meds
- Psych consult
  Response to change in meds

Nutrition / Hydration

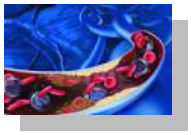
- Amount eaten at each meal
- Nausea, vomiting, diarrhea
- Mouth care, dentures, dental cares
- Consultation with dietician
- Encouragement of fluid intake
- Skin turgor
- I & O
-

Pain

- Type of pain, severity
- Pain med given and response
- Physician notification if pain management ineffective
- Other modalities used for pain control and effectiveness
- Location

Anticoagulation Therapy

- Vital signs
- Presence or absence of active abdominal, joint, or other pain
- Active signs of bleeding noted
- Color – cyanosis or pallor
- Labs
- Physician communication regarding PT/INR results



CHF

- Vital signs
- Lung assessment
- O2 sats
- Chest pain, actions taken and resident response
- Edema
- Color of skin, nail beds
- Capillary refill
- Interventions initiated (Lasix increased, IV Lasix, etc.)
- Monitor for increase / decrease in weight secondary to diuretics

CVA

- Vital signs
- Appliances required
- Problems with balance
- Safety measures needed
- Assistance needed for ADLs
- Ability to make needs known
- Therapy, restorative program
- Continence
- S/S of swallowing problems
- Change in level of consciousness, emotional status
- S/S of depression
- Interventions to prevent contractures

Fracture

- Vital signs
- Assistance needed for ADLs
- Maintenance of proper alignment of affected limb
- Preventive measures in use
- Response to pain medication
- Circulatory status of affected extremity (pulse present)
- Related surgical wound
- Edema
- Weight bearing status
- Precautions (i.e. hip)

GI Bleed

- Vital signs
- I & O
- Auscultation of bowel sounds
- Monitoring of sputum, emesis, stool
- Meal intake and nutritional status
- Monitoring labs (H&H)
- Hemoccult results
- Bowel function

MI / Hypertension

- Vital signs
- Anxiety
- Edema
- Monitoring of labs
- Nausea / vomiting
- Toleration of therapy
- Response to medications
- Chest Pain (recurrent / new)
- Radiating, describe (throbbing, dull, aching, etc.)
- Confusion / irritability, blurred vision, vertigo

ADL Documentation

- Number of staff assist needed for bed mobility, transfers, toilet use, bathing, dressing, eating, etc. (1, 2, etc.)
- Amount of assistance needed:
  - Supervision
  - Limited
  - Extensive
  - Total

Cancer

- Vital signs, especially after chemo or radiation treatments
- Therapeutic / diagnostic procedures
- Anorexia / Appetite
- Nutritional intake
- Pain: location, duration, type
- Nausea / vomiting
- Odor (affected tissue)
- Skin integrity
- Anxiety

Neurological / Seizure

- Vital signs
- Pain (locations)
- Level of consciousness
- Seizures (type, pattern)
- Injuries related to seizures
- Duration of episode
- Dizziness
- Symptoms at on-set
- Pupillary responses
- Medications

Note: Changes in condition should be care planned.
Responsible Party should be notified of each new treatment ordered (e.g., infections, antibiotics, medication changes, new skin breakdown, falls, etc.).