SKILLED NURSING COVERAGE AND DOCUMENTATION

The Evangelical Lutheran Good Samaritan Society

April 2017

THE EVANGELICAL LUTHERAN Good Samaritan Society®

In Christ's Love, Everyone Is Someone.

Skilled Nursing Documentation

Needs to tell your story

- What is being monitored by you as a nurse?
- Why are you concerned?
- What are you doing about it?
- Why does care require your skills as a nurse?
- Why the inpatient skilled setting?
- What are the clinical goals?

Admission Documentation

Admit Note should include:

- Conditions treated in hospital
- Complications treated/at risk for
- New medications
- PLOF
- Interventions/assessments
- Discharge plans

Practical Matter Statement:

- The skilled services can be provided only on an inpatient basis in SNF.

Daily Skilled Notes

Should include:

- What is being observed/monitored/assessed daily?
- Nursing interventions that address unstable conditions
- Complications/Risk factors and what you are doing to prevent
- Teaching/Training
- Medications and Treatments
  - Clinical response to meds/treatments and new meds/treatments
- Physician contact
- Documentation supporting interdisciplinary care plan approach with therapy

What should Daily Skilled Note include?

Each skilled note should answer 3 questions

- Why Me?
  - What about this resident's condition takes my skills as a nurse? Why a nurse and not my spouse or neighbor?
- Why Here?
  - Why does the resident need care in a SNF rather than AL or home?
- Why Now?
  - What clinical reasons are being monitored and why? What conditions, disease processes, etc. are at risk for instability and/or decline? What are the skilled interventions and the resident's physiological response?

Skilled Documentation Guidelines

- Helpful tool for guiding documentation
- Essential points to assess and document
- Promotes critical thinking:
  - Complications of disease/illness and how they inter–relate
  - Complications or risks impacting stability and affecting health status

Common Mistakes

- Failure to tell the complete story makes it difficult to validate or explain care decisions
- Failure to document meds / treatments
- Failure to document physician and/or family notification
- Failure to document change of condition or response to changes
- Failure to act that may result in re-hospitalizations

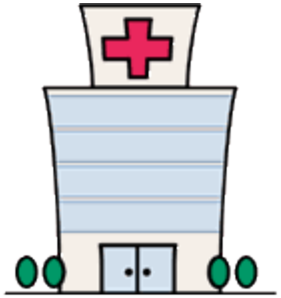
Rehospitalizations

Avoidable

- Condition not unstable
- Health Care provider not notified
- Nursing assessments not thorough
- No action taken

Unavoidable

- Condition unstable or complex with attempted management
- Worsening medical condition despite several days of treatment



INTERACT Tools

- **Inter**ventions to **R**educe **A**cute **C**are **T**ransfers
- Stop and Watch Early Warning Tool
- CICE (Change In Condition Evaluation)
- Interact File Cards (S/S T,U,V)
- Interact Care Path
  - UTI
  - Fever
- www.interact2.net

Discharge Skilled Care

Discharging from SNF

- Complete a skilled discharge note

Discharging from skilled level of care and remains in SNF:

- Complete a skilled discharge note

THE EVANGELICAL LUTHERAN Good Samaritan Society®
In Christ's Love, Everyone Is Someone.

Discharge Documentation

Discharge Note:

- Identify progress made toward regaining prior level of function or health status (or lack of) as a result of skilled nursing and/or therapy
- Teaching and training provided
- Home services (if applicable)
- Discharge instructions provided
- Resident's understanding