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CENTERS FOR MEDICARE & MEDICAID SERVICES

Comagine Health

Nursing Documentation Review Checklist

Documentation is essential to providing quality care and meeting the resident's needs. Ensuring that the care provided and the resident's response to that care is accurately reflected in the documentation informs ongoing care, reduces risk for liability and supports the best outcomes.

Use this checklist as part of a peer review of clinical documentation to assess completeness and quality of information included in the notes. This checklist can also be used to build competency with documentation.

ASSESSMENT	REASSESSMENT	CLINICAL/NURSING DOCUMENTATION REVIEW CHECKLIST	YES	NO	N/A
		DATE OF INITIAL ASSESSMENT: / **DATE OF REASSESSMENT:**			
		What is the change in condition (respiratory problems/distress, hypoglycemia, etc.)?			
ASSESSMENT/REASSESSMENT: Is thorough information documented for resident initial assessment?					
		Document initial resident change in condition. • *Describe the change in condition, the date and time of the identified change, who identified it.*			
		Describe specific symptoms the resident is experiencing using objective terms. • *Signs and symptoms related to body systems, pain and change in level of consciousness.*			
		Include subjective statements from the resident describing how they feel.			
		Record vital signs (actual values), including clinical judgment of the values. • *Example: Indicate whether they are within normal limits for the resident or abnormal.*			
		Does the resident exhibit symptoms of dehydration? • *Symptoms may include furrowed tongue, dark-colored and strong-smelling urine, decreased urine output, change in cognition, poor skin turgor, sunken eyes, rapid heart rate, low blood pressure.*			
		Does the resident exhibit symptoms of hypoglycemia? • *Symptoms may include sweating, confusion, tremors, irritability, change in sleep, unsteadiness, vomiting, lethargy.*			
		Does the resident exhibit symptoms of hyperglycemia? • *Symptoms may include increased urination, shortness of breath, fruity-smelling breath, increase in confusion, increased fluid intake.*			
		Describe skin. • *Example: Intact or not, color, cool, clammy, diaphoretic, color of nail beds and lips.*			
		Describe respiratory effort. • *Example: Shallow, rapid, labored, pursed-lipped breathing, use of accessory muscles.*			
		Describe lung sounds. • *Example: Crackles, rhonchi, rales, wheezes.*			
		Is there presence of edema? If so, is the location of edema documented? • *Example: Feet, lower legs, dependent edema that would be in the back or elsewhere.*			
		Describe any change in ADL ability.			
		Describe any change in cognition, mood or normal behavioral expressions.			
		Describe any change in food or fluid consumption.			
		Include pertinent labs and other diagnostics. • *Example: Weight, CBC, CMP, BUN, creatinine, electrolytes, C&S, CXR, EKG, thyroid panel, blood sugar, liver panel, cardiac enzymes.*			

ASSESSMENT	REASSESSMENT	CLINICAL/NURSING DOCUMENTATION REVIEW CHECKLIST	YES	NO	N/A
Indicate if the nurse included any of the following as a potential contributing factor to the change in condition.					
		Foley catheter – Risk for UTI.			
		Central line (PICC line, midline, port-a-cath, etc.) – Risk of central line infections.			
		Dialysis access site (fistula, peritoneal, central venous catheter) – Risk of site infections.			
		Antibiotic therapy – Risk for adverse effects, C-*diff.*			
		Oxygen therapy – Risk for desaturation.			
		Fluid restriction – Risk for hypernatremia (ensure indication for restriction is managed).			
		Wounds – Risk of infections.			
		IVF therapy – Risk of fluid overload/IV site infections.			
		Ventilator – Risk of respiratory infections, aspiration.			
		G-Tube – Risk of tube clogging, dehydration.			
		NURSING DIAGNOSIS			
		Describe what the resident is experiencing and/or the potential risks. • *Example: Change in level of function (ADLs, socialization, energy level); change in mood (increased anxiety, depression); change in cognition; change in appetite or lack of intake of food/fluids.*			
		PLANNING			
		Identify resident goals for care, advance care planning wishes, refusal of care (if applicable).			
		Include time frame for monitoring and reassessing resident.			
		IMPLEMENTATION OF TREATMENT PLAN *Physician orders and nursing interventions*			
		IV fluids and/or medications.			
		Medications specific to the treatments or medications held because of the symptoms.			
		Diet modifications – ice cubes, assistance to drink or eat, higher calorie intake, fluids encouraged.			
		Comfort care – oral care, cool cloth or ice pack, rest, massage, weighted blanket, dim lighting.			
		ADLs – additional assistance needed now because of fatigue, discomfort, or change in mobility.			
		Transmission-based precautions for suspected or confirmed infection.			
		MONITORING *Resident's response to care*			
		Is there documentation regarding resident's goals for care, wishes, advanced directives?			
		Has the care plan been updated to reflect changes?			
		Is there a daily or per-shift note from the time the change was identified until the time it resolved?			
		EVALUATION *Outcomes experienced by resident*			
		Have the symptoms improved or been resolved?			
		What is the resident's response? • *Accepted or if not, document alternatives approaches suggested and actions taken*			
		Date and by who, date of resolution and outcome (i.e., return to baseline; new normal).			
		Comments. • *Example: Transferred to hospital, returned date, follow-up notes from hospital.*			

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