LTC Charting: A Beginner's Guide

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Questions regularly arise regarding the topic of appropriate charting in LTC. Many nurses who are new to the realm of the nursing home setting are sometimes confused about what and how to document. Here is a list that barely scratches the surface of events and situations that warrant the need to write a nurses note in LTC.

The long term care industry (a.k.a. nursing home industry) employs a large share of new and experienced nurses in the United States. Furthermore, the number of nurses who secure employment in this specialty is projected to increase in the next ten years as the oldest members of today's upper middle-aged Baby Boomer cohort reach their 70s.

Questions regularly arise regarding the topic of charting. In other words, many nurses who are new to LTC are sometimes unsure about the whats, whens and whys that revolve around documentation in the nursing home setting. Here is a starting list of events and situations that would generate the need to write a nurses note in LTC.

Changes in Condition

Always write a detailed nurses note describing a resident's change in condition, along with a description of the prudent actions you took. Interventions can be as simple as administration of a PRN medication, repositioning, notification of the attending physician, implementation of new orders, or transfer to an acute care hospital.

New Orders

When a nursing home resident receives a new order from a physician or mid-level provider, record it. Make sure you notify the family or responsible party. For instance, this sentence will suffice: "New telephone order received for oyster calcium 500mg orally BID with meals; responsible party Chris Taylor (son) aware."

Response to Initial Doses

Always document the patient response to initial doses of medications within 24 hours of receipt of the first dose. "Received initial dose of oyster calcium 500mg with supper; no side effects or adverse reactions noted at this time" will be sufficient. Some facilities require documentation every shift for up to 72 hours after the initial dose of a medication is administered.

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Antibiotic (ABT) Charting

ABT is shorthand for 'Antibiotic Therapy.' In many states, the nurse must administer the initial dose of an antibiotic within four hours of receipt of the order from a healthcare provider. Many facilities have policies requiring nursing staff to document the resident's response to ABT every shift and up to 72 hours after the last known dose was given.

Falls

Document after every single fall. The vast majority of facilities require the nurse to notify the attending physician, complete incident report paperwork and make the family and/or responsible party aware, so be sure to follow the procedures of your workplace. The physician or mid-level provider on call may order x-rays, CT scans or pain medications, so be sure to include any new orders in your nurses note.

Do Not Mention Incident Reports (EVER)

Never document the existence of an incident report in your nurses notes. The incident report is an internal document intended to facilitate improvement of processes and systems at the facility. If a nurse records a note mentioning that an "incident report was done," this internal form is now subject to discovery by external attorneys if litigation arises in the future.

Skin Tears

Write a nurses note after spotting a skin tear that wasn't there previously. Prior to writing the nurses note, ask other staff members if they know the origin of the skin tear. Many nursing homes also require completion of incident reports for skin tears of unknown origin. In addition, the nurse might need to notify the physician and obtain orders for dressing changes, application of steri-strips, triple antibiotic ointment, or another treatment that seems appropriate.

Bruises

Many facilities require staff to write a nurses note regarding bruises that were not previously present. In addition, facility policy may require the nurse to prepare incident reports on all bruises of unknown origin.

Resident Refusals

Residents sometimes refuse showers, treatments, meals and/or medications. To cover your behind, always document every instance of refusal. Some facility policies may require notification of the attending physician and the responsible party. This is helpful if the resident begins to physically decline after refusing treatment because your notes prove that the physician and/or others are aware of the refusals.

Medicare Charting

If a resident's primary payor source is Medicare, nursing staff must document on the medical record once every 24 hours. Some facilities require a nurses note on Medicare residents once each shift. A sufficient Medicare note should include a recent set of vital signs, the reason why the resident is receiving skilled services, and a succinct description of his/her condition today.

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Residents Who Go Out On Pass

Chart the approximate date and time each resident goes out on pass. Most facilities will require the resident or responsible party to sign in and out with each pass. Once the resident or responsible party has signed out, the facility and its staff are no longer legally responsible for any poor outcomes that occur during the time away.

Aberrant Behavior

Unfortunately, some residents will engage in behaviors that make others cringe. Some residents smear feces, masturbate in front of others, fight with roommates, spit on the dining doom floor, and engage in other unbecoming behaviors. Document these behaviors and notify the resident's attending physician. Many nursing homes will also require notification of the family or responsible party. Always remember to maintain safety if a resident is starting physical altercations.

Appointments

Generate a nurses note when you schedule an appointment. Something to the effect of "Appointment with Dr. Skylar of orthopedics made for Monday, March 3rd at 2:45pm; facility van driver will transport to and from doctors office" will work just fine.

In addition, chart when the resident returns to the nursing home. "Pt. returned from ortho appointment in no observed acute distress; new orders received for weight bearing as tolerated to both lower extremities and tramadol 50 mg orally q6h PRN pain. Responsible party Jane Simmons (niece) aware."

Seen by Physician or Mid-level Provider During Rounds

Some residents are forgetful and will claim that the doctor never sees them. Moreover, some troublesome families will claim that the doctor never sees the resident. To minimize trouble, write a quick note each time a resident is seen by a provider during rounds. "Pt. seen by Dr. Clark; no new orders received at this time" is adequate.

Response to PRN Medications

Residents take PRN medications for a variety of issues such as pain, constipation, itching, spasm, fever, and so forth. Document the response: "Dulcolax 10mg orally given this a.m.; resident had large, soft BM after lunch." Documenting the response to PRN medications will cover the facility and the staff in case an accusation is later made that "those nurses did nothing to help my grandma!"

Routine Dialysis Appointments

Some residents leave the nursing home for dialysis appointments three times a week at regularly scheduled times. Document their departure, arrival, and your quick assessment of the thrill, bruit, and appearance of the vascular access. Several years ago a doctor accused the nurses at my former workplace of failing to send a resident to her dialysis appointments. Our documentation protected the facility. In addition, the resident's daughter recalled when we sent her mother to the dialysis center using our facility's van.

Labs

Critical lab results require immediate notification of the doctor or provider on call. Document that you made this notification, including orders received. Some lab results that are slightly out of range, such as INRs, will also require prompt notification and a nurses note.

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