COLLABORATIVE NURSING DOCUMENTATION

The following section is designed to assist the clinician in providing information to the nursing staff in effort to facilitate collaborative nursing documentation regarding a patient receiving therapy.

There are discipline specific checklists that provide corresponding suggestions for nursing documentation.

These materials are also valuable to use for an in-service to the nursing staff regarding how nursing can best describe a patient's functional status/ability.

REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
Medical Diagnosis: _____
Therapy/Treatment Diagnosis: _____

This checklist is designed to assist the charting nurse in describing the patient's functional ability on the unit. The intent is to help facilitate nursing documentation that is functional in nature and reflects the patient's performance as it relates to their rehab program. The rehab activity or program is checked and corresponds to suggested patient activities, or functional performances which might be noted in the nursing narrative.

Occupational Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Feeding	Describe patient's ability to feed self. This comment should include any set up needed, as well as any assistive devices the patient is using. Is there any cueing required? (example: The patient feeds self 50% of meal using a built up spoon and plate guard.)
____Grooming/Hygiene	Discuss the resident's ability to self-groom and perform routine ADL tasks. Please describe the use of any adaptive equipment or other assistance needed such as cueing or set up (example: Brushes teeth and combs hair if prompted by staff.)
____Bathing	Please note the resident's ability to bathe or participate in the bathing/showering process. This should include the ability and degree of participation exhibited by the resident as well as any assistance required. (example: Resident needs assistance with tub and shower. Is able to wash face and upper body with set up and minimal cueing.)
____Dressing	Please note the resident's ability to perform or participate in dressing. Use of adaptive devices or any required assistance should be noted. (example: Patient puts on own shirt. Requires staff assistance to dress lower body and is unable to use reacher yet.)
____Sitting Balance	Describe the resident's ability to balance unsupported. This should be functional and include the activity requiring balance. (example: Resident sits at bedside for meals, but becomes fatigued by the end of meal.)
____Transfers	Observations of the resident's ability to transfer should be noted including ability and participation, as well as any assistance needed. (example: Transfer to raised toilet seat with assist of one nurse aide.)
____W/C Mobility	This note should include a statement concerning maneuvering skill as well as endurance. (example: Resident propels self from bed to hall, endurance is poor, forgets to lock brakes.)
____Activity Tolerance	Observations related to resident's endurance for sitting and participation in an activity should be made. (example: The resident complains of fatigue after sitting 1 – 1 ½ hours in a wheel chair.)

COMMENTS: _____
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REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
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This checklist is designed to assist the charting nurse in describing the resident's functional ability on the unit. The intent is to help provide nursing documentation that is functional in nature and reflects the resident's performance as it relates to their Rehab program. The Rehab activity or program is checked and corresponds to suggested resident activities, or functional performances which might be noted in the nursing narrative.

Speech Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Swallowing/Chewing	Notes should include mention of the resident's ability to swallow including drooling, difficulty chewing, pocketing, coughing, choking, gagging. (example: Resident drools when give PO water. Resident coughs occasionally when given PO fluids.)
____Speech	Describe the resident's ability to be understood verbally. Include comments about intelligibility and length of sentences or word strings. (example: Speech is difficult to understand, single words are only occasionally understood.)
____Cognitive Retraining	The level of cognitive ability should be described in functional terms. Describe orientation to self-time and staff include impact of cognition or orientation to ADLs. (example: The resident is oriented to self only and is easily confused and distracted during meals.)
____Auditory Comprehension	Please note resident's ability to understand the spoken word. Does the resident respond appropriately to verbal instructions? Do comprehension problems affect ADLs? (example: Resident requires cueing and supervision for dressing and meals.)

COMMENTS: _____
_____
_____
_____

REHAB/NURSING DOCUMENTATION OF FUNCTIONAL ABILITY

Date: _____ Resident: _____
Medical Diagnosis: _____
Therapy/Treatment Diagnosis: _____

This checklist is designed to assist the charting nurse in describing the resident's functional ability on the unit. The intent is to help provide nursing documentation that is functional in nature and reflects the resident's performance as it relates to their Rehab program. The Rehab activity or program is checked and corresponds to suggested resident activities, or functional performances which might be noted in the nursing narrative.

Physical Therapy

Rehab Activity	Suggested Nursing Observation/Documentation
____Ambulation	Address the resident's ability to ambulate on the unit. Include distance and any assistance required. This could include staff or a device such as a walker. (example: Ambulates in hall with the assistance of a CNA. Resident ambulates 25 feet to and from the bathroom with a walker and contact guard of one.)
____Transfers	Discuss the resident's ability to transfer and how much assistance if any is required. (example: Resident transfers from bed to chair with the assistance of one CNA. Resident requires cueing not to bear weight on left leg.)
____Bed Mobility	Describe the resident's ability to move about the bed including positioning devices used and assistance provided. (example: Resident rolls side to side with use of the side rails with minimal cueing. A pillow is placed between knees.)
____Supine to Sit	Describe resident's ability to sit up from a recumbent position. Include any assistive devices such as half rails or staff assistance.
____Sit to Stand	Describe the resident's ability to rise from a sitting position. Include any assistance required as well as an understanding of any compensatory techniques. (example: Resident needs assist of 2 to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.)
____Balance	Discuss the resident's ability to sit or stand without loss of balance. This should include any compensatory devices or assistance required.

COMMENTS: _____
_____
_____
_____

SUPPORTIVE NURSING DOCUMENTATION

Occupational Therapy

The following table provides examples of how nursing can document resident status related to *occupational therapy.*

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
G1b(A.B.)	Transfers	Transfers to raised toilet seat with assist of one nurse aide.
G1e	Locomotion on unit/wheelchair skills	Wheelchair endurance poor; forgets to lock brakes. Resident complains of fatigue after sitting 1 – 1 ½ hours in wheelchair.
G1f	Locomotion off unit (outside room)	Resident propels self from bed to hall. Requires frequent rests.
G1g(A.B.)	Dressing	Resident puts on own shirt. For lower body dressing, he needs nursing staff assist as he is not yet able to use reacher.
G1h(A,B)	Eating	Feeds self 50% of meal with built-up spoon; some pocketing of food in right cheek.
G1j(A,B)	Personal hygiene	Brushes teeth and combs hair if prompted by nursing staff.
G2(A,B)	Bathing	Needs nursing staff assist with tub and shower. Attempts to wash face and upper body.
G3b	Sitting balance	Sits at bedside to eat meals, but becomes fatigued by end of meal.

SUPPORTIVE NURSING DOCUMENTATION

Speech Therapy

The following table provides examples of how nursing can document resident status related to *speech-language pathology*.

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
B3	Orientation	Resident is oriented to place and person, but not time. **NOTE:** If the resident is not oriented, nursing should report how the disorientation is interfering with ADLs.
C3	Modes of expression	Resident is using a communication board to request items. When communication board is offered, resident uses it to request items for ADLs. Nursing staff uses board to get the resident to express needs. Does not consistently follow instructions.
C4	Making self understood	Listening to resident is confusing. Resident is unable to make himself understood with any degree of consistency. Speech is difficult to understand; occasional single words understood. Resident is unable to explain what he wants. Attempts to point but is unsuccessful.
C6	Ability to understand others	Smiles and turns head when greeted. Resident follows simple commands but cannot express needs. Nods yes/no, but not always correctly.
K1b	Swallowing problem	Resident has difficulty swallowing liquids. Resident coughs frequently when eating. Resident pockets food.

SUPPORTIVE NURSING DOCUMENTATION

Physical Therapy

The following table provides examples of how nursing can document resident status related to *physical therapy*.

MDS Section to Review	MDS Title/Functional Skill	Nursing Documentation Example
G1a(A,B)	Bed mobility	Resident holds onto bed rail to pull self onto right or left side. Pillow is placed between knees.
G1b(A,B)	Transfers	Resident sits with assist, but cannot stand up without assistance of two nursing staff.
		Resident needs assist of two nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.
G1c(A,B)	Walks in room	Working with therapist on ambulation training. Unsafe with nursing staff
G1d(A.B.)	Walks in corridor	
G1e(A.B.)	Locomotion on unit	Attempts to take several steps when transferring from bed to chair. Unsafe with nursing staff.
GF(A.B.)	Locomotion off unit	Resident is receiving training in stair climbing with physical therapists to prepare for D/C home.

PT Nursing Documentation Examples

Bed mobility	Resident holds onto bed rail to pull self onto R or L side. Pillow is placed between knees.
Transfers	Resident sits with assistance but cannot stand up without assistance of 2 nursing staff, OR Resident needs assistance of 2 nursing staff to stand. Unable to bear weight on legs. Needs support at knees to keep from buckling.
Walk in room Walk in corridor	Working with therapist on ambulation training. Unsafe with nursing staff
Locomotion on unit	Attempts to take several steps when transferring from bed to chair. Unsafe with nursing staff.
Locomotion off unit	Resident is receiving training in stair climbing with physical therapists to prepare of D/C home.

ST Nursing Documentation Examples

Orientation	Resident is oriented to place & person, but not time. NOTE: If resident is not oriented, nursing should report how the disorientation is interfering with ADL's.
Modes of Expression	Resident is using a communication board to request items. When communication board is offered, resident uses it to request items for ADL's. Nursing staff uses board to get the resident to express needs. Does not consistently follow instructions.
Making Self Understood	Listening to resident is confusing. Resident is unable to make himself understood with any degree of consistency. Speech is difficult to understand; occasional single words understood. Resident is unable to explain what he wants. Attempts to point but is unsuccessful.
Ability to Understand	Smiles & turns head when greeted. Resident follow simple commands, but cannot express needs. Nods yes/no, but not always correctly.
Swallowing problem	Resident has difficulty swallowing liquids. Resident coughs frequently when eating. Resident pockets food.

OT Nursing Documentation Examples

Transfers	Transfers to raised toilet seat with assistance of one nurse aide.
Locomotion on unit/Wheelchair skills	Wheelchair endurance poor; forgets to lock brakes. Resident fatigue after sitting 1 – 1 ½ hours in wheelchair.
Locomotion off unit/outside room	Resident propels self from bed to hall. Requires frequent rests.
Dressing	Resident puts on own shirt. For lower body dressing, he needs nursing staff assistance as he is not yet able to use reacher.
Eating	Feeds self 50% of meal with built up spoon; some pocketing of food in right cheek.
Personal Hygiene	Brushes teeth and combs hair if prompted by nursing staff.
Bathing	Needs nursing staff to assist with shower.
Sitting balance	Sits at bedside to eat meals but becomes fatigued by end of meal.

Other documentation hints:

Psych. Medications: target behavior, interventions prior to use, non-med interventions.
Tube Feeding: bowel sounds, lung sounds due to potential for aspiration, tolerance-diarrhea/vomiting.
Hydration Status: skin turgor, oral mucous, taking fluids, fluid restrictions.
HTN: facial flushing, headache, dizzy, tinnitus, epistoxis.
Wounds: response to TX, s/s infections, pain.
DM: s/s hypo/hyperglycemia, if IDDM-why unable to inject.
Wt: up or down.
Respiratory-based DX: lung sounds, sob, response to o2-inhalers-TX.
Labs: abnormal values.