

DOCUMENTATION TOOLKIT FOR THE NURSE LEADER

Table of Contents

1	Introduction
2	Documentation Toolkit Objectives
2	Purpose of Documentation
3	Four Pillars of Documentation
4	The Nursing Process and Documentation
5	The Nursing Process
6	The Link Between the Nursing Process and Documentation
8	Nurse Education: The Nursing Process
9	Application Ideas
10	Nurse Competency and Documentation Skills
11	Defining Competency
11	Clinical Condition Documentation Guides
12	Acute Change in Condition
13	Behavioral Expressions
14	Dehydration
15	Delirium/Mental Status Change
16	Diabetes - Symptoms Of Hypoglycemia and Hyperglycemia
17	Gastrointestinal Conditions
18	Gastric Tube Feeding and Care
19	Infection/Sepsis
20	Implanted Port/Peripheral IV Catheter
21	Symptoms of Cardiac Condition
22	Symptoms of a Respiratory Condition or Respiratory Infection
23	Tracheostomy Care and Suctioning
24	Daily Wound Care
25	Audit Tool: Documenting Clinical Conditions
26	Nurse Education: Assessment of Acute Changes in Condition
33	Incidents and Other Special Situation Documentation Guides
34	Injury of Unknown Origin
35	Newly Discovered Skin Anomaly
36	Post-Fall Assessment
37	Resident to Resident Altercation
38	Suicidal Ideation or Expressions of Hopelessness
39	Medication Error
40	Audit Tool: Documenting Incidents and Other Special Situations
41	Nurse Education: Post-Fall Nursing Assessment, Care, and Documentation

43	Improving the Nurse's Competency for Documentation: Resident Risk Assessments
43	Purpose of Risk Assessments
44	Audit Tool: Documenting Risk Assessments
45	Trauma-Informed Care Risk Assessment Guidance
46	Nurse Education: Pressure Injury Risk Assessment
47	Application Ideas
47	Additional Resources

48 Clinical Leadership

49	Clinical Leadership Actions that Support Documentation
50	Nurse Leader Discovery Activity of Responsibilities and Workflows
52	Daily Clinical Brief
54	Communication: Whiteboard, 24-Hour Report, and Electronic Dashboard
55	Eliminate and Avoid Duplicative Documentation Requirements
56	Nurse Education: Communication with Physicians - SBAR
58	Care Planning
58	Care Planning Process
58	Regulatory Requirements of the Care Plan
60	Comprehensive Person-Centered Care Plan Audit Tool
62	Comprehensive Person-Centered Care Planning Cheat Sheet
63	Baseline Care Plan
69	Special Considerations for Documenting Skilled Care and Services
69	Medicare Documentation Requirements
70	Audit Tool: Skilled Care Documentation
72	Skilled Care Services and Documentation Communication Tool
73	Nurse Education: Documenting Skilled Care Bingo
80	Documentation and PDPM
83	Application Ideas
83	Additional Resources

84 Organizational Management

85	Legal Considerations for Documentation
85	Common Legal Terms
86	Audit Tool: Legal Review Documentation Checklist
87	Nurse Education: Do's and Don'ts Tip Sheet
88	Nurse Education: The Key Witness is the Medical Record
89	Regulatory Compliance Considerations and Documentation
89	Requirements of Participation
89	Survey Readiness
90	Survey Readiness: Critical Element Pathways, Observations, Reviews, and Policy Calendar
94	Electronic Medical Record/Health Record (EMR/EHR)
94	Audit Tool: EMR/EHR Physician's Orders
96	Nurse Education: Tip Sheet for EMR/EHR
97	Application Ideas
97	Additional Resources
98	Abbreviation List
99	References