

Skilled Nursing Charting Guidelines – 9. Shift Documentation

A. NEUROLOGICAL

1. Level of Consciousness
2. Pupils (Size / Reaction)
3. Speech / Swallowing
4. Bowel / Bladder function
5. Contractures
6. Other deficits

B. CARDIOVASCULAR

1. Skin Color / Temp

C. GASTROINTESTINAL

1. Nausea / Vomiting / Diarrhea
2. Constipation
3. Bowel Sounds
4. Abdominal Distention / Pain
5. Guaiac Stool / Urinary Hematuria
6. GI – oral intake
7. Choleliths / Hemolysis

D. PAIN MANAGEMENT

E. RESPIRATORY

1. Risk Assessment
 2. Weight Bearing Status
 3. Site – Right / Left
 4. Character S/S of Breathing
 5. Surgical Site – Description
 6. Non-Removal Dressing
 7. Neurovascular Status – DASH
 8. Edema
 9. S/S of Infection
10. Other Pulmonary Conditions / Other
Fractures / Other Surgical Conditions
1. Surgical Site

F. LABS

1. Interpretation
 2. N/Peds
 3. Lab Changes
- ### G. VITAL SIGNS
- ### H. HEAD/NECK/HEENT
1. Head Assessment
 2. Eye Peds (Snell / Worth)
 3. Hearing (A/B)
 4. S/S of Dysphagia
- ### I. SAFETY
1. Mobility Assessment
 2. Skin Condition

Skilled Nursing Charting / Documentation Guidelines

1. Unit Assessment
2. Insulin / Medication Adjustments

E. DASH/DASH

1. Pain Management
2. Charis Radiation Received
3. N/Peds – Alert
4. Nausea / Vomiting
5. Bowels / Stoma / Apical
6. S/S of Dehydration
7. Neurovascular Status

F. CARDIOVASCULAR

1. S/S of CHF / Hematoma
2. Frequency / Incontinence
3. Foley, AP Tube
4. Aphthousitis / Constipation
5. Urinary Retention
6. PVR / Bladder Scan
7. Bowels / Peds/eds
8. Mental Status

G. LABS

1. Interpretation
2. N/Peds
3. Lab Changes

H. HEAD/NECK/HEENT

1. Head Assessment
2. Eye Peds (Snell / Worth)
3. Hearing (A/B)
4. S/S of Dysphagia
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I. RESPIRATORY

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J. SAFETY

1. Mobility Assessment
2. Skin Condition

K. MOBILITY

1. Mobility Assessment
2. Appearance of Wound
3. Response to Therapy
4. I/O Monitoring
5. Labs
6. Other Changes

Skilled Nursing Documentation Sheet

Richard Bailey



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