NURSING HOME CHART NOTES- WHAT YOU NEED FOR LITIGATION

CONTENTS:	CAN INCLUDE:	OBTAINED:
ADMINISTRATIVE CHART NOTES	Face Sheet Admission Form Consents Living Will and Durable Power of Attorney Contracts	
PRIOR RECORDS/ HOSPITAL CHART NOTES	Transfer Notes (from acute care hospital) Emergency Room Records Ambulance Records Discharge Notes and Instructions from other facilities (acute care, rehab and SNF)	
ORDERS	Pre Printed Orders and Telephone Orders Physician Communications and Written Orders, to and from facilities	
PROGRESS NOTES	Admission History and Physical Progress Notes Consultations (May be infrequent; used to determine potential negligence by providers)	
PHARMACY MONTHLY REPORTS	Weekly medication dosage orders, under pharmacy management (as in blood thinners) Pharmacist to review medications on monthly basis	
NURSING ADMISSION ASSESSMENT	Initial assessment Assists as baseline at time of admission Weekly, 30, 60 and 90 day assessments	
MINIMUM DATA SET (MDS)	Done within 7 days of admission, as well as change of condition or admission/ readmission Thereafter done every 90 days An assessment tool that helps to determine payment with both Medicare and Medicaid. Higher patient needs reflect increased payment	
RESIDENT ASSESSMENT PROTOCALS	Mentation, urinary incontinence, falls, nutritional status, pressure ulcers and restraints Part of the MDS; an assessment tool to provide total evaluation. Used for development of nursing care plan; can contain many components, dependent on patient status	
CARE PLAN	Care plan, typically based on above-mentioned tools	
NURSING PROGRESS NOTES	Usually not daily chart notes, done especially with change of condition	
DAILY NURSING NOTES/ FLOW SHEETS	Activities of Daily Living (ADL), Vital Signs Intake and Output Weights (24 Hour charting- each shift, by both RN and CNA.)	
MONTHLY NURSING SUMMARIES	Weekly summaries Summaries can often be missing or inconsistent	
MEDICATION ADMINISTRATION RECORD (MAR)	All oral and injectable medications (insulin) Oxygen Over the counter and as needed medications Narcotics (may be one per sheet) Oral medications administered by medication aide, narcotics and treatment meds below by RN. Can assist with potential for chemical restraints	
TREATMENT ADMINISTRATION RECORD (TAR)	Restorative nursing notes Anticoagulants Skin care/ dressings Administered by RN	
ASSESSMENTS	Skin care Fall Risk Side Rail Bowel and Bladder Pressure Ulcer (including photos) Dietary/weight (this is separate from general dietary)	
THERAPIES	Physical Therapy Occupational Therapy Speech Therapy Respiratory Therapy	

	To include initial assessment, care plan, goals and progress notes	
DIETARY	Dietician notes and Tube Feeding Assessment	
SOCIAL SERVICES	Initial Assessment and Progress Notes	
ACTIVITIES RECREATIONAL THERAPIES	Initial Assessment and Activity Notes	
LABS /IMAGING	All Labs and Imaging Studies (as well as EKGs)	
OTHER	Specific policies and procedures Guidelines Training Documents	