Hospice Documentation Cheat Sheet

This cheat sheet can be used as an informative resource for documentation creation or as an educational tool for what needs to be included to ensure adequate hospice documentation.

Be sure to comply with company guidelines and regulations.

Hospice Documentation Creation Cheat Sheet

Patient Admission:

- · Collect comprehensive medical history, demographics, and preferences.
- Document advance directives and goals of care.

✓ Initial Assessment:

- Conduct a thorough physical and psychosocial assessment.
- Record vital signs, pain levels, and emotional well-being.

Care Plan Development:

- Create an individualized care plan based on assessments.
- Include interventions, medications, and goals aligned with patient preferences.

✓ Interdisciplinary Collaboration:

- · Communicate with team members about patient status and care plan.
- · Document contributions from nurses, social workers, chaptains, etc.

Ongoing Assessments:

- Regularly assess and document changes in symptoms and patient condition.
- Update care plan as needed based on ongoing assessments.

✓ Medication Management:

- Document all medications administered, dosage, and effects.
- Monitor for side effects and document any adjustments made.

Symptom Management:

- Document patient symptoms and effectiveness of interventions.
- Adjust care plan to address changes in symptomatology.

Hospice Nursing Documentation Examples

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Hospice Nurse Patient Visit Notes Abatron Health, 2020-10-15 Patient Visit Notes For Hospice Nurses Keeping concise and accurate notes is crucial for correct patient care and legally required in the most situations Although Bedside Charting is the generally preferred method of note taking for Hospice Nurses you quickly realise that it is not always practical given the hands on rapidly changing nature of Hospice Care This book is designed to simplify the process of patient note taking and contains all essential information for appropriate care It s also a great resource that helps to compile all your records into one convenient location which should be kept for a number of years should any legal situations arise It was designed with consultation and guidance from Dr M Smithe It is designed specifically for Hospice and home care Nurses and contains the following Index page Quick Recap of which patient is on each page and the date of visit Patient Visit Logs and Notes for each Patient 1 Double Page Spread per Visit Blank Notes Pages at the end of the book Each Patient Note Spread Contains the following Date Scheduled PRN Start and Finish Time Patient Name Mileage start and finish For traveling hospice workers Patient Pain 1 10 and description Temperature Blood Pressure Respiratory rate Heart Rate SO2 O2 LPM Last BM Left and Right MAC Weight Family Facility Updated Yes No Next Visit Date Medication supply confirmed Lined notes 3 4 page per patient visit Notes for next visit 6 x blank input columns for personal notetaking unique to each hospice nurse Book Features 130 Pages 6 x 9 inch very convenient size Printed on white paper Perfect bound softcover book

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