DOCUMENTATION TO OPTIMIZE RESIDENT SAFETY – COVID-19

Assessment, Care and Treatment, and Clinical Decision-Making, **Not Documented**, Is Difficult to Remember and Defend

Documentation Best Practices

- Know, Communicate and Document the Resident's Baseline Status. Changes in Status Can Occur Quickly – Actively Observe and Report Changes in Condition.
- Document Clinically Pertinent Assessments and Interventions with Change in Condition
  - **Vital Signs** – Temperature, Pulse Oximetry, Respiratory Rate, Blood Pressure, Pulse
  - **Change in Energy Level** – Weakness, Fatigue, Malaise
  - **Pain** – Sore Muscles, Sore Throat, Headache, Body Aches, Chills
  - **Respiratory Status** – Cough (Productive/Non-Productive), Shortness of Breath/Difficulty Breathing, Lung Sounds
  - **Other Symptoms** – Loss of Smell/Taste, Nausea/Vomiting, Diarrhea
  - **Be Alert for Emergency Warning Signs** – e.g., Trouble Breathing, Persistent Pain or Pressure in the Chest, New Confusion, Inability to Wake or Stay Awake, Bluish Lips or Face
    (Source – CDC/Centers of Disease Control and Prevention and MU MDS & Quality Research Team)
- Chart Assessments and Care Concurrently. Avoid End-Of-Shift Charting
- Know and Follow Facility Policy and Procedures Related to Documentation, Assessments and Care Planning. Document the Effectiveness of Interventions.

Communication

- Document Communication with Physicians and Other Providers. Note with Whom You Spoke, Resident Information Provided, and Orders Received.
- Document Communication with Family Members or Other Legally Responsible Parties (e.g., Power of Attorney). Note with Whom You Spoke, and Information Shared.
- Document Resident and Family Teaching
- Document Complete Transfer Communication, A Structured Format Such as SBAR (Situation, Background, Assessment and Response) Is Recommended. (Source – Institute for Healthcare Improvement, SBAR Tool)