

# 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, chaplains, 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.

**Communication Log:**

- Record discussions with patients, families, and interdisciplinary team.
- Document changes in patient condition, preferences, or goals.

**End-of-Life Care Planning:**

- Document discussions about end-of-life preferences and advance care planning.
- Record any specific wishes the patient or family may have.

**Regulatory Compliance:**

- Ensure documentation meets regulatory standards.
- Regularly review and update documentation to align with guidelines.

**Quality Assurance:**

- Review documentation for accuracy and completeness.
- Use documentation data for quality improvement initiatives.

**Legal and Ethical Considerations:**

- Adhere to legal and ethical standards in documentation.
- Ensure accuracy in reflecting care provided and meet regulatory requirements.

**Patient and Family Education:**

- Document education provided regarding disease process, medications, and end-of-life care.
- Capture discussions about advance care planning and end-of-life preferences.

**Review and Revise:**

- Periodically review documentation practices for continuous improvement.
- Stay updated on changes in documentation standards or policies.

**Use Clear Language:**

- Employ clear and concise language.
- Avoid unnecessary jargon or acronyms for clarity.

**Objectivity:**

- Use objective language when describing observations.
- Differentiate between subjective and objective information.

**Customize for Individual Patients:**

- Customize templates to capture specific patient information.
- Ensure flexibility for diverse patient needs.

**Document Emotional and Spiritual Support:**

- Record interventions addressing emotional and spiritual needs.
- Document counseling, bereavement support, and spiritual care provided.

**Real-Time Documentation:**

- Aim to document care activities close to the time of occurrence.
- Capture accurate details for timely updates.

**Consistency:**

- Use consistent terminology and abbreviations.
- Create a standardized and easily understandable record.