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.