**Policy**

To provide consistent documentation in the electronic medical record.

**Procedure**

1. Progress notes related to the observation/assessment should be attached to the observations.
2. If a section of an observation is not applicable, document an explanation that it does not apply in the “Describe, if necessary” box.
3. Complete observations section by section.
4. Activity Assessment: To be completed by activity personnel (or designee) at least upon admission and annually for residents with an anticipated stay of greater than 30 days.
5. Short-Term Stay Activity Assessment: To be completed by activity personnel (or designee) upon admission for residents with an anticipated stay of less than 30 days.
6. Admission Assessment: To be completed by the admitting nurse (or designee) upon admission.
7. Admission Care Plan: This is the baseline care plan. It must be completed within 48 hours. See “Care Planning” policy.
8. Weekly Skin Assessment: May be done by a licensed nurse (if the facility has or utilizes a wound nurse) upon admission and with every MDS when the resident has a skin condition. For daily documentation of skin integrity conditions, licensed nurses will rely on the SKIN INTEGRITY EVENTS.
9. Daily Skilled Documentation, Care Path or Focused Observation: To be completed by a licensed nurse every shift with exception of eight-hour night shifts on skilled residents.
10. Bowel and Bladder: To be completed by a licensed nurse upon admission, quarterly and annually.
11. Toileting Assessment: To be completed by the appointed nursing staff when it has been determined the resident is a possible/probable candidate for a TIAN program.
12. Johns Hopkins Fall Risk Assessment: To be completed by a licensed nurse upon admission, quarterly and annually.
13. Comprehensive Nutritional Assessment: To be completed by the dietary technician or dietician upon admission, quarterly, annually.
14. Nutritional Risk (NAR): See “Residents at Nutritional Risk” policy.
15. Neurological Checks: Complete when someone has hit their head or has had an unwitnessed fall. Neurological checks are to be completed initially and then every two hours for 24 hours and can be discontinued if the resident remains neurologically asymptomatic.
16. Oral Cavity Assessment: To be completed by a licensed nurse when the Admission Assessment indicates that the resident has oral cavity problems, and then quarterly and annually thereafter. May be done when a weight loss Event is opened.
17. Self-Administration of Medication Assessment- To be completed by a licensed nurse upon admission. The physician MUST SIGN this assessment. Print it out and place in the physician’s folder/box.
18. Pain Assessment: To be completed by a licensed nurse on admission when the Admission Assessment indicates that the resident is experiencing pain. May be done when a Pain Event is opened.
19. Swallow Precautions: May be done by any licensed professional when the resident has been determined to have possible or probable swallowing difficulties.
20. Safe Smoking Risk Assessment: Completed by a licensed nurse upon admission, quarterly and annually on residents who will be smoking during their stay.
21. Psychosocial Well-Being/Behavior/Mood Assessment and Cognitive Assessment: Completed by Social Services and/or licensed nursing upon admission, quarterly and annually.
22. AIMS: To be completed by a licensed nurse upon admission, quarterly and annually if the facility does not track side effect of psychoactive medications.
23. Geriatric Depression Scale/Mood Assessment: Social Services may complete this assessment as an alternative to the PQH-9 when not required by a scheduled MDS assessment.
24. Behavior Management Follow Up: Completed by anyone on the IDT to assessment type and frequency of behaviors and monitor effectiveness of non-pharmacologic and pharmacological interventions.
25. PQH-9: Completed by Social Services as required per MDS schedule.
26. Cornell Scale for Reduction Assessment Depression and/or Geriatric Depression Scale: To be completed by Social Services upon admission, quarterly and annually.
27. Skin Risk Assessment: To be completed by a licensed nurse upon admission, quarterly and annually and as needed. Contains the Braden Scale risk prediction assessment.
28. Braden Scale: The Skin Risk Assessment is the preferred Observation for skin risk. Braden Scale may be used PRN between set assessment intervals.
29. Weekly Skin Assessment, Non-Pressure Wounds: Completed to track non-pressure ulcer wounds such as burns, lacerations, etc.
30. Social History Assessment: To be completed by Social Services upon admission for residents expected to stay longer than 30 days.
31. Short Stay Social History Assessment: To be completed by Social Services upon admission for residents who are expected to stay 30 days or less.
32. Admission Functional Abilities Assessment: To be completed within eight days of admission if therapy staff unable to complete Section GG of the MDS.
33. Discharge Functional Abilities Assessment: To be completed at the time of discharge if therapy staff unable to complete Section GG of the MDS.
34. Discharge Planning Assessment: To be completed by Social Services upon admission.
35. Discharge Summary: To be completed by Social Services and the IDT when discharge is imminent.
36. Discharge Plan and Instructions: To be completed by staff nurse upon discharge.
37. Screening Request: To be completed by therapy staff as indicated.
38. Fall Screen: To be completed by therapy staff as indicated.
39. Wheelchair Evaluation: To be completed by therapy staff as indicated.