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.