Skilled Need Documentation Quick Reference

(Free Resource from “Defining What Medicare Considers a Skilled Nursing Need” by Arielle Tamez, RN BSN)

What Counts as a Skilled Need:

A skilled need is a service that requires the knowledge, judgment, and skill of a licensed nurse and cannot be safely or effectively performed by the patient or caregiver alone.

Examples That Meet Criteria:

- Wound care requiring assessment of healing, infection prevention, or VAC management
- Medication teaching and monitoring after dosage or drug change
- Observation and assessment of unstable conditions (CHF, COPD, infection risk)
- New or changed treatments requiring close supervision

Examples That Do NOT Meet Criteria:

- Routine medication refills without new changes
- Stable chronic disease monitoring without active teaching or reassessment
- General wellness checks without documented skilled reasoning

The Skilled Documentation Formula:

Use this simple structure to make your notes Medicare-defensible:

Skilled Action + Clinical Reason + Risk if Unaddressed

Example: “Assessed wound bed for granulation tissue, applied dressing per protocol, reinforced infection prevention teaching. Patient remains at risk for infection without skilled wound management.”

Top 5 Documentation Red Flags:

1. “Monitored patient status” (without explaining why).
2. “Reinforced teaching” (no evidence of active learning).
3. Repetitive phrases without patient progress or rationale.
4. Missing follow-up or communication to physician.
5. No mention of risk, change, or skilled assessment outcome.

Tip for Nurses:

If you can explain *why your presence matters* to the patient’s safety, you’re probably documenting a skilled need.

Want More Examples?

Get the complete guide with real-world charting phrases and templates in “Defining What Medicare Considers a Skilled Nursing Need: A Practical Documentation Guide with Real-World Home Health Nursing Examples.”

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