

Dialysis Assess/ Documentation on Return	Falls	Nutritional Status
<ul style="list-style-type: none"> • Date/Time • Observation of Shunt • Skin Assessment • Edema • Ask about lunch consumption/ fluid intake • Review Dialysis notes: Document weight, amt. fluid pulled off, how resident tolerated dialysis, any other pertinent information from dialysis notes 	<ul style="list-style-type: none"> • Date/Time • Incident specifics (What is observed.) • Vital signs (lying and standing B/P) • If diabetic, blood sugar • If respiratory diagnosis – O₂ sat level • Injury? <ul style="list-style-type: none"> – What resident was trying to do – Interventions tried – Resident response to interventions (Add intervention to Care Plan if effective.) • MD and family notified? 	<ul style="list-style-type: none"> • Swallowing disorders: i.e. choking, holding food in mouth, pain when swallowing • Oral and dental status • Complaints of poor appetite • % of p.o. intake • Amount of parenteral or tube feeding • Weight loss • Interventions and response to them • RD requested
Pain (Routine) Assessment/Documentation	Pain (PRN) Assessment/Documentation	Restorative Nursing Services
<ul style="list-style-type: none"> • Date/Time • Location of pain • Description of pain and score on pain scale 0-10 • If pain noted: On scale of 1-10, what is resident's goal for pain relief? • Does pain limit ADL function during day? • Does pain interfere with sleep? • Is resident's pain goal met? • Was physician notified if Tx not effective? 	<ul style="list-style-type: none"> • Date/Time • Location of pain • Description of Pain – burning, sharp, etc. • On scale of 0-10, how severe is pain? • On scale of 0-10 what is resident's goal for pain relief? • Does pain limit ADL function during day? • Does pain affect sleep? • Indicate PRN med given/document on scale of 0-10 pain level 30 min. to 1 hr post med • Did resident meet pain goal? 	<ul style="list-style-type: none"> • Chart reason for and effect of service of the following: <ul style="list-style-type: none"> – Urinary and/or bowel toileting program – Passive and/or active ROM – Splint or brace assistance – Bed mobility and/or walking training – Transfer training – Dressing and/or grooming training – Eating and/or swallowing training – Amputation/prosthesis care – Communication training
Special Treatments, Procedures and Programs	<p style="text-align: center;">Documentation is a matter of good clinical practice and is an expectation of trained and licensed health care professionals.</p> <p style="text-align: center;">❧</p>	
<ul style="list-style-type: none"> • Chart date, time and effect if receives any of the following: <ul style="list-style-type: none"> – Chemotherapy – Radiation – Oxygen therapy – Suctioning – Tracheostomy care – Ventilator or respirator – BIPAP/CPAP – IV medications – Transfusions – Dialysis – Hospice Care – Respite Care – Isolation – Vaccinations 		

Nursing Documentation Guidelines In Long Term Care

Jin-Ying Zhang



Nursing Documentation Guidelines In Long Term Care:

Embracing the Tune of Appearance: An Mental Symphony within **Nursing Documentation Guidelines In Long Term Care**

In a global taken by displays and the ceaseless chatter of instantaneous communication, the melodic beauty and emotional symphony produced by the prepared term often disappear in to the background, eclipsed by the persistent noise and disruptions that permeate our lives. Nevertheless, situated within the pages of **Nursing Documentation Guidelines In Long Term Care** a stunning fictional prize full of organic thoughts, lies an immersive symphony waiting to be embraced. Constructed by a masterful composer of language, that charming masterpiece conducts visitors on an emotional trip, well unraveling the hidden melodies and profound affect resonating within each cautiously crafted phrase. Within the depths with this emotional review, we will discover the book is central harmonies, analyze their enthralling writing design, and submit ourselves to the profound resonance that echoes in the depths of readers souls.

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