#### Dialysis Assess/ Fallis. Nutritional Status Documentation on Return Dante/Times Distar/Times Swallowing disorders: Observation of Shunt. · Incident specifics (What is i.e. choking, holding food in Skin Assessment observed.) mouth, pain when swallowing Vital signs (lying and standing B/P) Oral and dental status Edema · If diabetic, blood sugar Complaints of poor appetite Ask about lunch consumption/ fluid intake If respiratory diagnosis — % of p.o. intake O. sat level Amount of parenteral or tube Review Dialysis notes: Document weight, amt. fluid - Injury? feeding pulled off, how resident tolerated. - What resident was trying to do Weight loss · Interventions and response to dialysis, any other pertinent - Interventions tried information from dialysis notes - Resident response to interventions (Add intervention to RD requested Care Plan if effective.) MD and family notified? Pain (Routine) Pain (PRN) Restorative Nursing Services Assessment/Documentation Assessment/Documentation Chart reason for and effect of Date/Time Date/Time service of the following: Location of pain Location of pain - Uninary and/or bowel tolleting Description of pain and score on Description of Pain – burning. pain scale 0-10 sharp, etc. - Passive and/or active ROM If pain noted: On scale of 1-10. On scale of 0-10, how severe is Splint or brace assistance. what is resident's goal for pain - Bed mobility and/or walking redied? On scale of 0-10 what is resident's. training Does pain limit ADL function goal for pain relief? - Transfer training during day? Does pain limit ADL function during - Dressing and/or grooming Does pain interfere with sleep? day? Is resident's pain goal met? · Does pain affect sleep? - Eating and/or swallowing · Was physician notified if Tx not Indicate PRN med given/document effective? training on scale of 0-10 pain level 30 min. - Amputation/prosthesis care to 1 hr post med - Communication training Did resident meet pain goal? Special Treatments. Procedures and Programs · Chart date, time and effect if receives any of the following: - Chemotherapy

Documentation is a matter of good clinical practice and is an expectation of trained and



licensed health care professionals.



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- BIPAP/CPAP IV medications - Transfusions

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**Albert A Gayle** 

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Foundations of Health Information Management - E-Book Nadinia A. Davis, 2023-05-15 Selected for Doody's Core Titles 2024 with Essential Purchase designation in Health Information Management Foundations of Health Information Management 6th Edition is an absolute must for anyone beginning a career in HIM By focusing on healthcare delivery systems electronic health records and the processing maintenance and analysis of health information this engaging easy to understand text presents a realistic and practical view of technology and trends in healthcare It readies you for the role of a Registered Health Information Technician who not only maintains and secures accurate health documentation but serves as a

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States. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Investigations and General Oversight, 1982 Legal Aspects of Documenting Patient Care Ronald W. Scott, 2000 This Second Edition Of Our Easy To Use Reference Takes A Risk Management Approach To Patient Care Documentation It Shows Clinicians From A Wide Variety Of Disciplines How To Be Objective Precise Unambiguous And Timely When Documenting Treatment Related Matters The Content Is Written In Straightforward Lay Language And Includes Sample Documentation Forms The New Edition Includes Information On Computerized Documentation Coverage Of Telehealth Issues Updates On JCAHO CARF And NCQA Accreditation And Documentation Problems Specific To Non Hospital And Managed Care Settings

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