

Dialysis Assess/ Documentation on Return	Falls	Nutritional Status
• 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	• 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? – What resident was trying to do – Interventions tried – Resident response to interventions (Add intervention to Care Plan if effective.) • MD and family notified?	• 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
• 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?	• 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?	• Chart reason for and effect of service of the following: – 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	Documentation is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. 	
• Chart date, time and effect if receives any of the following: – Chemotherapy – Radiation – Oxygen therapy – Suctioning – Tracheostomy care – Ventilator or respirator – BIPAP/CPAP – IV medications – Transfusions – Dialysis – Hospice Care – Respite Care – Isolation – Vaccinations		

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Patrick Vollmar



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