DOCUMENTATION BY EVENTS

Admission to the facility

- Date and time of admission
- Location admitted from and type of transportation
- Did anyone come with the resident
- Age, sex, race, and general description
- Advance Directive
- Head to Toe assessment to include but not limited to: Condition of skin, wounds/open areas, hygiene, breaks or bruises, contractures.
- Observation of skin condition by responsible party.
- Skin dressings, bandages, sutures and surrounding area.
- Height/ weight
- Vital signs
- Pain level
- Mobility status
- Prosthetic devices, indwelling tubes, ostomy, hearing aid, eye glasses, and any other devices present on admission (devices utilized by the resident not present on admission i.e. glasses, hearing aid- notification/communication to responsible party to bring those items.
- Cognitive status
- Ability to communicate
- Continence status
- Known allergies and food/drug intolerance
- Attending physician
- Physician's orders/transfer orders
- Adaptive equipment utilized i.e wheelchair/walker/cane
- Oral exam- condition. Presence of dentures present
- Resident's notification/communication of high risk areas. Response/ understanding of high risk areas.
- Responsible party notification/communication of high risk areas. Response/understanding of high risk areas.
- Concerns expressed by resident/responsible party

Resident's Physician visit

- Date, time and reason for visit
- Physician's comments regarding resident's current condition
- New orders, procedures, or diagnostic tests ordered
- Resident's response
- Follow up documentation if necessary
- Responsible party communication/notification (date and time notified)

Outside appointment with physician, dentist, dialysis treatment, wound clinic, etc.

- Date, time, and destination
- Reason for appointment
- Responsible party notification (date and time)
- Resident physical and mental condition on leaving
- Method of transportation
- By whom accompanied

SAMPLE

DOCUMENTATION BY EVENTS

- Condition/assessment prior to leaving facility and upon return
- Any procedures done/orders received
- Subsequent follow up documentation if applicable

Change in condition and/or behavior

- Date and time identified
- Nursing observation/ assessment , identified or what was reported
- Condition of resident prior to change identified
- Vital signs
- Immediate nursing actions taken
- Persons notified, including physician and responsible party and their response (date and time notified)
- Document orders received
- Statement of resident/responsible party , if applicable
- Subsequent follow up documentation until the situation is stable or resolved

Incident Documentation

- Brief description of incident – FACTS only
- Type of incident: ex: FOF, skin tear, etc.
- Location of incident
- Position in which resident was found
- Assessment completed and results
- Assessment completed prior to moving the resident
- Identify obvious injuries: location and size
- Any indication of pain or denial of complaints of pain
- Immediate care rendered
- Physician orders, if applicable
- Interventions currently in place and utilized at time of incident
- Equipment ordered/in use at time of incident /working order, etc
- Bed Order- Type/Height in use at time of incident- if applicable
- Immediate interventions, i.e. medications and/or interventions to reduce recurrence of incident, etc.

- Physician and responsible party notification of incident (name, date and time notified)

- If resident sent to the ER, date and time
- If resident sent to ER and returned, identify the time and return, status at time of return and any new orders.
- Update care plan with intervention once root cause is determined
- Follow up documentation according to facility policy and until injuries have resolved, if applicable

SAMPLE

DOCUMENTATION BY EVENTS

Incident with potential head injury

- Brief description of incident – FACTS only
- Location of incident
- Position in which resident was found
- Assessment completed and results
- Identify obvious injuries : location and size
- Any indication of pain or denial of complaints of pain
- Results of neuro check assessment
- Resident's condition prior to incident
- Any complaints voiced by the resident
- Assessment completed prior to moving the resident
- Physician and responsible party notification of incident (date and time notified)
- Physician notification of potential head injury to include notification of anticoagulant use
- Physician orders, if applicable
- Interventions currently in place and utilized at time of incident , working order, etc
- Immediate interventions, i.e. medications and/or interventions to reduce recurrence of incident, etc.
- If resident sent to the ER, date and time
- If resident sent to ER and returned, identify the time and return, status at time of return and any new orders.
- Update care plan with intervention once root cause is determined
- Follow up documentation according to facility policy and until injuries have resolved, if applicable

PRN medication administration

- Date and time
- Reason for administration
- Pain level, before and after medication administered
- Medication and dosage
- Route, including anatomical site
- Follow up entry describing the results

Refusal of medication, treatment, nutrition, fluids, etc.

- Date and time
- Type of refusal
- Potential complications and adverse effects reviewed
- Resident's cognitive status
- Notification of family and physician with date and time
- Alternative treatment discussed with resident/responsible party and documented
- Resident/responsible party response/understanding
- Chronic refusals identified in interdisciplinary care plan
- MD progress note for chronic refusals

SAMPLE

DOCUMENTATION BY EVENTS

Dental Visit

- Date/Time of exam
- Visit details i.e cleaning/dentures/extraction
- Resident response to treatment rendered
- Physician orders, if applicable
- Oral assessments until treatments/concerns resolved
- Responsible party notification (date and time notified)

Room transfer

- Date and time of transfer
- Old/new room number
- Reason for move
- Resident's/Roommate's reaction
- Follow up entry within several days
- Physician order to transfer from certified to non-certified bed and reason
- Notification of responsible party, with date and time

Social visit out of facility

- Date, time and destination
- Physical and mental condition when leaving
- Type of transportation
- Did anyone accompany the resident
- Medications released
- Any medications administered prior to leaving
- Expected date and time of return
- Upon return, document a description of resident's physical and mental condition, body audit as well as medications returned

Discharge or transfer to hospital or other nursing facility

- Events leading to transfer
- Date and time of transfer
- Physician's order to transfer
- Physical and mental condition at time of transfer
- Assessment of resident prior to discharge to include skin audit
- Reason for transfer, signs and symptoms
- Method of transportation
- Did anyone accompany the resident
- Time that responsible party was notified
- Statement that advance directive was honored
- Completed transfer form
- Any bed hold notifications/documentation requirements

Discharge home or to other care facility

- Physician's order to discharge
- Date and time of discharge
- Physical and mental condition, including skin condition
- Method of transportation
- Name of anyone accompanying the resident
- Destination
- Notification of responsible party

SAMPLE

DOCUMENTATION BY EVENTS

- Post discharge plan that has been developed with resident and responsible party
- Disposition of remaining medications
- Disposition of personal belongings
- If without physician's permission, signing of "against medical advice: release by resident or responsible party

Restraints

- Behavior/diagnosis that indicates the need/continued need
- Physician's order
- Signed consent
- Mental status
- Number and type of restraint
- Location of restraint
- Times applied /removed
- Vital Signs
- Condition of extremities, sensation/circulation/color
- Skin care provided
- Nutrition (food/ fluids) offered
- Toileting offered
- Range of motion
- Activities offered
- Notification to responsible party
- Education to resident/responsible party
- Care plan updated

Antipsychotics

- Order for antipsychotic medication
- Clinical indication
- Attempts to decrease/ discontinue and results
- Non-pharmacological interventions and results
- Education of potential side effects/ health risks
- Side effects/reactions observed

Death

- Events precipitating nurse's examination of resident
- DNR status
- Date and time vital signs absent
- Skin color and temperature, pupil reaction, response to painful stimulus
- Date and time physician notified
- Physician's orders to transfer to funeral home
- Date and time responsible party and other persons notified
- Person who pronounced resident deceased, with time
- Statement regarding "advanced directives honored"
- Funeral home notified, with time
- Time body released to funeral home
- Disposition of personal belongings

Nutrition

- Admission nutrition screening; date/time completed

SAMPLE

DOCUMENTATION BY EVENTS

- Referrals to dietitian/ recommendations
- MD diet/snack orders
- Nutritional support/interventions based on assessment
- Adaptive equipment i.e weighted spoon
- Resident or family Non-compliance with interventions/ reasons for non-compliance
- Resident/family education for non-compliance
- Level of assistance required to eat
- Measures to encourage intake of food and fluid
- Monitored intake of food and fluid
- Method/Adequate hydration provided
- Continual involvement of the dietitian with regular follow up and notes
- Weight- regular monitoring based on intake and weight trends
- MD order for weight monitoring
- Adjustments to diet and medications based on diagnosis/ labs i.e Diabetes
- Signs of dehydration monitored i.e. weight, skin turgor, urinary output, labs out of range
- Medication supplements

Wound

- Admission skin assessment
- Detailed description/measurements of all wounds present on admission
- Resident/family awareness of wound(s)
- Wound prevention measures
- Risk assessments/repeated at regular intervals
- Risk factors, comorbidities, conditions
- Wound observations/measurements
- Daily observations of skin surrounding wound(s)
- Daily observations of dressings
- MD wound care orders/changes
- Changes in wound appearance, parameters, pain level, interventions
- Assessment of pain/medications given
- Wound category changes
- Communication-regarding changes in wound status. Specify communications with other healthcare providers, resident, family, etc.
- Resident behaviors i.e pulls dressing off, and plans to address behaviors
- Non-compliant with plan of care and educational interventions communicated to resident and family
- Any resident behaviors: Refusal of treatment, refused to turn and repostion , etc. and how education was provided – alternative options provided
- Wound appliances
- Nutritional status/interventions
- Pressure reducing devices
- Turning/ positioning measures

SAMPLE

DOCUMENTATION BY EVENTS

- Activity/mobility
- Distinguish end-of –life wounds from PI's or other wounds

SAMPLE