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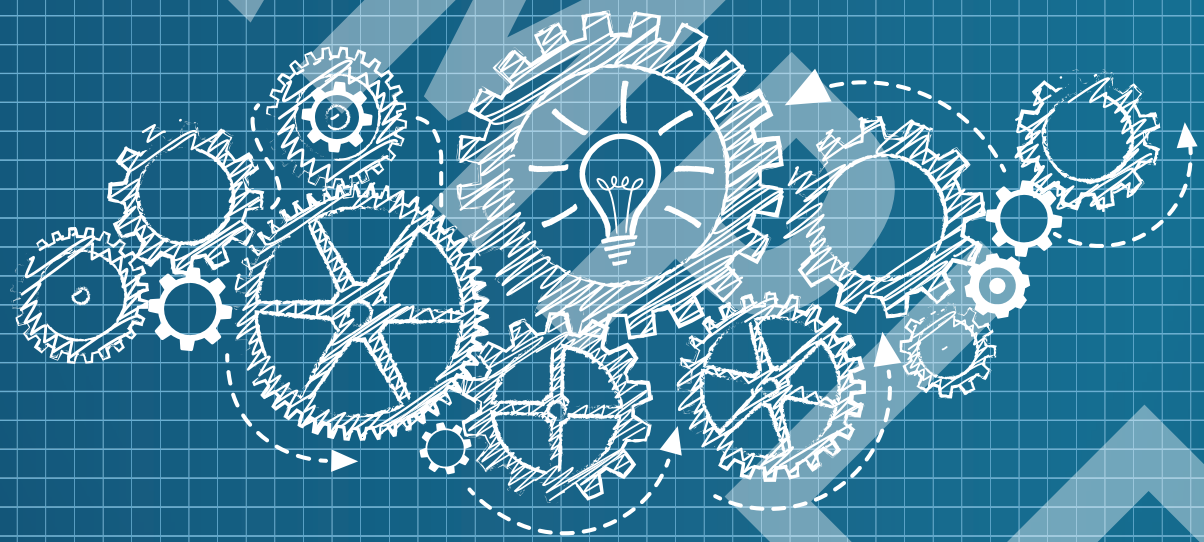
DOCUMENTATION TOOLKIT FOR THE NURSE LEADER



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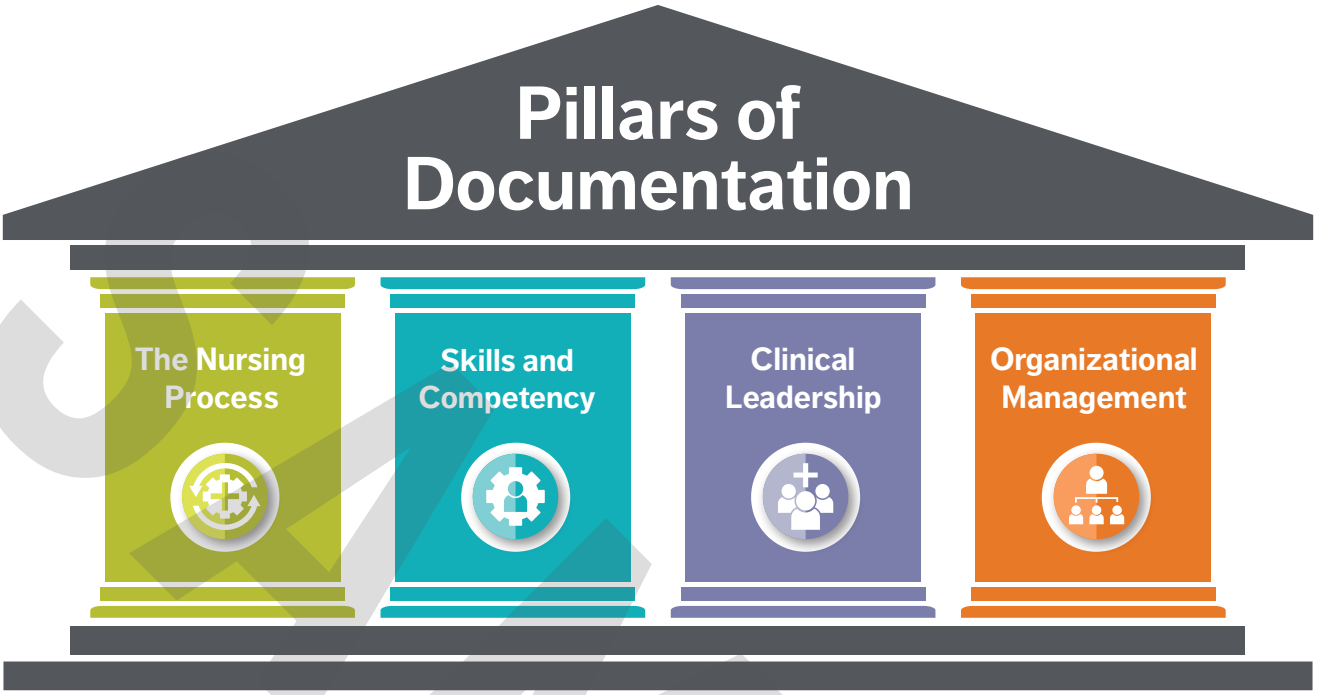
DOCUMENTATION TOOLKIT FOR THE NURSE LEADER

Table of Contents

Four Pillars of Documentation

This toolkit will address the four pillars of documentation and provide a comprehensive set of resources to assist the nurse leader to systematically improve documentation. It is important to understand that each pillar is necessary to provide the structure nurses need to document. Each section will explain the pillar and provide nurse education, tools, application ideas, and additional resources.



ACUTE CHANGE IN CONDITION

ASSESSMENT - Data and information gathered from assessing the resident

Objective: tangible and measurable data

- Symptoms resident is experiencing - be specific with objective terms describing the symptoms, e.g., change in level of consciousness; pain; specific signs and symptoms related to the body systems
- VS - WNL for resident or abnormal - e.g., fever, rapid or slowed pulse, change in respiratory effort, change in normal BP, decreased O_2 sat
- Symptoms of dehydration - furrowed tongue, dark-colored and strong-smelling urine, decreased urine output, change in cognition, skin turgor slow to respond over sternum, sunken eyes, rapid heart rate, low BP
- Symptoms of hypoglycemia - sweating, confusion, tremors, irritability, change in sleep, unsteady, vomiting, lethargic
- Symptoms of hyperglycemia - increased urination, short of breath, fruity-smelling breath, increase in confusion, increased fluid intake
- Skin - color, cool, clammy, diaphoretic, color of nail beds and lips
- Respiratory effort - e.g., shallow, rapid, labored, pursed-lipped breathing, use of accessory muscles
  - Lung sounds - rhonchi, rales, wheezes
- Presence of edema
- Change in ADL ability
- Change in cognition, mood, or normal behavioral expressions
- Change in food or fluid consumption
- Pertinent labs and other diagnostics - weight, CBC, CMP, BUN, creatinine, electrolytes, C&S, CXR, EKG, thyroid panel, blood sugar, liver panel, cardiac enzymes

Subjective: verbal statements

- Resident's description of the symptoms they feel
- Other statements by resident and/or responsible party

NURSING DIAGNOSIS - How the signs and symptoms are impacting the resident

- Individualize to what the resident is experiencing and/or what the potential risks are

PLANNING - The resident's goals and wishes and/or desired outcomes

- Resident's goals and wishes, including refusals of care
- Change in the care plan

IMPLEMENTATION - Nursing interventions and physician orders

- IV fluids and/or medications
- Medications specific to the treatments or medications held because of the symptoms
- Diet modifications made as a result of the change
- Comfort care - oral care, cool cloth or ice pack, rest, massage
- Ice cubes, favorite fluids, assist to drink
- ADLs - additional assistance needed now due to fatigue or discomfort
- Use of transmission-based precautions for suspected or confirmed infection

EVALUATION - Outcomes experienced by the resident

- Is there relief of symptoms?
- Is resident accepting of the nursing interventions? If not, document alternatives suggested and actions taken.

Sample Narrative Note:

Color pale. Skin cool and diaphoretic. Respirations shallow and rapid with expiratory wheezing while resting in bed. PRN inhaler administered with decrease in wheezing noted. HOB elevated to 30 degrees. O_2 sat 88% on room air. O_2 @ 2L NC applied, and O_2 sat up to 90%. O_2 increased to 5L via NC, and O_2 sat up to 94%. Afebrile. Pulse rapid and thready. BP elevated above resident's normal. Denies chest pain, back pain, or shoulder pain. Tongue furrowed. Skin turgor slow to respond over sternum. Urine dark yellow. Bowel sounds x4. Denies N&V. No change in cognition. No edema. Complains of feeling "very tired" and "winded." Unable to reposition self in bed at this time. One staff weight-bearing assist provided to reposition resident on right side. Oral care provided and ice chips placed on bed side table. Resident drank 200 ml of water with staff encouragement. Physician notified of resident status. New orders received for EKG, CXR, CBC, and nebulizer treatment.

Audit Tool: Documenting Clinical Conditions

Nursing Process Components **Directions:** Identify each medical record with resident initials. Place a check mark in the box when the component is noted in the documentation. Total the check marks and divide by 5 to determine the percentage rate of completion.	**Medical Record 1** Initials: ____	**Medical Record 2** Initials: ____	**Medical Record 3** Initials: ____	**Medical Record 4** Initials: ____	**Medical Record 5** Initials: ____	**Rate of Completion**
Does the documentation reflect the **assessment** components that should be captured?						/5 = __%
Does the documentation reflect how the **symptoms/problems** affect the resident?						/5 = __%
Does the documentation reflect the **plan of care** including the resident's goals and wishes?						/5 = __%
Does the documentation reflect **nursing interventions**?						/5 = __%
Does the documentation reflect the **evaluation or the outcomes** of the nursing interventions?						/5 = __%

Additional Comments/Corrective Actions by Reviewer	
Medical Record 1	
Medical Record 2	
Medical Record 3	
Medical Record 4	
Medical Record 5	

POSSIBLE CORRECTIVE ACTIONS:

- Reinforce good documentation by praising nurses when they capture all components of the nursing process in documentation.
- Target improvement and professional development when trends emerge in the audit indicating specific components of the nursing process are not consistently captured.
- Share results of audits with nursing staff. Offer praise and acknowledgement when trends in the quality and consistency of documentation improve or maintain at an acceptable threshold.

Nurse Education: Post-Fall Nursing Assessment, Care, and Documentation

Target Audience: Nurse

Objectives:
- Identify the necessary components of the nurse's initial post-fall assessment.
- Describe potential complications and injuries that can occur from a fall.
- Discuss nursing interventions applicable to stabilize a resident during the initial post-fall assessment.
- Practice the skills necessary to complete a post-fall assessment.
- Critique and improve a nurse's narrative note describing the findings of a post-fall assessment.

Directions: The Staff Development Coordinator will be the "game show host," and the DNS or other nurse leader will be the "judge." Divide nurses into two teams that will compete against each other for a grand prize (which can be something silly). Flip a coin to decide which team will have the opportunity to answer the first question. The host will read the case and then ask the first question. Teams have one minute to discuss what they think the answer is. At the end of one minute, a loud buzzer or funny sound indicates time is up. The team that won the coin toss will give their answer. After the first team gives their answer, the second team may give their answer or pass. If the judge likes the second team's answer better, they steal the point from the first team. Whichever team wins the point gets the chance to answer the next question first. The host can use this time to provide additional information and answer questions the nurses may have. Sample answers are provided. Before using the sample answers, make sure they align with the facility's policies and procedures.

Host questions and commentary in blue.

Welcome teams to the Post-Fall Assessment Challenge! Today, you'll be competing against each other for the ultimate prize of *(fill in what prize they are competing for)*. I will read a case to you and ask you questions. Each team will have one minute to discuss what they think the right answer is. The team that wins the coin toss will answer first. The second team will answer the question after the first team. The judge will determine which team's answer is the best. Let's give a round of applause to our judge, *(fill in the name of the judge).* Let's get started.

Mrs. Washington is a 72-year-old female who lives in the memory care neighborhood. She has the following diagnoses: Alzheimer's disease, hypertension, diabetes, osteoarthritis, and osteoporosis. Mrs. Washington ambulates ad-lib. The CNA enters her room and sees her lying on her right side in front of her bathroom door and calls for your help.

1. **You arrive on the scene. What is the first priority, second priority, and third priority?**
   Answer:
   First - Ensure basic life support needs are met, including airway, breathing, and circulation.
   Second - Identify obvious injuries or signs of potential injuries and provide immediate supportive care and first aid.
   Third - Designate what responsibilities others have. If it is a life-threatening situation, you may have to immediately designate someone to call for assistance, i.e., code 911.

2. **As you conduct the assessment and identify any signs of an injury or an obvious injury, what common fall-related injuries are the most common in the geriatric resident?**
   Answer:
   - Musculoskeletal injuries, such as hip fracture or muscle tear
   - Dislocation of joints, such as the shoulder, hip, or cervical spine
   - Head and neck injuries, such as a subdural hematoma or cervical fracture
   - Skin and deeper tissue trauma, such as bruises, abrasions, skin tears, or internal bleeding

3. **What do you have to do before you move the resident?**
   Answer:
   - Before a resident can be moved, you must assess them for an injury to the spinal column, obvious fractures, bleeding, level of consciousness.

4. **When is it appropriate to include a neurological check in the post-fall assessment?**
   Answer:
   - It is appropriate when a resident hits their head or if it is unknown if they hit their head.