Nursing Documentation: Good vs. Bad

Admission – GOOD

80-year-old female admitted to SNF following hospitalization for right hip fracture r/t fall, and secondary HTN and CHF. Prior to fall, resident lived at home with spouse. Arrived via W/C Express. Daughter and husband at center waiting for resident. Resident alert, recognizes family. Resident is WBAT and unable to rise from w/c. Transfer from w/c to bed and positioning required max assist of 2. Rates pain 8/10 with mobility but after positioned on bed and resting rates 2/10. Discharge goal to return to home. Speech is clear. Lips moist. Alert/orientated x 3. Short of breath with transfer.O2 sats 91% at rest on room air. Lung sounds-crackles bilateral. Denies pain with respirations. Loose non-productive cough noted. Abdomen soft, Last reported BM this morning. Foley cath prior to surgery and removed yesterday. Continent. Venipuncture sites to both hands and forearm with bruising, no swelling, redness or increase warmth. Clear dressing to right hip with 4x4 gauze covering surgical incision. Redness surrounding incision. No swelling, minimal increase in warmth. No drainage noted on dressing. Bruising noted to right hip green-purple color 6cmx10cm. Denies pain to lower extremities. – Homans. Toes warm to touch. No increase redness, open areas or spongy areas to heels. TED hose on and can be removed at HS. Orders reviewed. New medications include: Lisinopril 10 mg q day for HTN. Lasix 40 mg q day. Lasix increased r/t CHF symptoms. Refused Lasix during hospital stay secondary to increase pain with movement. Resident provided education on signs and symptoms of CHF exacerbation such as SOB with activity, moist lung sounds, increase in edema and/or weight gain. Provided education on pain management. Resident educated on need to reposition frequently to decrease risk of pneumonia and skin breakdown. Coumadin 5 mg every day in the hospital. INR was elevated this am at 4.0. INR goal is 1.8-2.5 Coumadin will be on hold tonight and resumed at Coumadin 3.5 mg tomorrow. Recheck labs ordered. Hydrocodone 5/500mg q 6 hours prn pain. Appt. in 2 weeks for repeat x-rays and staple removal. Call light explained. Resident agrees not to attempt self transfer due to increase risk of falling. As a practical matter, resident requires daily skilled nursing for surgical incision dressing changes, unstable CHF, risk for DVT, dehydration, med management, teaching and education for safety awareness and use of adaptive equipment. Resident requires skilled therapy for gait and balance impairments, ADL deficits. ------------------------------------RN

Admission – BAD

Admit to skilled level of care for nursing and therapy services. 80-year-old female admit to room 302. Diagnosis includes right hip fracture and chronic CHF. Resident arrives via W/C Express. Resident tearful. C/O pain to right hip. Resident transferred from w/c to bed. Resting. Transfer sheet received and orders noted. Resident has orders for PT and OT. No added salt diet. Resident can weight bear as tolerated.--RN

Daily Note – GOOD

Daily weight 150#. Resident working with OT for dressing this AM. Ate 100% of meal and drank 480cc of fluids. Lasix accepted with education reinforced on symptoms of CHF exacerbation. Resident requested pain med for pain rated at 8/10. Resident provided education on side effects of pain med that include constipation. Resident states she will ask for prune juice at lunch. Dietary notified of request. Confusion noted. Orientated to self only. Crackles to bilateral lower lobes. Loose non-productive cough noted. Shortness of breath with activity noted. OT reports O2 at 89% during dressing Rest period provided and O2 sats improved to 93%. Resident re-educated on deep breathing exercises. Voids cloudy urine, c/o burning with voiding. Education provided on symptoms of UTI and to increase fluid intake. Op-site dressing to right hip intact. 4x4 gauze under Op-site is dry. No redness, increase in warmth, or swelling noted. Bruising to hip continues to fade. No new bruising noted. No c/o LE pain pedal pulse present bilateral. Heels checked no open areas or discoloration. Edema present bilateral. Resident required weight bearing support of 2 to transfer and ambulate from bed to w/c. Requires skilled nursing services to assess and observe for pain, complicating factors for infection, pneumonia, DVT, exacerbation of CHF, anticoagulant therapy, skin breakdown and

decrease in activity, teaching and training for safety awareness, hip precautions and disease processes. --RN

Resident works with PT on gait impairment and balance. Resident reports less pain in therapy when pain med given prior to therapy. PT reports resident was able to raise and lower self into chair. Re-enforced education of hip precautions. PT reports O2 sats were at 89% RA with activity, recovered in less than 5 min with rest period. Maintained O2 at 90-91% for rest of session. HR 70 and regular Nursing continues to observe/assess for pain management, exacerbation of CHF complications of pneumonia, education of hip precautions. ---RN

Received results of lab work this AM. INR is 2.1 and within range. Dr notified of lab results and current dose of Coumadin. Dr. also made aware that resident lost 5# since admit. Lung sounds have improved. Resident continues on increased dose of Lasix 40 mg daily. Labs scheduled for next week. Received and noted Dr. order to continue Coumadin 3.5 mg po daily. Decrease Lasix to 20 mg PO daily. Check BMP and PT/INR in 5 days. Nursing continues to assess for pain management, as well as management of anticoagulant and diuretic therapy, exacerbation of CHF, and dehydration. ------RN

Daily – BAD

Resident requires assist with dressing. Reluctant to ambulate to bathroom due to pain. Dressing to right hip is intact. Appetite is good. VSS. Resident went to PT and OT this morning. --RN

Working with OT for dressing today. Ambulates few steps from bed to chair with FWW and assist. To Dining room for meals appetite good. Husband and daughter here for afternoon. Dressing to right hip intact. VSS. Daughter reports that mother has had several episodes of coughing during their visit this afternoon. ---RN

Discharge Note – GOOD

PT and OT report resident has met goals and feel she is ready for discharge from therapy services. Home eval completed. Recommendations have been followed by family to place railings to outside steps and to steps into garage, removed throw rugs in the kitchen and dining area and decreased clutter in kitchen area. Resident independently ambulates >250 feet with FWW, independent with ADL tasks re: dressing, toileting, transfers. Resident will use FWW in home for safety. Resident is independent in use of adaptive equipment used for dressing includes: dressing stick, reacher, sock aid. FWW and equipment available in home. Resident consistent with hip precautions. Surgical incision is healed and open to air. Follow-up visit 2 weeks ago x-rays showed hip healing well. Coumadin and TED hose dc'd at doctor visit. Norvasc dc'd 7 days ago. Orders to discharge to home with current meds: EC ASA 325 mg x 2 weeks then decrease to 81 mg daily prophylaxis, Lasix 20 mg PO daily, Continue low salt diet. Resident, husband and daughter met with RD regarding diet education. Resident and husband both express understanding of diet restrictions. Resident will continue to monitor weight daily. Resident and family educated on recognizing symptoms of CHF exacerbation such as weight gain, SOB and edema and when doctor should be notified. Therapy recommended Home Health to follow. Doctor requested follow up at clinic in 2 weeks, appointment made and given to resident and daughter. Orders noted for discharge home tomorrow with Home Health to follow. ---RN

Discharge Note – BAD

PT and OT plan to discharge today. Resident plans to discharge home tomorrow. Doctor notified and orders received to discharge to home on current meds and diet. Follow up at clinic in 2 weeks. Appointment made and given to resident. --RN