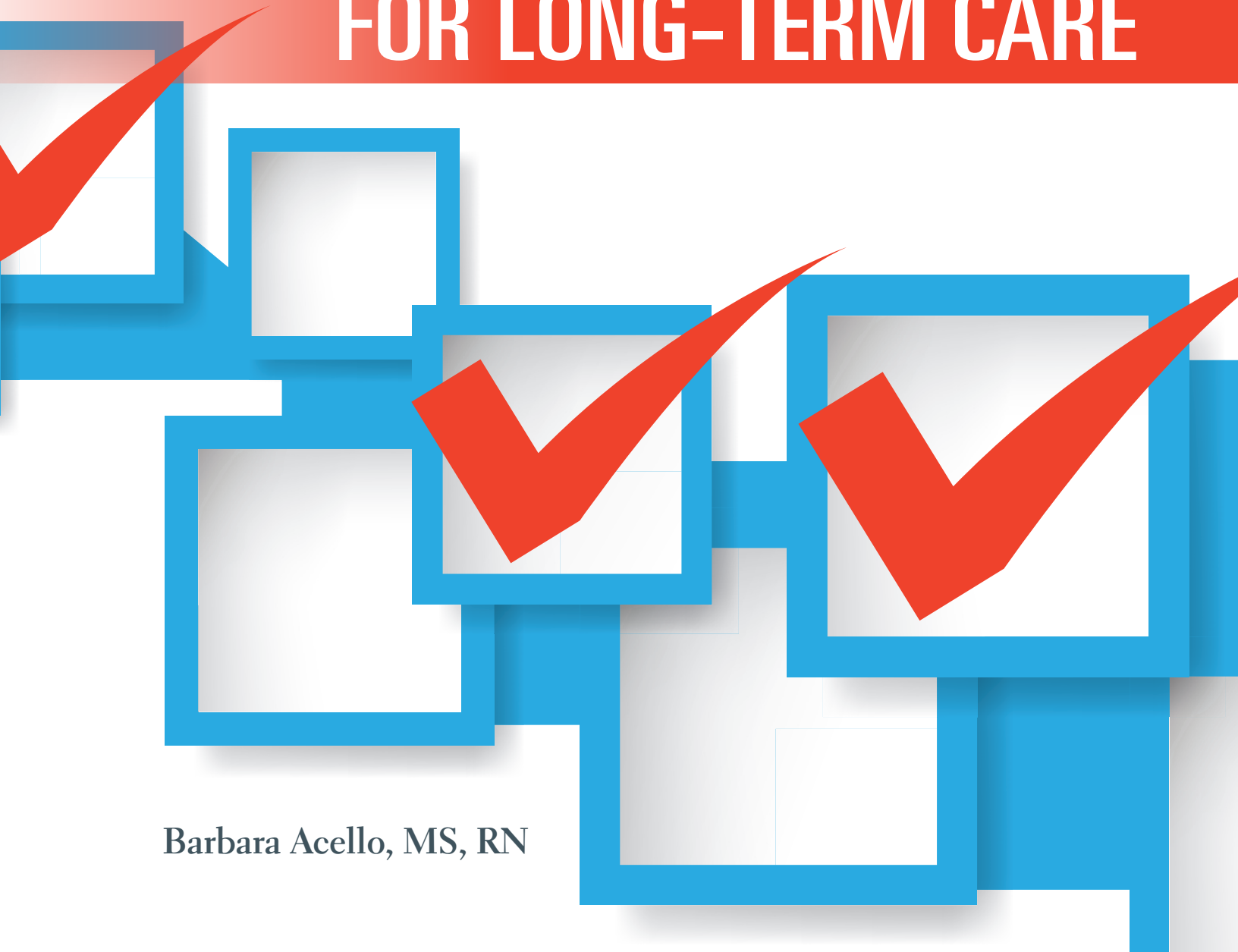
# Clinical Documentation Quick Reference

## FOR LONG-TERM CARE



Barbara Acello, MS, RN

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HCPro

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# About the Author

## Barbara Acello, MS, RN

**Barbara Acello, MS, RN,** is an independent nurse consultant and educator in Denton, Texas. She is a member of the Texas Nurses' Association, NANDA International, and the American College of Healthcare Administrators, where she was honored with the Educator of the Year Award for 2007 and the Journalism Award for 2009. Mrs. Acello's employment has evolved since her graduation in 1971. She has worked as director of nursing, administrator, and long-term care facility consultant and educator; and held numerous corporate-level positions in eight states. Presently, she is involved with freelance consulting, lecturing, and writing. She has written many textbooks, journal articles, and other materials related to acute and long-term care nursing, and nursing assistant practice and education. Although she has worked in acute care, emergency room, and EMS, long-term care is her preferred practice setting. She is committed to improving working conditions, education, and professionalism for nurses and nursing assistants in long-term care facilities. She may be contacted at *bacello@spamcop.net*.

# Purpose

Long-term care facilities must ensure that their documentation reflects the nursing process and reveals that residents receive care that meets minimum acceptable standards of practice. Each resident's clinical record must be accurate and complete—evidence of resident assessment, staff interventions, and the resident's response to treatment must be documented. Special procedures performed for the resident's safety and well-being must also be documented.

Omissions in documentation suggest that basic, rudimentary care was not provided or that physician orders were not followed. If the accuracy of the clinical record is questionable, other healthcare providers cannot depend on data to assess and manage the resident's problems, and in a court of law, the chart certainly will not support the argument that your facility provided adequate care. In addition, inaccurate documentation undermines the credibility of the writer.

Nurses cannot choose between giving care and keeping records. Medical records and documentation are part of the care we give as well as the validation that conscientious care was delivered. Your documentation must follow the requirements of your state's nurse practice act. The adage "If it wasn't documented, it wasn't done" is as valuable today as it was when you learned it in nursing school.

In addition to organizing your documentation based on the five steps of the nursing process—assessment, nursing diagnosis, planning, implementation, and evaluation—your charting should leave no question in a reader's mind that you continually and carefully assessed the resident's condition and monitored his or her progress. Not only does this help ensure legal credibility, but it also ensures that your charting is timely, accurate, truthful, and appropriate (Habel, 2003).

Nurses are responsible for regular, ongoing monitoring of residents who have experienced an acute illness, infection, incident, or other unusual event. Any change in condition, no matter how minor, falls into this category.

In addition, Medicare and other payers require objective daily documentation related to each resident's medical condition, primary diagnosis, and complications, if any. If the resident is ill, unstable, or has fallen, standards of nursing practice require that nurses conduct a focused assessment of any involved systems based on the

nature of the resident's problem at least once each shift.

For example, for a resident with upper respiratory infection, the nurse should complete and document a focused respiratory assessment of the eyes, ears, nose, mouth, neck, and lungs. In some situations, more frequent assessment and documentation will be necessary.

This book provides an easy-to-follow guide for focused nursing assessments and documentation of conditions commonly encountered in the long-term care facility. Written in a list format, this lists assessments both by system and condition. Paging through the book, readers will find it is composed almost wholly of bulleted lists describing what to assess and document for issues such as:

- Common problems and conditions seen in the long-term care facility
- Problems and conditions that increase the risk for readmission to the hospital
- Common conditions for which Medicare coverage is needed
- Problems and conditions with the potential for becoming unstable or emergent
- Problems and conditions for which additional monitoring is needed
- System assessments to identify problems

In addition, to help with any "writer's block" when it comes to assessment and documentation, the nursing notes included in this guide offer succinct lists and guidelines.

The guide also contains useful assessment tools and resources for which nurses are accountable but that they may not have committed to memory. It's an invaluable resource to ensure that assessments and documentation are focused, concise, and thorough.

## How to Use These Guidelines

Use good judgment when determining the frequency for applying the assessment and documentation guidelines. When assessing a stable resident to satisfy Medicare requirements, once every eight hours is usually sufficient. An unstable resident may require monitoring every four hours, every two hours, or even hourly or more often. Stay in tune with your residents' needs and always err on the side of caution.

The content of this book includes the top 20 causes of hospital readmission, as well as additional conditions for which skilled nursing assessment and intervention are necessary. Our goal is to make it a functional tool that will be used daily by nurses in all levels of care.

When a resident requires monitoring and focused assessment, consider photocopying the guidelines appropriate to the condition(s) you are monitoring and placing them on the chart cover or immediately inside the cover so nurses know exactly what to assess and document. This is not known to be a survey problem. Surveyors are generally pleased that nurses have guidelines available and know what to assess and document.

Nurses may not be familiar with all the assessment points, signs, and symptoms for the many conditions. Using the assessment points and documentation information listed here is easier and faster than looking up each diagnosis in a book.

If you have comments or content suggestions for future editions, please feel free to submit them to *bacello@spamcop.net*.

# What to Document

In long-term care facilities, a complete assessment is not usually performed every shift unless a resident is ill or is being monitored. Policies and state laws vary on the frequency of narrative charting, but for stable residents, this is generally weekly or monthly. Daily care, treatments, and medications are usually documented on flow sheets.

Acute conditions should be monitored every shift until 24 hours after the condition is resolved or according to facility policy. Documentation should reflect the results of this monitoring, as well as nursing interventions taken.

Clinical documentation that contributes to identification and communication of residents' problems, needs, and strengths; monitors their condition on an ongoing basis; and records treatment and response to treatment is a matter of good clinical practice and an expectation of licensed healthcare professionals (Morris, Murphy, & Nonemaker, 2003). Remember the following:

- If your assessment reveals an abnormality, your documentation should describe what nursing action you took. In most cases, simply describing an abnormality is inadequate, as is a notation that simply says "will continue to monitor." The nursing process and plan of care should guide all your care and documentation. Review the steps in the nursing process. Do not document an abnormal observation without documenting the other steps related to it in the nursing process. For example, do not document "crackles in lungs" without documenting nursing actions, physician notification, resident response, and follow-up evaluation and care.
- If the resident has a potentially painful condition, such as arthritis or a pressure ulcer, document your regular pain assessments and nursing intervention used to relieve pain. Never make statements that the patient is "smiling; does not appear in pain." Always use an appropriate pain assessment tool in your documentation.
- The purpose of monitoring a resident with an acute illness who receives antibiotic therapy is to monitor the condition. Avoid writing notes that state, "No adverse reaction to antibiotic." Although making such a statement is acceptable, this is a secondary assessment that should only be used as part of a more comprehensive entry. Document vital signs, focused system assessment, and other

nursing observations related to the condition for which the resident receives the antibiotic. This shows you are aware of and are monitoring the problem. For example, write, "Urine clear amber. Resident denies pain and burning on urination."

- Always document any change in condition along with the resident's vital signs, your actions, and your notification of physician, family, or others. If the resident remains unstable as a result of a change in condition, ongoing assessment and documentation are necessary. Regularly document vital signs, neurological checks, and other observations.
- If a resident falls, has a fever, or has any change in condition, document every shift until 24 hours after the abnormality is resolved. Do focused assessments of the affected body systems. Take vital signs every shift and, if abnormal, more often.
- Document all unusual occurrences, such as falls, wandering, drug reactions, or changes in condition. Document your notifications about these unusual occurrences to physician, family, and others. Also document nursing actions and the resident's response.
- Follow facility policies for completing incident reports, but regardless of whether your facility uses incident reports, nurses are responsible for documenting the details of all unusual incidents and events in residents' medical records. This documentation should include the nature of the event or incident, assessment, care, notifications, and follow-up monitoring.

Care given:

- When documenting, remember you are talking about a person. Review the medical record of a resident with a gastrostomy tube, pressure ulcer, or other chronic condition. Does most of the documentation address the condition? If so, staff are not documenting holistically. Address the entire person; the condition is secondary. Use the nursing process.
- Nursing facilities are required to document the resident's care and response to care during the course of his or her stay, and this documentation is expected to chronicle, support, and be consistent with the findings of each Minimum Data Set (MDS) assessment. Always keep in mind that government requirements are not the only reason—or even the major reason—for clinical documentation (Morris et al., 2002).
- Make sure your care and documentation are consistent with acceptable professional standards of practice, state laws, facility policies and procedures, and the resident's plan of care.
- Record all nursing care given, including the resident's response to treatment. Describe teaching, as well as the resident's response

and understanding. List specific instructions you have given.

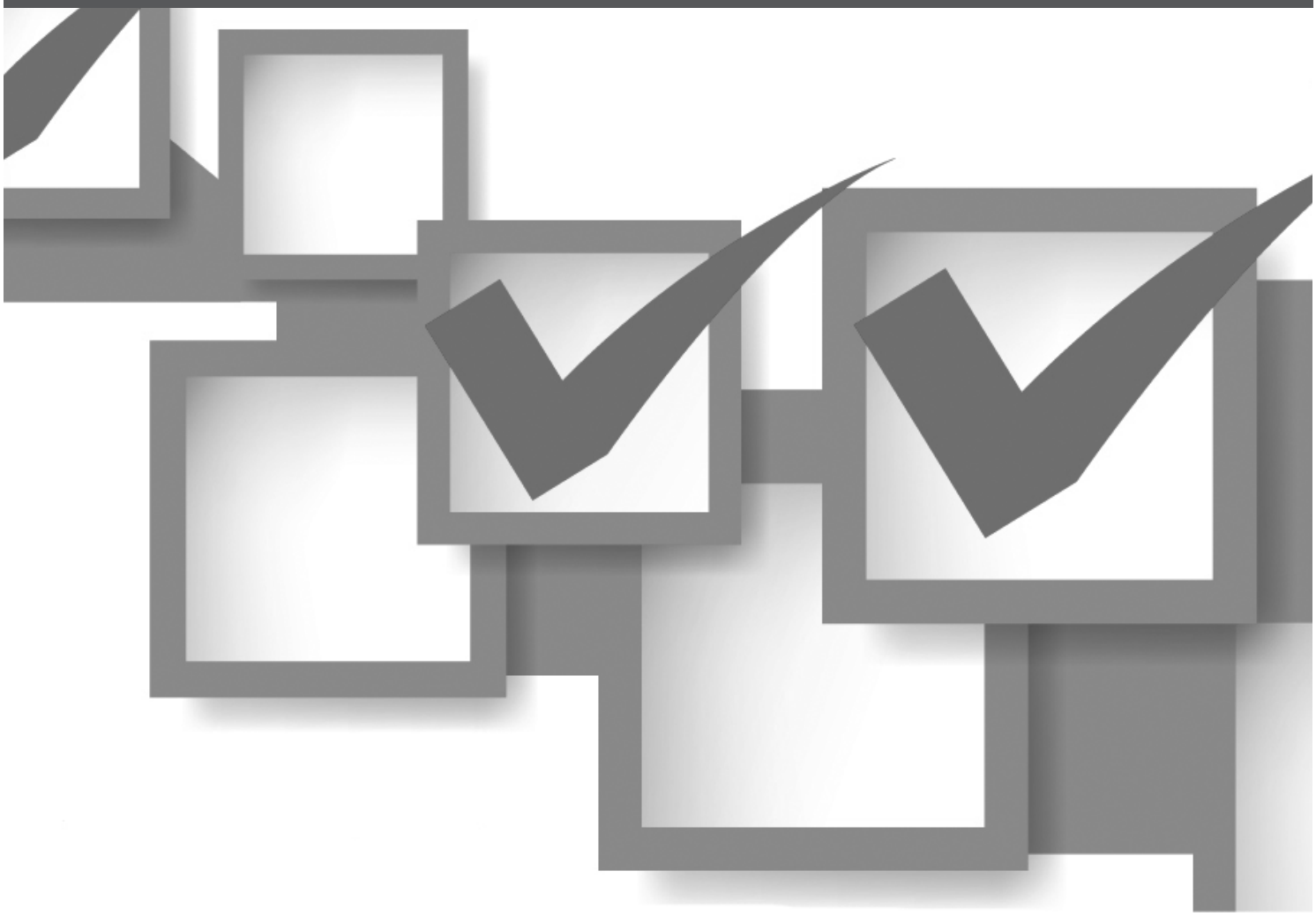
- Document all safety precautions taken to protect the resident. This may be done on a flow sheet. Be specific. For example, stating "fall precautions" does not tell the reader what you did.
- Always document the reason for giving a PRN medication and the resident's response.
- When following a physician's order, always leave a "paper trail." That is to say, document an assessment of the resident, implementation of valid orders, notification of the physician, his or her response, and the outcome.

# Communication

- Document communication with others regarding the resident.
- If a change in a resident's condition warrants physician notification, communicate essential information in a clear and logical manner that expedites understanding and intervention. Have all essential data available before calling a physician. Be direct and descriptive—paint a word picture for the physician. Document his or her response.
- On weekends or during second and third shifts, you may communicate with an on-call physician instead of with the attending physician. He or she is probably not familiar with the resident. Clearly summarize the resident's background before describing the problem. Document the physician's response.
- Document all your attempts to reach the physician. If you observe significant or serious changes in the resident's condition, do not just chart them—notify the physician. If he or she does not respond, notify the alternate physician, on-call physician, or medical director.
- Document reservations about a physician's orders and action taken. Legally, you must advocate for the residents. If, in your professional judgment, you believe the physician's orders place a resident in jeopardy, intervene and clarify the treatment plan with him or her. If the physician is unresponsive, contact your supervisor and go up the chain of command from there. Document the actions you take to advocate for the resident.
- Document notifications and referrals, such as notifying a social worker about the need for behavioral intervention, or a dietitian about a pressure ulcer, weight loss, or abnormal lab values.
- When obtaining physician orders for medications, get a diagnosis to correspond with the medication. State the reason why the medication is being given. Many medications have multiple uses.
- Be sure that new physician telephone orders are consistent with other information on the chart. For example, you notify a physician about a 10-pound weight loss for a resident on a planned reduction program. The physician, who may not remember the resident, orders Ensure four times a day to promote rapid weight gain. Or, worse yet, a physician who is not familiar with the resident may order a drug that duplicates existing medication therapy. Make sure you are familiar with the resident's plan of care and his or her medications before calling a physician.

# Assessment and Documentation Guidelines by System

## SECTION 1



# Guidelines for Assessing and Documenting Acute Conditions

Acute conditions should be monitored every shift until 24 hours after the condition is resolved, or according to facility policy. Documentation should reflect the results of this monitoring and all nursing interventions taken. If an abnormality is documented, a corresponding nursing action should be taken and documented. Avoid statements such as, "Will continue to monitor." If continued monitoring is warranted, subsequent nurses' notes must describe the monitoring that was done within an appropriate time frame.

# Initial Documentation Guidelines for All Conditions for Which Monitoring Is Required

Assess and document the following every shift:

- Systems/problems with signs and symptoms of acute illness, injury, or high risk condition.
- The resident's actual problems and/or complaints, if possible.
- Conditions that are unstable or that may become unstable.
- If the results of an assessment are positive, describe the nursing action taken. Nursing action must be taken for positive (abnormal, potentially problematic) assessment findings. Assessments with no action make both the nurse and the facility legally vulnerable, and place the resident at risk (e.g., "Assessment reveals crackles in lungs." Nursing action: contact healthcare provider, vital signs, increase fluids to liquefy secretions, encourage coughing and deep breathing, etc.).
- Negative findings (e.g., "No chest pain, no cyanosis").
- Vital signs. If abnormal, describe nursing action taken.
- Pulse oximetry.
- If the abnormal findings are chronic or acute.
- Recent laboratory values, if any.
- Response to treatment. If on antibiotic therapy, describe the condition for which antibiotics are administered, and signs and symptoms related to that condition. Do a focused assessment on systems involved and document your findings. Documenting "No side effects to antibiotic therapy" should not be the sum total of documentation for the shift. Use a flow sheet for documenting absence of side effects to antibiotics (i.e., "No side effects noted this shift related to antibiotic therapy").
- Other new medications and side effects, if any.
- Signs/symptoms of dehydration and/or inadequate fluid intake (which causes hypovolemia).
  - Consider intake and output (I&O) monitoring.
- Any other changes from the resident's usual condition (what he or she is like on a normal day).
- Whether other residents in the facility are being treated or have recently experienced the same or similar signs and symptoms.
- Whether a relationship exists between a current sign or symptom and a new medication, food or fluid intake, a change in activities, change in physical or mental condition, etc.

## Mandatory Documenting and Reporting

The following signs and/or symptoms may be present to a greater or lesser extent if an abnormality with any body system is present. The presence of any of these conditions warrants initial assessment, reporting to the healthcare provider, documentation of findings and notifications, and ongoing monitoring until the condition is stabilized:

- Pulse rate below 60 or above 100
- Pulse irregular, weak, or bounding
- Blood pressure below 100/60 or above 140/90, unless this is usual for resident
- Unable to hear blood pressure or to palpate pulse
- Pain over center, left, or right chest
- Chest pain that radiates to shoulder, neck, jaw, or arm
- Shortness of breath, dyspnea, or any abnormal respirations
- Headache, dizziness, weakness, paralysis, vomiting
- Cold, blue, gray, cyanotic, or mottled appearance
  - Blue color of lips or nail beds, mucous membranes
- Cold, blue, numb, or painful feet or hands
- Feeling faint or lightheaded, losing consciousness
- Marked change in mental status
- Respiratory rate below 12 or above 20
- Irregular respirations
- Noisy, labored respirations
- Dyspnea, struggling, gasping for breath
- Cheyne-Stokes respirations
- Wheezing
- Retractions
- Blood sugar over 300
- Blood sugar less than 60
- Sodium over 145
- Blood urea nitrogen (BUN) over 22
- White blood cell count (WBC) over 11,000
- Hematocrit greater than three times the hemoglobin value
- Potassium below 3.5 or over 5.5
- Chloride over 107
- BUN/creatinine ratio > 23
- Report the prothrombin time and INR on the day they were drawn
- Levels above or below the therapeutic range of any drug
  - Hold the next dose if elevated until the healthcare provider can be contacted
- Blood glucose > 300 in diabetic
- Culture & sensitivity colony count > 100,000

# Cardiovascular Conditions

Assess and document the following every shift:

- Vital signs.
- Pulse: regular, irregular, weak, thready, strong, etc.
- Capillary refill.
- Pulse oximetry.
- Presence or absence of chest pain. If present, describe onset, duration, location, radiation, and description. Complaints of pain in the shoulder, arm, or jaw.
- Lung sounds. If new abnormalities are noted, is healthcare provider aware?
- Describe the resident's color: pink, pale, gray, etc.
- Presence or absence of cyanosis.
- Presence or absence of dyspnea.
- Resident's skin temperature; describe temperature of distal extremities.
- Activity tolerance.
- Oxygen use, times, liter flow, resident response.
- Presence or absence of cough. If present, describe if productive or nonproductive. If productive, describe appearance of sputum.
- Presence or absence of distended neck veins.
- Presence or absence of anxiety.
- Presence or absence of diaphoresis.
- Presence or absence of weakness, dizziness, or fatigue.
- Presence or absence of indigestion or nausea.
- Complaints of palpitations.
- Complaints of numbness.
- Complaints of headache.
- Complaints of visual disturbances.
- Describe the resident's mental status.
- If pedal edema present, describe; measure with tape measure and record.
- Signs or symptoms of thrombophlebitis.
- Intake and output. Assess if fluid retention or I&O do not balance.
- Note the following observations about the radial pulse:
  - Strong
  - Weak
  - Absent
  - Equal (=) bilaterally
  - > on right
  - > on left

- Note the following observations about the pedal pulse:
  - Strong
  - Weak
  - Absent
  - Equal (=) bilaterally
  - > on right
  - > on left
- Note whether edema is present/absent:
  - No edema present
  - Nonpitting
  - Pitting (estimate 1+ through 4+ on edema scale)

Also see *"Renal Failure, Acute: Prerenal Azotemia."*

## Essential Documentation and Healthcare Provider Notification

- Vital signs (for baseline value)
- Abnormal pulse below 60 or above 100
- Blood pressure below 100/60 or above 140/90
- Unable to palpate pulse or hear blood pressure
- Chest pain
- Chest pain that radiates to neck, jaw, shoulder, or arm
- Shortness of breath
- Headache, dizziness, weakness, vomiting
- Blue, or gray appearance/color
- Cold, blue, painful feet or hands
- Shortness of breath, dyspnea, or abnormal respirations
- Loss of consciousness
- Abnormal capillary refill (>3 seconds)
- Abnormal pulse oximeter (89% or below)
- Abnormal lung sounds
- Pitting edema in combination with other signs and symptoms

# Endocrine System Conditions

- Vital signs
  - Assess for chills, fever
  - Assess for tachycardia or bradycardia
  - Monitor blood pressure daily for a week; assess for hypertension, hypotension
- Auscultate the lungs for abnormal sounds
  - Assess for laryngeal spasm, crowing respirations, cyanosis
- Describe respiratory pattern, including rate, rhythm, effort, and use of accessory muscles
- Height
- Weight
- Determine if there is a history of weight loss
- Determine whether anorexia, increased appetite, decreased appetite, nausea, vomiting, diarrhea, or weight gain despite anorexia are present
- Determine whether increased appetite and weight loss are present
- Inspect the skin for excessive oiliness and dryness
- Inspect the skin for flushing, warmth, cool to touch, moisture
- Assess for intolerance to heat, elevated body temperature
- Assess for intolerance to cold, reduced body temperature
- Inspect the skin for excessive or absent areas of pigmentation
- Inspect the skin for excessive hair growth or loss
- Inspect the skin for red and open areas (pressure ulcers)
- Inspect the skin for other open areas such as skin tears, fissures, and abrasions
- Examine the shape and color of the nails
- Determine whether the nails are thin, thick, or brittle
- Ascertain headache history
- Examine the eyes for exophthalmos (bulging or protrusion)
- Determine whether visual changes such as blurred vision or double vision are present
- Determine whether the resident has blindness in part of the visual field
- Examine the eyes for periorbital swelling
- Observe the resident's facial expression; determine if swelling is present
- Evaluate females for excess facial hair and a deep voice

- Assess the resident for coarse features, large lower jaw, thick lips and tongue, bulging forehead, bulbous nose, large hands, large feet
- Gently palpate the thyroid gland
- Assess the extremities for edema/fluid retention
- Assess for excessive thirst
- Assess for signs and symptoms of dehydration
- Evaluate polyuria, polydipsia, and polyphagia
- Assess for nervousness, anxiety, insomnia
- Monitor for change in level of consciousness
- Evaluate outstretched hands for tremors
- Assess sensitivity to pain or touch in extremities
- Evaluate muscle strength/weakness
- Monitor for neuromuscular irritability, twitching, muscle cramps, muscle spasm, spasticity, tetany, or excessive clumsiness
- Evaluate joint range of motion; pain and stiffness; determine if joint hypertrophy is present
- Evaluate for numbness or tingling in lips, fingers, feet, toes
- Inability to differentiate heat from cold
- Inability to sense and differentiate sharp and dull, and soft and rough stimuli
- Assess for skeletal tenderness, pain on weight bearing
- Evaluate the resident's mental and emotional status
- Evaluate the resident's demeanor (e.g., dull, apathetic, excitable, nervous)
- Evaluate the resident's ability to process information and answer questions
- Assess for ongoing malaise, fatigue, weakness
- Monitor fingerstick blood glucose, if indicated
- Perform a dipstick test for glucose, ketones, albumin in urine
- Monitor urine specific gravity

# Eye, Ear, Nose, Throat Conditions

- Vital signs
- Respiratory status; describe irregularities, patterns, wheezing
- Presence or absence of headache; if present, describe intensity, location, responsiveness, mental status, etc.
- Describe nasal congestion, if present:
  - Difficulty breathing out of one or both nostrils
  - Describe nasal drainage, if present
  - Loss of ability to smell
  - Noisy breathing
  - Snoring (stertorous respirations)
  - Nasal voice quality
  - Complaints of sinus headache
  - Pain (note area)
- Describe condition of pharynx, complaints of sore throat:
  - Visual exam reveals white patches on tonsils, enlarged or reddened tonsils
  - Difficulty swallowing
  - Pain on swallowing
  - Malaise
- Presence or absence of cough; if present, describe productive or nonproductive and color and character of sputum
- External appearance of eyes, such as exudate from eyes, edema of eyelids, complaints of itching, redness, pain, excess tearing, sclera reddened
- Describe alterations in vision, if any:
  - Pupil response
- Describe condition and appearance of tongue: midline position, color or fissures, etc.
- Describe appearance of gums and oral mucosa (area between gums and cheek will stay moist even with a mouth breather unless resident is dehydrated)
- Describe drainage from ears, hearing alteration, ringing, pressure, popping, dizziness when moving, etc.
- Determine whether other residents in the facility are being treated or have recently experienced the same or similar signs and symptoms

Also see *"Pupil Assessment."*

# Gastrointestinal System Conditions

- Vital signs.
- Determine/study whether a relationship exists between the current signs or symptoms exhibited by the resident and other factors (e.g., the resident complains of nausea, has had vomiting, or diarrhea). Is there a relationship between the vomiting and medication administration time, initial doses of new medication, time of day, intake of certain foods or fluids, etc.?
- Consider whether food and fluid intake are normal for the resident.
- New medications and side effects, if any.
- Monitor for signs/symptoms of dehydration, inadequate fluid intake (which causes hypovolemia). Consider I&O monitoring.
- Note any other changes from the resident's usual condition (what he or she is like on a normal day).
- Determine whether other residents in the facility are being treated or have recently experienced the same or similar signs and symptoms.
- If resident is on warfarin, review and report most recent prothrombin time (PT) and international normalized ratio (INR), coagulation status, signs of internal bleeding.
- Check for and consider other recent laboratory values or flat plate abdomen, other x-rays, if any.
- Sores or ulcers inside the mouth. Note condition of mucous membranes. (Note: the area between the gums and cheek will stay moist even with a mouth breather unless resident is dehydrated.)
- Difficulty chewing or swallowing food.
- Unusual or abnormal appearance of bowel movement; such as dark and tarry (assuming the person is not taking iron); parasites, and foreign bodies.
- Jaundice.
- Blood, mucous, or other unusual substances in stool.
- Hard stool, difficulty passing stool.
- Unusual color stool; stool that is dark in color, shiny, dry, and hard is usually old.
- Abdominal distention:
  - Flatus

- Complaints of pain, constipation, diarrhea, bleeding, but staff has been able to verify the problem.
- Complaints of cramping.
- Frequent belching (eructation), heartburn, or reflux.
- Changes in appetite.
- Excessive thirst.
- Fruity smell to breath.
- Complaints of indigestion or excessive gas.
- Choking.
- Coffee ground appearance of emesis or stool.
- Nausea and/or vomiting.
- Diarrhea or loose stools, verified by staff. (Document number of stools in 8-hour shift; describe appearance.) Facilities should define diarrhea; some staff believe the residents have diarrhea if they have one loose stool. Diarrhea is multiple loose stools within a predetermined time frame. Make sure all staff are familiar with and use the same definition. Considerations for facility definitions are
  - Three or more loose stools within a 24-hour (or other specified) time period
  - A frequent and/or profuse discharge of loose or fluid evacuations from the intestines
  - A condition characterized by watery stools, increased frequency of stools, or both compared with what is normal for the resident
- Constipation or fecal impaction. Evaluate recent documentation of bowel movements; determine whether it reflects a change from the resident's usual pattern.
- Consider past history gastrointestinal (GI) problems, such as ileus, bowel obstruction, impaction, gastritis, GI bleeding, etc.

## Abdomen Assessment

Assess and document:

- Soft
- Flat
- Distended
- Taut
- Tender, painful (specify location)

## Bowel Sounds

- Active
- Hyperactive
- Hypoactive
- Absent

## Gastrointestinal System Infection

Assess and document:

- Length of time signs and symptoms have been present and if there is a relationship between a new medication or food
- What measures (if any) will relieve symptoms, and effectiveness of these measures

- Vital signs
- Dryness of the oral mucosa and skin turgor
- The contour of the abdomen to determine if it is flat, round, concave, or distended
- Whether abdominal distention interferes with breathing
  - Auscultate bowel sounds in all four quadrants.
  - Palpate the abdomen after auscultation (doing this first will interfere with bowel sounds). Describe the location, pitch, quality, and frequency of bowel sounds (which usually occur every five to 30 seconds).
- Jaundice
- Loss of appetite
- Change in food or fluid intake
- Monitor food consumption
- Document and assess intake and output

Complaints of indigestion or excessive gas:

- Check for abdominal distention
  - If present, measure abdominal girth at the widest point with a tape measure
  - Evaluate the effect of distention on the resident's respirations
  - An amazing newspaper article about the effects of distention on a 78-year-old woman's respirations is available at *http://tinyurl.com/63k9fby*
- Nausea, vomiting
- Abdominal pain

Monitor for unusual or abnormal appearance or color of bowel movement:

- Check for visible blood, mucus, or other unusual substances in stools.
- Using a guaiac test, check stools for occult blood.
- Review bowel activity record; determine whether constipation or fecal impaction check are indicated. If the resident has an indwelling catheter, check for leakage, which may also occur with constipation or fecal impaction.
- Determine whether other residents in the facility are being treated or have recently experienced the same or similar signs and symptoms.

Diarrhea:

- If the resident has had three or more loose (unformed, watery) stools, determine whether he or she has received antibiotics in the last 30 days. If so, maintain a high degree of suspicion for *Clostridium difficile (C. diff).*
- If other residents are experiencing diarrhea, consider Norovirus. This is the most common cause of diarrheal outbreaks in hospitals and long-term care facilities. The main signs and symptoms are sudden onset of vomiting and diarrhea, headache, fever (usually low-grade), chills, and abdominal pain and/or cramps.

# Genitourinary System Conditions, Urinary Problems, Types of Urinary Incontinence Seen in Adults

- Vital signs.
- Urinary output too low.
- Oral intake too low. (Should be a minimum of 1500 mL/day.)
- Fluid intake and output not balanced.
- Abnormal appearance of urine: dark, concentrated, red, cloudy.
- Unusual material in urine: blood, pus, particles, mucous, sediment.
- Complaints of difficulty urinating.
- Complaints of pain, burning, urgency, frequency, pain in lower back.
- Flank pain.
- Urinating frequently in small amounts.
- Sudden onset incontinence.
- Bladder does not empty completely.
- Check for periorbital edema.
- Edema elsewhere on body.
- Sudden weight loss or gain.
- Respiratory distress.
- Change in mental status.
- Check for and consider recent laboratory values, if any.
- Evaluate new medications and side effects, if any.
- Monitor for signs/symptoms dehydration, inadequate fluid intake (which causes hypovolemia).
  - Consider I&O monitoring

Also see *"Renal Failure, Acute: Prerenal Azotemia."*

**Table 1.1**

| Urinary Problems | |
|---|---|
| **Condition** | **Definition** |
| Anuria | Absence of urinary output (less than 50 mL/day) |
| Bacteriuria | Bacteria in urine |
| Bilirubinuria | Bilirubin in urine due to obstruction or hepatitis |
| Dysuria | Difficult urination, painful urination |
| Enuresis | Bedwetting; voiding involuntarily during sleep |
| Frequency | Voiding frequently; more often than every 2-3 hours |
| Glycosuria | Glucose in the urine |
| Hematuria | Blood in the urine |
| Hesitancy | Difficulty starting urination |
| Incontinence | Inability to control urination |
| Ketonuria | Ketones in urine due to abnormal carbohydrate metabolism |
| Neurogenic bladder | Loss of normal bladder function due to a neurogenic condition; the bladder usually does not store or expel urine correctly |
| Nocturia | Increased urination at night |
| Oliguria | Scant urination; output less than 400 mL/day |
| Polyuria | Increased volume of urine due to a medical condition |
| Proteinuria | Excreting excessive protein in the urine |
| Retention | Inability to empty the bladder completely |
| Urgency | Strong urge to void; difficulty getting to the toilet on time |

**Table 1.2**

**Types of Urinary Incontinence Seen in Adults**
**(Does not apply to childhood conditions)**

| Type of Incontinence | Definition/Cause | Signs and Symptoms |
|---|---|---|
| Stress | Loss of control of urethral sphincter related to weak musculature; the sphincter does not stay closed, resulting in leakage. Usually caused by childbirth, neurologic problems, and aging. Low estrogen in menopause believed to be a factor. | Common in women, also seen in men who have had prostate surgery. Urine loss occurs during physical activities that cause exertion or increase intra-abdominal pressure. For example, coughing, sneezing, laughing, postural changes, standing from a sitting position, and lifting. Amount of urine lost is usually small. |
| Urge | Bladder empties involuntarily when the urge is strong. The person cannot stop the urine stream. Musculature does not relax correctly as bladder fills. Caused by conditions that make the bladder more irritable, most commonly infection. Other common causes are tumors, neurological problems, reproductive problems, and constipation. | Incontinence occurs following a sudden strong need to void; sphincter relaxation may cause escape of urine without symptoms. Bladder will empty even if it is not full. Once the bladder begins to empty, the resident will be unable to stop or control the urine flow. Drinking small amounts of liquid or hearing water running may trigger urine loss. The resident uses the bathroom many times each day. He or she is often up at night to urinate. Common in men with prostatic enlargement and in women. |
| Mixed incontinence | Combination of urge and stress incontinence. | Combination of urge and stress symptoms above; one symptom (urge or stress) may be more troublesome to the resident than the other. This type of incontinence is most common in women. |

**Table 1.2**

## Types of Urinary Incontinence Seen in Adults (cont.)
**(Does not apply to childhood conditions)**

| Type of Incontinence | Definition/Cause | Signs and Symptoms |
|---|---|---|
| Overflow | Overdistention of the bladder. The bladder is a muscle. When it is stretched to its limit, it contracts and empties involuntarily. It may empty only enough to relieve pressure, and not empty completely. There is no way of knowing without catheterizing for residual or doing a bladder scan. Some residents with this condition have a neurogenic bladder. | Common in residents who use the bedpan or urinal in bed because position inhibits bladder emptying. Also seen in conditions of the prostate, and some neurologic conditions. Frequent or constant dribbling, urge or stress incontinence symptoms, urgency, frequency of urination. The resident may feel as if the bladder never empties completely. He or she passes small amounts of urine and may not feel the urge to void. The resident may urinate many times each day because the bladder is not emptying completely. |
| Functional | Chronic impairments of physical and/or cognitive functioning. This type of incontinence is caused by restraints or immobility. The resident probably recognizes the signals to void, but does not have the physical ability to go to the bathroom. | Urge incontinence or functional limitations. The resident may or may not be able to communicate the need to toilet. Incontinence is related to the inability to walk or otherwise ambulate to the toilet. (Includes residents using restraints who have limited mobility.) |
| Unconscious or reflux | Paralysis and neurologic dysfunction. | Common in paraplegia and tetraplegia. Postvoiding or continuous incontinence; severe urgency with bladder hypersensitivity. The resident may not be aware of the need to use the toilet, depending on the urological problem. |
| Transient (temporary) | Temporary condition caused by other medical problems, such as constipation or fecal impaction causing bladder leaking, medications, urinary infection, etc. | Sudden bladder leakage. The problem subsides when the causative condition is identified and eliminated. |

## Genitourinary System Infection

- Vital signs.
- Urinary output too low.
- Oral intake too low. (Should be a minimum of 1500 mL/day.)
- Abnormal appearance of urine: dark, concentrated, red, cloudy.
- Change in appearance, color, odor of urine that does not promptly respond to increased fluids.
- Unusual material in urine: blood, pus, particles, mucous, sediment, etc.
- Complaints of pain, burning, urgency, frequency, pain in lower back.
- Foul odor to urine.
- Edema.
- Sudden weight loss or gain.
- Respiratory distress.
- Change in mental status.
- Unexplained deterioration of physical function.
- New or worsening cognitive impairment, increasing confusion.
- Delirium.
- Agitation, restlessness.
- Lethargy.
- Anorexia.
- Decline in mobility.
- Falls.
- Nonspecific complaints of feeling ill.
- New episode of incontinence, increased frequency of incontinence, and/or nocturia.
- Cough.
- Nausea, vomiting.
- Abdominal pain.
- Flank pain.
- Not emptying bladder completely or at all.
- Body language or other behavior suggesting pain.
- Determine whether other residents in the facility are being treated or have recently experienced the same or similar signs and symptoms.

Also see *"Renal Failure, Acute: Prerenal Azotemia."*

# Clinical Documentation Quick Reference FOR LONG-TERM CARE

Barbara Acello, MS, RN

This resource, designed to be used at the resident's bedside, will help nurses improve their efficiency and quality of documentation by guiding them through 150 of the most common conditions, procedures, and situations encountered in a long-term care facility.

With a detailed and comprehensive description of each symptom or condition, nurses will have a thorough list of what to check for and what to document during every shift, based on the specific circumstances of a given resident.

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***Clinical Documentation Quick Reference for Long-Term Care*** will:

- Help nurses save time while achieving accurate, comprehensive documentation for every resident in their care
- Provide frontline staff with documentation guidance for the most common clinical situations they will encounter

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