NURSES' SUMMARY: SEVEN DAY LOOK BACK Date:_____

Check/circle appropriate responses and fill in the box.

VITAL SIGNS: T_____ P_____ R_____ B/P_____ WT_____ HT_____

HEARING, SPEECH AND VISION — Section B

HEARING: Ability to hear (with hearing aid or hearing appliances if normally used)
- ❑ Adequate – no difficulty in normal conversation, social interaction, listening to TV
- ❑ Minimal difficulty – difficulty in some environments (e.g. when person speaks softly or setting is noisy)
- ❑ Moderate difficulty – speaker has to increase volume and speak distinctly
- ❑ Highly impaired – absence of useful hearing

HEARING AID: Hearing aid or other hearing appliance used
- ❑ No
- ❑ Yes: ___Rt ___Lt
- ❑ Present but not regularly used

SPEECH CLARITY: Select best description of speech pattern
- ❑ Clear speech – distinct intelligible words
- ❑ Unclear speech – slurred or mumbled words
- ❑ No speech – absence of spoken words

MAKES SELF UNDERSTOOD: Ability to express ideas and wants, consider both verbal and non-verbal expression
- ❑ Understood
- ❑ Usually understood – difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
- ❑ Sometimes understood – ability is limited to making concrete requests
- ❑ Rarely/never understood

ABILITY TO UNDERSTAND OTHERS: Understanding verbal content, however able (with hearing aid or device if used)
- ❑ Understands – clear comprehension
- ❑ Usually understands – misses some part/intent of message **but** comprehends most conversation
- ❑ Sometimes understands – responds adequately to simple, direct communication only
- ❑ Rarely/never understands

VISION: Ability to see in adequate light (with glasses or other visual appliances)
- ❑ Adequate – sees fine detail, including regular print in newspapers/books
- ❑ Impaired – sees large print, but not regular print in newspapers/books
- ❑ Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects
- ❑ Highly impaired – object identification in question, but eyes appear to follow objects
- ❑ Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

CORRECTIVE LENSES: (Contacts, glasses, or magnifying glass used) ❑ No ❑ Yes
- ❑ Eye prosthesis: ___Rt ___Lt
- ❑ Present but not regularly used

Comments:_____

_____

_____

COGNITIVE PATTERNS — Section C

- ❑ Alert and oriented x 3
- ❑ Disoriented: Person, Place, Time
- ❑ Comatose: Persistent, vegetative state/no discernible consciousness

SHORT TERM MEMORY:
- ❑ Seems or appears to recall after 5 minutes
- ❑ Memory problem

LONG TERM MEMORY:
- ❑ Seems or appears to recall long past
- ❑ Memory problem

MEMORY/RECALL ABILITY:
- ❑ Current season
- ❑ Location of own room
- ❑ Staff names and faces
- ❑ That he or she is in a nursing home
- ❑ None of the above were recalled

COGNITIVE SKILLS FOR DAILY DECISION MAKING:
- ❑ Independent – decisions consistent/reasonable
- ❑ Modified independence – some difficulty in new situations only
- ❑ Modified impaired – decisions poor, cues/supervision required
- ❑ Severely impaired – never/rarely made decisions

DELIRIUM:
- ❑ Inattention – Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- ❑ Disorganized thinking – Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ❑ Altered level of consciousness – Did the resident have altered level of consciousness? (e.g., **vigilant** – startled easily to any sound or touch; **lethargic** – repeatedly dozed off when being asked questions, but responds to voice or touch; **stuporous** – very difficult to arouse and keep aroused for the interview; **comatose** – could not be aroused)
- ❑ Psychomotor retardation – Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

Comments:_____

_____

_____

MOOD — Section D

- ❑ No mood symptoms present
- ❑ Little interest or pleasure in doing things
- ❑ Feeling down, depressed, or hopeless
- ❑ Trouble falling or staying asleep, or sleeping too much
- ❑ Feeling tired or having little energy
- ❑ Poor appetite or overeating
- ❑ Feeling bad about yourself – or that you are a failure or have let yourself or your family down

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' SUMMARY: SEVEN DAY LOOK BACK

MOOD (Cont'd.) — Section D

- ❑ Trouble concentrating on things, such as reading the newspaper or watching television
- ❑ Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
- ❑ Thoughts that you would be better off dead, or of hurting yourself in some way
- ❑ Short-tempered, easily annoyed

Comments:_____

BEHAVIOR — Section E

- ❑ No behaviors exhibited
- ❑ Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
  - ❑ Behavior occurred 1 to 3 days
  - ❑ Behavior occurred 4 to 6 days but less than daily
  - ❑ Behavior occurred daily
- ❑ Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
  - ❑ Behavior occurred 1 to 3 days
  - ❑ Behavior occurred 4 to 6 days but less than daily
  - ❑ Behavior occurred daily
- ❑ Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)
  - ❑ Behavior occurred 1 to 3 days
  - ❑ Behavior occurred 4 to 6 days but less than daily
  - ❑ Behavior occurred daily
- ❑ Rejection of care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being
  - ❑ Behavior occurred 1 to 3 days
  - ❑ Behavior occurred 4 to 6 days but less than daily
  - ❑ Behavior occurred daily
- ❑ Wandering
  - ❑ Behavior occurred 1 to 3 days
  - ❑ Behavior occurred 4 to 6 days but less than daily
  - ❑ Behavior occurred daily
  - ❑ Wandering placed the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)
  - ❑ Wandering significantly intrudes on the privacy or activities of others
- ❑ Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
- ❑ Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
- ❑ Behavior symptom(s) impact on resident
  - ❑ Puts the resident at significant risk for physical illness or injury
  - ❑ Significantly interferes with resident's care
  - ❑ Significantly interferes with resident's participation in activities or social interactions

BEHAVIOR (Cont'd.) — Section E

- ❑ Behavior symptom(s) impact on others
  - ❑ Puts others at significant risk for physical injury
  - ❑ Significantly intrudes on the privacy or activity of others
  - ❑ Significantly disrupts care or living environment
- ❑ Change in behavior or other symptoms
  - ❑ Same ❑ Improved ❑ Worse
  - ❑ NA – no prior MDS assessment

Comments:_____

FUNCTIONAL STATUS — Section G

ADL ASSISTANCE

CODE 1: SELF-PERFORMANCE Activity 3 or More Times 0. Independent 1. Supervision 2. Limited Assistance 3. Extensive Assistance 4. Total Dependence for Entire 7 Days Activity 2 or Less Times 7. Activity Occurred 1 or 2 Times 8. Activity Did Not Occur for Entire 7 Days — **Code 1**	CODE 2: SUPPORT PROVIDED 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire period; family and/or non-facility staff provided 100% of the time — **Code 2**
Bed mobility	Bed mobility
Transfer	Transfer
Walk in room	Walk in room
Walk in corridor	Walk in corridor
Locomotion on unit	Locomotion on unit
Locomotion off unit	Locomotion off unit
Dressing	Dressing
Eating	Eating
Personal hygiene	Personal hygiene
Toilet use	Toilet use
Bathing	Bathing

FUNCTIONAL LIMITATION IN RANGE OF MOTION/ CONTRACTURES:

- ❑ ___Rt ___Lt Upper extremity (shoulder, elbow, wrist, hand)
- ❑ ___Rt ___Lt Lower extremity (hip, knee, ankle, foot)

BALANCE DURING TRANSITIONS AND WALKING

CODE:
0. Steady at all times
1. Not steady, but able to stabilize without staff assistance
2. Not steady, only able to stabilize with staff assistance
3. Activity did not occur

	Code
Moving from seated to standing position	
Walking (with assistive device if used)	
Turning around and facing the opposite direction while walking	
Moving on and off toilet	
Surface-to-surface transfer (transfer between bed and chair or wheelchair	

MOBILITY DEVICES: (check all normally used)

- ❑ Cane/crutch
- ❑ Wheelchair (manual or electric)
- ❑ Walker
- ❑ Limb prosthesis

Comments:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' SUMMARY: SEVEN DAY LOOK BACK

BLADDER — Section H

BLADDER APPLIANCES:

- ❑ Indwelling catheter (including suprapubic catheter and nephrostomy tube)
  Dx:_____
  Type:_____ Date:____/____/____
- ❑ External (condom) catheter
- ❑ Ostomy (including urostomy, ileostomy, and colostomy)
- ❑ Intermittent catheterization

URINARY TOILETING PROGRAM:

- ❑ Bladder retraining
- ❑ Scheduled toileting
- ❑ Prompted voiding
- ❑ Does not use toilet/commode/urinal
- ❑ Pads/briefs utilized

URINARY CONTINENCE:

- ❑ Always continent
- ❑ Occasionally incontinent (less than 7 episodes of incontinence)
- ❑ Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
- ❑ Always incontinent (no episodes of continent voiding)
- ❑ Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

BLADDER SYMPTOMS:

- ❑ Burning
- ❑ Discharge
- ❑ Retention/distention
- ❑ Nocturia
- ❑ Frequency/urgency
- ❑ Pain with voiding
- ❑ Hematuria

Comments:_____

BOWEL — Section H

BOWEL SOUNDS:

- ❑ Present
- ❑ Hyperactive
- ❑ Absent
- ❑ Hypoactive

Comments:_____

BOWEL CONTINENCE:

- ❑ Always continent
- ❑ Occasionally incontinent (one episode of bowel incontinence)
- ❑ Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
- ❑ Always incontinent (no episodes of continent bowel movements)
- ❑ Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days

BOWEL TOILETING PROGRAM:

Is a toileting program currently being used to manage the resident's bowel continence?

- ❑ No
- ❑ Yes

BOWEL (Cont'.d) — Section H

BOWEL PATTERNS:

- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Enema/suppository
- ❑ Fissures/fistulas

Comments:_____

HEART/CIRCULATION — Section I

- ❑ Regular rhythm/WNL
- ❑ Radial pulse irregular
- ❑ Apical pulse irregular

EDEMA:

- ❑ Dependent
- ❑ Pitting: +1
- ❑ Pedal: Lt
- ❑ Pitting: +2
- ❑ Pedal: Rt
- ❑ Pitting: +3
- ❑ Abnormal peripheral pulses
- ❑ Pitting: +4
- ❑ Vertigo/dizziness
- ❑ Weight increase

RESPIRATORY:

- ❑ Normal
- ❑ SaO_2 _____% _____% _____%
- ❑ Labored breathing
- ❑ Nebulizer Tx
- ❑ Shallow respirations
- ❑ Suctioning
- ❑ Rales/rhonchi
- ❑ Tracheostomy/care
- ❑ Wheezing
- ❑ Ventilator/care
- ❑ Cough
- ❑ BiPAP/CPAP
- ❑ Orthopnea
- ❑ O_2 @_____L/minute
  - ❑ PRN
  - ❑ Nasal cannula
  - ❑ Continuous
  - ❑ Mask

Comments:_____

PAIN INTENSITY — Section J

NUMERIC RATING (00-10) _____ (Enter 99 if unable to answer)

VERBAL DESCRIPTOR SCALE

- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Very severe, horrible
- ❑ Unable to answer

Comments:_____

PAIN MANAGEMENT — Section J

- ❑ No pain
- ❑ Pain within past **5 days**
- ❑ Scheduled pain management regimen
- ❑ Received PRN medications
- ❑ Received non-medication pain interventions

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' SUMMARY: SEVEN DAY LOOK BACK

PAIN MANAGEMENT (Cont'd.) — Section J

INDICATORS OF PAIN OR POSSIBLE PAIN:

- ❑ Non-verbal sounds (crying, whining, gasping, moaning, or groaning)
- ❑ Vocal complaints of pain (that hurts, ouch, stop)
- ❑ Facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ❑ Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)

FREQUENCY OF PAIN INDICATORS:

- ❑ Indicators of pain/possible pain observed 1 to 2 days
- ❑ Indicators of pain/possible pain observed 3 to 4 days
- ❑ Indicators of pain/possible pain observed daily

Comments:_____

_____

_____

OTHER HEALTH CONDITIONS — Section J

- ❑ None
- ❑ Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring)
- ❑ Shortness of breath or trouble breathing when sitting at rest
- ❑ Shortness of breath or trouble breathing when lying flat
- ❑ Current tobacco user
- ❑ Life expectancy of less than 6 months
- ❑ Fever
- ❑ Vomiting
- ❑ Dehydrated
- ❑ Internal bleeding

Comments:_____

_____

_____

FALL HISTORY — Section J

- ❑ Fall any time in the **last month** prior to admit or reentry
- ❑ Fall any time in the **last 2-6 months** prior to admit or reentry
- ❑ Fracture related to fall in the **6 months** prior to admit or reentry
- ❑ Fall **since admit/reentry** or **prior assessment**

Coding:

0. **None**
1. **One**
2. **Two or more**

___ No injury (no evidence of any injury noted or physical assessment by nurse or primary care clinician; no complaints of pain or injury by the resident; no change in resident behavior noted after the fall)

___ Injury – except major (skin tears, lacerations, superficial bruises, hematomas and sprains; any fall-related injury that causes resident to complain of pain)

___ Major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma)

Comments:_____

_____

_____

SWALLOWING/NUTRITIONAL STATUS — Section K

SWALLOWING DISORDER:

- ❑ Loss of liquids/solids from mouth when eating or drinking
- ❑ Holding food in mouth/cheeks or residual food in mouth after meals
- ❑ Coughing or choking during meals or when swallowing medications

WEIGHT LOSS:

- ❑ Loss of 5% or more in last month or loss of 10% or more in last 6 months
  - ❑ On physician-prescribed weight-loss regimen
  - ❑ Not on physician-prescribed weight-loss regimen
- ❑ Gain of 5% or more in last month or gain of 10% or more in last 6 months
  - ❑ On physician-prescribed weight-gain regimen
  - ❑ Not on physician-prescribed weight-gain regimen

NUTRITIONAL APPROACHES:

- ❑ Parenteral/IV feeding
  - ❑ While not a resident
  - ❑ While a resident
- ❑ Feeding tube – nasogastric or abdominal (PEG)
  - ❑ While not a resident
  - ❑ While a resident
- ❑ Mechanically altered diet (pureed foods, thickened liquids)
  - ❑ While not a resident
  - ❑ While a resident
- ❑ Therapeutic diet (low salt, diabetic, cholesterol)

PERCENT INTAKE BY ARTIFICIAL ROUTE:

- ❑ While not a resident (select one % and one fluid intake when applicable)
  - ❑ 25% or less
  - ❑ 26-50%
  - ❑ 51% or more
  - ❑ 500 cc/day or less fluid intake via IV or tube feeding
  - ❑ 501 cc/day or more fluid intake via IV or tube feeding
- ❑ While a resident (select one % and one fluid intake when applicable)
  - ❑ 25% or less
  - ❑ 26-50%
  - ❑ 51% or more
  - ❑ 500 cc/day or less fluid intake via IV or tube feeding
  - ❑ 501 cc/day or more fluid intake via IV or tube feeding
- ❑ During entire 7 days (select one % and one fluid intake when applicable)
  - ❑ 25% or less
  - ❑ 26-50%
  - ❑ 51% or more
  - ❑ 500 cc/day or less fluid intake via IV or tube feeding
  - ❑ 501 cc/day or more fluid intake via IV or tube feeding

Comments:_____

_____

_____

_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' SUMMARY: SEVEN DAY LOOK BACK

ORAL/DENTAL STATUS — Section L

- ❑ All natural teeth present, intact
- ❑ Dentures
  - ❑ Partial ❑ Full upper ❑ Full lower
- ❑ Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
- ❑ Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
- ❑ Obvious or likely cavity of natural teeth
- ❑ Inflamed or bleeding gums
- ❑ Loose or broken natural teeth
- ❑ No natural teeth or tooth fragment(s) (edentulous)
- ❑ Normal mouth tissue (pink and moist)
- ❑ Mouth or facial pain, discomfort or difficulty with chewing
- ❑ Unable to examine

Comments:_____

_____

_____

SKIN CONDITIONS — Section M

DETERMINATION OF PRESSURE ULCER RISK:

- ❑ Stage 1 or greater, scar over bony prominence, or a non-removable dressing/device
- ❑ Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- ❑ Clinical assessment
- ❑ No determination of risk

RISK OF PRESSURE ULCERS:

- ❑ At risk for developing pressure ulcers
- ❑ Not at risk for developing pressure ulcers

UNHEALED PRESSURE ULCER STAGE 1 OR HIGHER:

- ❑ No ❑ Yes

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE:

___ Number of unhealed Stage 1 pressure ulcers

___ Number of unhealed Stage 2 pressure ulcers

- ___ Number of Stage 2 ulcers present on admit/entry or reentry
- Date of oldest Stage 2 __ __/__ __/__ __ __ __

___ Number of unhealed Stage 3 pressure ulcers

- ___ Number of Stage 3 ulcers present on admit/entry or reentry
- ___ ___.___ Pressure ulcer length of largest Stage 3 (head to toe)
- ___ ___.___ Pressure ulcer width of largest Stage 3 (side to side perpendicular) – same ulcer
- ___ ___.___ Pressure ulcer depth of largest Stage 3 (visible surface to deepest area) – same ulcer

___ Number of unhealed Stage 4 pressure ulcers

- ___ Number of Stage 4 ulcers present on admit/entry or reentry
- ___ ___.___ Pressure ulcer length of largest Stage 4 (head to toe)
- ___ ___.___ Pressure ulcer width of largest Stage 4 (side to side perpendicular) – same ulcer
- ___ ___.___ Pressure ulcer depth of largest Stage 4 (visible surface to deepest area) – same ulcer

SKIN CONDITIONS (Cont'd.) — Section M

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE (Cont'd.):

- ❑ Unstageable: non-removable dressing
  - ___ Number of unstageable pressure ulcers due to non-removable dressing/device
  - ___ Number present on admission/entry or reentry
- ❑ Unstageable: slough and/or eschar
  - ___ Number of unstageable pressure ulcers due to slough and/or eschar covering the wound bed
  - ___ Number present on admission/entry or reentry
- ❑ Unstageable: deep tissue
  - ___ Number of unstageable pressure ulcers with suspected deep tissue injury in evolution
  - ___ Number present on admission/entry or reentry
- ❑ Venous and arterial ulcers
  - ___ Number of venous and arterial ulcers present

MOST SEVERE TISSUE TYPE FOR ANY PRESSURE ULCER:

- ❑ Epithelial tissue (new skin growing in superficial ulcer can be light pink and shiny even with darkly pigmented skin)
- ❑ Granulation tissue (pink or red tissue with shiny, moist granular appearance)
- ❑ Slough (yellow or white tissue that adheres to ulcer bed in strings or thick clumps or is mucinous)
- ❑ Eschar (black, brown or tan tissue that allows firmly to wound bed or ulcer edges, may be softer or harder than surrounding skin)

OTHER ULCERS, WOUNDS, SKIN PROBLEMS

- ❑ Infections of the foot (cellulitis, purulent drainage)
- ❑ Diabetic foot ulcers
- ❑ Other open lesion(s) on the foot
- ❑ Open lesion(s) other than ulcers, rashes, cuts
- ❑ Surgical wound(s)
- ❑ Burn(s) (second or third degree)
- ❑ Skin tear(s)
- ❑ Moisture Associated Skin Damage – MASD (incontinence, perspiration, drainage)
- ❑ Rashes
- ❑ Abrasions
- ❑ No skin problems

SKIN AND ULCER TREATMENTS:

- ❑ Pressure reducing device for chair
- ❑ Pressure reducing device for bed
- ❑ Turning/repositioning program
- ❑ Nutrition or hydration intervention (to manage skin problems)
- ❑ Pressure ulcer care
- ❑ Surgical wound care
- ❑ Application of nonsurgical dressings (with/without topical medications/other than to feet)
- ❑ Applications of ointments/medications other than to feet
- ❑ Application of dressings to feet (with/without topical medications)
- ❑ No skin and/or ulcer treatments

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' SUMMARY: SEVEN DAY LOOK BACK

SKIN CONDITIONS (Cont'd.) — Section M

SURGICAL WOUND SITE:

❑ Dressing present
❑ Surgical site intact (staples, sutures)
❑ No signs of infection (redness, warmth, edema, drainage)
Comments:_____
_____
_____

FOOT CARE:

❑ Toenails trimmed ❑ Application of dressings/corn pads
❑ Seen by podiatrist ❑ Special shoes/inserts/orthotics used

MEDICATIONS — Section N

INJECTIONS:

❑ No injections during the past 7 days
___ Number of days received injection of any type
___ Number of days received insulin injection
___ Number of days insulin orders were changed

MEDICATIONS RECEIVED (record number of days):

___ Antipsychotic ___ Antidepressant
___ Antianxiety ___ Hypnotic
___ Anticoagulant (warfarin, heparin, low-molecular weight heparin)
___ Antibiotic ___ Diuretic

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS — Section O

❑ Chemotherapy ❑ BiPAP/CPAP
❑ Radiation ❑ IV medications
❑ Oxygen therapy ❑ Transfusions
❑ Suctioning ❑ Dialysis
❑ Tracheostomy care ❑ Hospice care
❑ Ventilator or respirator ❑ Respite care
❑ Isolation or quarantine for active infectious disease
❑ Received no special treatments, procedures and/or programs

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (Cont'd.) — Section O

RESTORATIVE NURSING PROGRAMS (record number of **days** restorative program performed for at least 15 minutes)

___ Passive range of motion
___ Active range of motion
___ Splint or brace assistance
___ Bed mobility
___ Transfer
___ Walking
___ Dressing and/or grooming
___ Eating and/or swallowing
___ Amputation/prosthesis care
___ Communication
Comments:_____
_____
_____
_____

RESTRAINTS — Section P

Coding:

0. **Not used**
1. **Used less than daily**
2. **Used daily**

USED IN BED:

___ Bed rail
___ Trunk restraint
___ Limb restraint
___ Other

USED IN CHAIR OR OUT OF BED:

___ Trunk restraint
___ Limb restraint
___ Chair prevents rising
___ Other

PARTICIPATION IN SUMMARY

❑ Resident ❑ Dialysis staff ❑ Guardian or legal representative
❑ Family ❑ Significant other ❑ Clergy
❑ Staff members ❑ Hospice staff ❑ Other (specify:_____)

OTHER COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature/Title_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed