

## Instructions for Completing Long Term Care Resident Assignment Worksheet

This is your resident assignment worksheet patient for long term care. There is one resident per worksheet. The worksheets are to be completed prior to the start of pre conference at 0630. Complete all areas as follows:

- #1 - Fill in this section completely. This information is found in the resident's chart.
- #2 - Complete the Hearing and Sight sections. Write the mobility status of your Resident and all Treatments ordered. Write the assessments to be done based on the needs of your resident. Write the findings of your assessments in the "Nurse's Notes" section of the "Daily Assessments," on the days the assessments are completed. Significant change in behavior/condition or progress may also be documented in "Nurse's Notes."
- #3 - Fill in the medications as ordered. Write in the precautions (i.e., fall, swallowing, seizure, etc.) and highlight.
- #4 - Write in the vital signs schedule. Complete one full set of vital signs while caring for your residents. Complete the pain assessment every 4 hours, or more often, during the course of care as care is completed. Differentiate Resident's pain rating before and after non-pharmacological/ pharmacological pain interventions by diagonal line through the square ( i.e., 

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 ). Write in Resident's activity.
- #5 - Write in the blood glucose values at the designated times as ordered. Write in the oxygen method of delivery and the number of liters per minute. Write in your drug level lab values for quick reference. All Lab values are written on the "Normal Lab Studies Values" sheet. Write in the type of PO diet or place a ✓ if enteral. Circle the route of enteral feeding. Write the type of formula, rate of infusion and amount of water to be given. Circle whether your resident is continent or incontinent. Place a ✓ to indicate urine or bowel continence or incontinence.
- #6 - Select the priority nursing diagnosis and complete 1<sup>st</sup> level assessment, 2<sup>nd</sup> level assessment, nursing diagnosis and goal with goal outcomes.
- #7 - Check or circle those activities that apply or write "no" if the activity doesn't apply. Write a note under "Other" to describe what other/alternate activity your resident will be doing.
- #8 - Write in the date, time, type/purpose and location of the scheduled appointment in designated areas. If your resident's appointment is outside the facility, you must document the departure and return time. Document the driver is under "Comments" (i.e., facility driver or specific family member such as daughter).
- #9 - This section is to be completed daily as you complete care. Write in the dates for each day of care. Write the start and stop times for the process recordings. Place a ✓ to indicate the level of consciousness. Write the number of times the Resident is oriented. Place a ✓ if your resident is confused. Under comments, write in the areas that your Resident is oriented. For intake, document the percentage of PO meals eaten / then the amount of fluid in ounces or milliliters. For enteral feeding, record the total amount of formula infused for the shift. Indicate that the NG tube or G-tube has been checked for placement by marking a ✓ next to placement (when applicable). Record the amount of urine output and the number of bowel movements by marking a ✓ for each void and each bowel movement. Write a nurse's note for any variances.

### Instructions for Completing Report Sheet

- #1-8 - Fill in all information requested for each resident during report. If the information is not given to you during report, ask for it. Write any comments during report under "Comments." The report sheet covers 4 days of report for both residents.

Student Name: \_\_\_\_\_ Write in your name

## Long Term Care Resident Assignment Worksheet Week        Write week #

**Course:** (Course #)      **Site:** (Fill in Facility Name)      **Unit:** (Fill in Unit Assigned)      **Date(s):** (Fill in Dates)

Rm.#: _____ Pt. Initials: _____ Age: _____ Adm. Date: _____ Dx: _____ PMH: _____ <span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">1</span> Soc. Hx: _____ Wt.: _____ LOC: Awake ___ Alert ___ Responsive ___; Mental Status: Oriented x ___ Confused ___ Allergies: _____ Immunizations: _____ Code Status: DNR in Chart: Yes No Full Code: _____ Medical Directives: _____ MD: _____ RN _____	<b>Special Needs:</b> Hearing: R ___ L ___ Bilat: ___ Hearing Aid: _____ Sight: OD ___ OS ___ OU ___ Glasses: _____ Mobility: _____ Treatments: _____ <span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">2</span> Assessments: _____
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<b>Comments:</b> Meds:      Dose      Route      Time  <div style="border: 1px solid black; width: 100px; height: 100px; margin: 10px auto; border-radius: 50%; text-align: center; line-height: 100px;">3</div> Precautions: _____	Vital Signs: Q _____ T _____ P _____ R _____ BP _____  Pain      08      12 Day 1 <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Day 2 Day 3 Day 4 Activity: _____									Glucose: 07 _____ 1130 _____ O <sub>2</sub> via _____ @ _____ L/min <span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">5</span> Labs (Levels): _____ Diet: PO _____ Enteral _____ Nutrition: NGT/GT feeding Formula _____ Rate: _____ mL/hr; H <sub>2</sub> O _____ mL Check: Tube placement & Residual q shift Output: Continent / Incontinent Urine: _____ Bowel _____ Other: _____

1 <sup>st</sup> Level Assessment	2 <sup>nd</sup> Level Assessment	Nursing Dx	Goal	Daily Activities
	6		As Evidenced By: 1) _____ 2) _____ 3) _____	Hospitality Room/TV Room: am ___ pm ___ Dining Hall: Breakfast Lunch Dinner Toss ball @ 0900 _____ Physical Therapy _____ Scheduled Morning Activity @ 1000 _____ Mass @ 1100: Chapel ___ TV ___ Restroom after lunch _____ Afternoon Activity @ 1300 _____ Other: _____

Scheduled Appointments <span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">8</span>					
Date	Time	Type/Purpose	Location	Departure / Return Time	Comments

Daily Assessments <span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">9</span>			
Day 1	Day 2	Day 3	Day 4
Date: _____ Process Recording: Start _____ Stop _____ LOC: Awake ___ Alert ___ Responsive ___ Mental Status: Oriented x ___ Confused ___ Comments: Intake: PO ___ / ___ Enteral ___ NGT/GT: Placement ___ Residual ___ Output: Urine ___ BM ___	Date: _____ Process Recording: Start _____ Stop _____ LOC: Awake ___ Alert ___ Responsive ___ Mental Status: Oriented x ___ Confused ___ Comments: Intake: PO ___ / ___ Enteral ___ NGT/GT: Placement ___ Residual ___ Output: Urine ___ BM ___	Date: _____ Process Recording: Start _____ Stop _____ LOC: Awake ___ Alert ___ Responsive ___ Mental Status: Oriented x ___ Confused ___ Comments: Intake: PO ___ / ___ Enteral ___ NGT/GT: Placement ___ Residual ___ Output: Urine ___ BM ___	Date: _____ Process Recording: Start _____ Stop _____ LOC: Awake ___ Alert ___ Responsive ___ Mental Status: Oriented x ___ Confused ___ Comments: Intake: PO ___ / ___ Enteral ___ NGT/GT: Placement ___ Residual ___ Output: Urine ___ BM ___
Nurse's Notes	Nurse's Notes	Nurse's Notes	Nurse's Notes

Student Name: \_\_\_\_\_

## Long Term Care Resident Assignment Worksheet

**Course:** \_\_\_\_\_ **Clinical Site:** \_\_\_\_\_ **Unit:** \_\_\_\_\_ **Date(s):** \_\_\_\_\_

<p>Rm.#: _____ Pt. Initials: _____ Age: _____ Adm. Date: _____</p> <p>Dx: _____</p> <p>PMH: _____</p> <p>Soc. Hx: _____ Wt.: _____</p> <p>LOC: Awake ___ Alert ___ Responsive ___; Mental Status: Oriented x ___ Confused ___</p> <p>Allergies: _____ Immunizations: _____</p> <p>Code Status: DNR in Chart: Yes No Full Code: _____ Medical Directives: _____</p> <p>MD: _____ RN _____</p> <p>Comments: _____</p>	<p><b>Special Needs:</b></p> <p>Hearing: R _____ L _____ Bilat: _____</p> <p>Hearing Aid: _____</p> <p>Sight: OD _____ OS _____ OU _____</p> <p>Glasses: _____</p> <p>Mobility: _____</p> <p>Treatments: _____</p> <p>Assessments: _____</p>
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<p><b>Meds:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%;">Dose</th> <th style="width: 15%;">Route</th> <th style="width: 15%;">Time</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> <p><b>Vital Signs:</b> Q _____</p> <p>T _____ P _____ R _____ BP _____</p> <p><b>Pain</b></p> <table style="margin-left: 40px;"> <tr> <td></td> <td style="text-align: center;">08</td> <td style="text-align: center;">12</td> </tr> <tr> <td>Day 1</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Day 2</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Day 3</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Day 4</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p><b>Precautions:</b></p>	Dose	Route	Time					08	12	Day 1	<input type="checkbox"/>	<input type="checkbox"/>	Day 2	<input type="checkbox"/>	<input type="checkbox"/>	Day 3	<input type="checkbox"/>	<input type="checkbox"/>	Day 4	<input type="checkbox"/>	<input type="checkbox"/>	<p>Glucose: 07 _____ 1130 _____</p> <p>O<sub>2</sub> via _____ @ _____ L/min</p> <p>Labs (Levels): _____</p> <p>Diet: PO _____ Enteral _____</p> <p>Nutrition: NGT/GT feeding _____</p> <p>Formula _____</p> <p>Rate: _____ mL/hr; H<sub>2</sub>O _____ mL</p> <p>Check: Tube placement &amp; Residual q shift</p> <p>Output: Continent / Incontinent</p> <p>Urine: _____ Bowel _____</p> <p>Other: _____</p>
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	08	12																				
Day 1	<input type="checkbox"/>	<input type="checkbox"/>																				
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				Hospitality Room/TV Room: am ___ pm ___ Dining Hall: Breakfast Lunch Dinner Toss ball @ 0900 _____ Physical Therapy _____ Scheduled Morning Activity @ 1000 _____ Mass @ 1100: Chapel ___ TV ___ Restroom after lunch _____ Afternoon Activity @ 1300 _____ Other: _____
<p style="text-align: right;">As Evidenced By:</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p>				

### Scheduled Appointments

Date	Time	Type/Purpose	Location	Departure / Return Time	Comments

### Daily Assessments

Day 1	Day 2	Day 3	Day 4
<p><b>Date:</b> _____</p> <p><b>Process Recording:</b></p> <p>Start _____ Stop _____</p> <p>LOC: Awake ___ Alert ___ Responsive ___</p> <p>Mental Status: Oriented x ___ Confused ___</p> <p>Comments: _____</p> <p>Intake: PO ___ / ___ Enteral _____</p> <p>NGT/GT: Placement _____ Residual _____</p> <p>Output: Urine _____ BM _____</p> <p>Nurse's Notes <input type="checkbox"/> _____</p>	<p><b>Date:</b> _____</p> <p><b>Process Recording:</b></p> <p>Start _____ Stop _____</p> <p>LOC: Awake ___ Alert ___ Responsive ___</p> <p>Mental Status: Oriented x ___ Confused ___</p> <p>Comments: _____</p> <p>Intake: PO ___ / ___ Enteral _____</p> <p>NGT/GT: Placement _____ Residual _____</p> <p>Output: Urine _____ BM _____</p> <p>Nurse's Notes <input type="checkbox"/> _____</p>	<p><b>Date:</b> _____</p> <p><b>Process Recording:</b></p> <p>Start _____ Stop _____</p> <p>LOC: Awake ___ Alert ___ Responsive ___</p> <p>Mental Status: Oriented x ___ Confused ___</p> <p>Comments: _____</p> <p>Intake: PO ___ / ___ Enteral _____</p> <p>NGT/GT: Placement _____ Residual _____</p> <p>Output: Urine _____ BM _____</p> <p>Nurse's Notes <input type="checkbox"/> _____</p>	<p><b>Date:</b> _____</p> <p><b>Process Recording:</b></p> <p>Start _____ Stop _____</p> <p>LOC: Awake ___ Alert ___ Responsive ___</p> <p>Mental Status: Oriented x ___ Confused ___</p> <p>Comments: _____</p> <p>Intake: PO ___ / ___ Enteral _____</p> <p>NGT/GT: Placement _____ Residual _____</p> <p>Output: Urine _____ BM _____</p> <p>Nurse's Notes <input type="checkbox"/> _____</p>