6-2-25 Weekly Clinical Update

Back to documentation best practices this week…Thorough and complete documentation is a critical part of licensed nursing care, especially when residents in a nursing home are prescribed antibiotics.

Too frequently, nurse documentation when a resident is ordered an antibiotic looks something like: “Resident continues on ABT. No adverse reactions noted. Temp 98.2”…that’s all there sometimes is included during antibiotic treatment duration.

Let’s discuss what appropriate and thorough documentation looks like…

- Resident Condition Before and During Treatment
    - Document the initial signs and symptoms that led to antibiotic prescription, then specifically describe the resident’s signs and symptoms with each entry
    - Track vital signs, including temperature, blood pressure, and heart rate, to assess responses.
        - And include respiratory assessment if the resident is being treated for a respiratory infection
            - ❖ Symptoms such as cough, fever, shortness of breath, chest pain
            - ❖ Vital signs including:
                - ➢ Temperature
                - ➢ Respiratory rate
                - ➢ Oxygen saturation
                - ➢ Blood pressure
            - ❖ Lung sounds listening for abnormal breath sounds including:
                - ➢ Wheezing
                - ➢ Crackles
                - ➢ Diminished breath sounds
            - ❖ Work of breathing
                - ➢ Nasal flaring
                - ➢ Accessory muscle use
                - ➢ Retractions
            - ❖ Skin and mucous membranes
                - ➢ Cyanosis
                - ➢ Pallor
            - ❖ Notation of most recent diagnostic tests
    - Record any improvement or worsening of symptoms throughout the antibiotic course.
- Medication Administration
    - Record exact time, dosage & method of administration
    - Note prescribing physician, start date and expected duration of treatment
    - Document any missed or delayed doses & reason for such occurrences

    - Note ANY and ALL adverse reactions related to medication administration, including & especially if resident is co-administered:
        - Anticoagulant therapy
        - Antacids & supplements (calcium, magnesium, iron, & zinc)
        - Cardiac medication
            - Amiodarone
            - Beta Blockers
        - Diabetic medications (metformin)
        - CNS depressants (benzodiazepines & opioids)
        - Statins
        - Immunosuppressants
    - Document ANY and ALL side effects & adverse reactions
        - Allergic reactions
            - Rash
            - Swelling
            - Difficulty breathing
        - GI disturbances
            - Nausea/vomiting
            - Diarrhea
            - Cognitive changes
            - Secondary infections such as C. *difficile*
        - Document any adjustments in medications including switching antibiotics or discontinuation of use
- Laboratory & Diagnostic Tests
    - Include relevant lab results such as WBC, UA, wound cultures, chest X-ray results
    - Record any changes in lab values that indicate infection resolution or complications
    - Note physician orders for additional tests related to antibiotic effectiveness
- Resident Response and Nursing Interventions
    - Describe pain levels, mental status, mobility changes during treatment
    - Track hydration & nutritional support (antibiotics may cause loss of appetite or taste perversion)
    - Document any interventions to improve compliance, such as medication reminders or modified administration techniques
- Document education provided to resident and/or family members

It is noted that this list is comprehensive and perhaps considered time consuming…BUT these items for documentation is considered “best practice” and truly does make a positive impact on coordination of care.