Progress notes Selection Criteria					
From	31/08/2024	**To**		**Note Status**	Current
Created By		**Contains**		**Sort by**	DateCreated
Residents	Selected	**Include Un-admitted**	No	**Follow-up Due**	
Unit Name		**Sub-Unit Name**		**Read/Unread**	Unread
Categories:					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6242526			Christine Allen [RN - Registered Nurse]	29/09/2024 21:49:45	Current
Category	*Doctor,Communication				

Note Body

Betty states having had her BO this morning following suppository
Betty's moods remain quite low
Affect appears very sad, at times is teary
Staff often sit and talk with Betty and give comfort to Betty
Betty states she tries hard but doesn't feel she is getting better
Staff continue to assist in cheering Betty up
C/o leg pain tonight stating she thinks it may be her medications
MO continues with regular reviews with Betty

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6242458			Rebecca Phillips [RN - Registered Nurse]	29/09/2024 11:14:02	Current
Category					

Note Body

The following details are saved through the form - Bowel Chart

Bowel Records

Record ID: 64411909 - New
Date: 29/09/2024
Hour: 1100
Minutes: 13
Comments: BNO X 6 DAYS - DUROLAX SUPP GIVEN

Commented By : Rebecca Phillips [RN - Registered Nurse] on 29/09/2024 11:15:

Betty told staff she has not opened bowels for 6 days
Abdomen is soft and bowel sounds present
PR examination attended with consent
Soft faceas in rectum
Betty had tried to pass motion but could not

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6242375			Kerry kliendiensnt [RN - Registered Nurse]	28/09/2024 15:46:06	Current
Category					

Note Body

Betty had breakfast in bed
has ventured out and around facility before lunch
does not look as flat in affect today

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6242228			Frank Reed [Doctor - GP]	27/09/2024 17:54:13	Current
Category	*Doctor				

Note Body

No change in depression .
Gets dizzy when she walks medium distances.
Bloods reviewed:
1 Hb improved post Fe injection
2 Ferritin 616 - was 24
3 CRP risen from 8.9 to 20.8
.
OE Abdo ?bloated No masses BS normal No renal tenderness
Heart NAD Lungs clear No nodes in neck or axillae
.
?Cause of CRP ?neoplasm ?Inflammatory process
.
Discussion re antidepressant Rx - was on Tryptanol many tears ago. No side effects recalled. Aware of its sedating properties.
Willing to try a course. Start at 10mg .Gradually cease Venlafaxine

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241772			Sandy Rouse [Enrolled Nurse]	25/09/2024 11:58:34	Current
Category	Wound care				

Note Body

The following details are saved through the form - Wound / Skin Management Plan and Evaluation

Wound & Skin (acute) Management Plan & Evaluation Records

Record ID: 64362752
Frequency of dressing change. (E.g. Every three (3) days).: Weekly

Date the wound check or dressing change is next due (as per the frequency indicated).: 02/10/2024
Date the wound photo is next due. (This may not always be at the same time the wound check or dressing change is due).: 02/10/2024

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241602			Agency RN [RN - Registered Nurse]	24/09/2024 10:36:37	Current
Category	Medication				

Note Body

Contact made with Raymond's regarding new webster pack.
Was meant to be delivered Monday - Raymond's has ensured it will be delivered this afternoon.

RN - K.Coombes

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241492			Agency RN [RN - Registered Nurse]	23/09/2024 14:04:03	Current
Category	Pain Management				

Note Body

Betty has been in good spirits most of day
c/o of abdominal pain after lunch - abdo soft when palpated
Heat pack offered - refused
resting on bed

RN - K.Coombes

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241422			Lolobeth Amoroto Toepfer [NA - Nurse Assistant]	23/09/2024 05:03:08	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64387910 - New
Date: 23/09/2024
Hour: 0500
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241320			Kerry kliendiensnt [RN - Registered Nurse]	22/09/2024 08:34:28	Current
Category					

Note Body

Betty not feeling the best complained of feeling a bit dizzy and not able to get out of bed today, breakfast in bed given . RN was attending to obs and BTF. DR Reed rang to enquire about Bettys condition today. he talked to her and has written up prn anti spasmodic medication for her. he will call this pm to check again

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241275			Christine Allen [RN - Registered Nurse]	21/09/2024 19:22:54	Current
Category					

Note Body

The following details are saved through the form - Weight & Vital Signs

Pulse (bpm) : 75.0
BP - Systolic (mmHg) : 139.0
BP - Diastolic (mmHg) : 84.0
Temp (°C) : 35.5
Resps. (pm) : 18.0
SO2 : 94.0
Notes : Unwell. low mood, teary
Time : 17:40

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241274			Christine Allen [RN - Registered Nurse]	21/09/2024 19:21:35	Current
Category					

Note Body

The following details are saved through the form - Weight & Vital Signs

Pulse (bpm) : 97.0
BP - Systolic (mmHg) : 149.0
BP - Diastolic (mmHg) : 81.0
Temp (°C) : 35.7
Resps. (pm) : 18.0
SO2 : 98.0
Time : 15:50

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241273			Christine Allen [RN - Registered Nurse]	21/09/2024 19:12:39	Current
Category	Communication,Medication				

Note Body

Betty c/o pain this evening
Panadol X 2 administered for same
Betty states pain in abdo area
C/o loose BO
Betty's moods observed very low
Appears sad and teary
States feeling useless, weak and exhausted
Comforted by staff
Contacted Doctor Reed regarding same as Betty has had a change in medications which may be the cause of further decline in mood
Doctor Reed considered may be the cause
Doctor has ceased citalopram and will contact psych geriatrician for advice
Observations attended, all WNP for Betty

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241211			Kerry kliendiensnt [RN - Registered Nurse]	21/09/2024 08:32:42	Current
Category					

Note Body

The following details are saved through the form - Weight & Vital Signs

Pulse (bpm) : 75.0
BP - Systolic (mmHg) : 158.0
BP - Diastolic (mmHg) : 73.0
Temp (°C) : 36.0
Resps. (pm) : 18.0
BGL (mmol/l) : 6.8
SO2 : 99.0
Time : 08:15

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6241210			Kerry kliendiensnt [RN - Registered Nurse]	21/09/2024 08:31:55	Current
Category					

Note Body

Staff report that betty was walking back to room after breakfast and went pale and felt faint
On examination betty looks pale and has had a small vomit
temp 36, BP 158/73 and HR 75 regular, RR18. Sp02 99% r/a. BGL 6.8mmol.
medications had been given prior to food. advised staff to give medications with food and continue to monitor as had recent change in medications

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240901			Frank Reed [Doctor - GP]	19/09/2024 18:28:25	Current
Category	*Doctor				

Note Body

Fluctuating moods. Depression /anxiety up and down. Nervous when out with people at MVH.
Started new a'depressant 2/7 ago.
Too early to determine any response but looks better and more settled.
Reassured.

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240861			Ashin Johnson [Clinical Nurse Specialist]	19/09/2024 14:59:00	Current
Category	Infection				

Note Body

The following details are saved through the form - Infections

Infection Records

Record ID: 64373792 - New
Date this INFECTION was identified - DO NOT alter this date once chosen: 13/09/2024
Urinary Tract Infection: Yes
UTI - WITHOUT INDWELLING CATHETER: Yes
Change in character of urine: Yes
New or increased burning pain on urination, frequency or urgency: Yes
Organism isolated as confirmed by Pathology: Escherichia Coli
Antibiotics/treatment used and length of time ordered for: TRIMETHOPRIM 300mg, 1 Tab Daily 14/09/2024-20/09/2024
Care Interventions: - Hydration Monitoring- To promote fluid intake
- Observe for Fever, urgency, dysuria, frequency.
- Regular Toileting Assistance

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240860			Ashin Johnson [Clinical Nurse Specialist]	19/09/2024 14:59:00	Current
Category	Infection				

Note Body

New Infection Reported

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240701			Peter McMahon [NA - Nurse Assistant]	19/09/2024 05:33:58	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64372561 - New
Date: 19/09/2024
Hour: 0500
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240569			Sandy Rouse [Enrolled Nurse]	18/09/2024 12:26:19	Current
Category	Wound care				

Note Body

The following details are saved through the form - Wound / Skin Management Plan and Evaluation

Wound & Skin (acute) Management Plan & Evaluation Records

Record ID: 64362752
Date of Wound Review (This will be the date you update every time you check or change the dressing).: 18/09/2024
Date the wound check or dressing change is next due (as per the frequency indicated).: 19/09/2024

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240355			Agency RN [RN - Registered Nurse]	17/09/2024 13:39:09	Current
Category	Incident				

Note Body

The following details are saved through the form - Incident Form

Incident Records

Record ID: 64365282 - New
Date of Incident: 18/09/2024
Witness to Incident: None
Details of incident: Betty stated she knocked her leg on residents bed in R20
What was resident doing at time of incident (if applicable): visiting another resident
Injury Details (if applicable): haematoma present, nil broken areas.

Immediate actions taken: Cold packs applied to reduce swelling. Observe daily.

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240354			Agency RN [RN - Registered Nurse]	17/09/2024 13:39:09	Current
Category	Incident				
Note Body					
New Incident Reported					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240323			Sandy Rouse [Enrolled Nurse]	17/09/2024 09:55:26	Current
Category	Wound care				
Note Body					
The following details are saved through the form - Wound / Skin Management Plan and Evaluation Wound & Skin (acute) Management Plan & Evaluation Records Record ID: 64362752 Date the wound check or dressing change is next due (as per the frequency indicated).: 17/09/2024					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240290			Christine Allen [RN - Registered Nurse]	16/09/2024 21:08:43	Current
Category	*Doctor,Communication				
Note Body					
RN attended to Betty this afternoon Observed lower R) leg haematoma Betty acquired same in room 20 Betty knocked her leg on the end of Audrey's bed Betty alerted staff to incident Staff gave cold packs to reduce swelling and help pain Betty appeared with low mood again Quite teary in evening Commenced on Trimethoprim for 6 days Citalopram delivered this afternoon To commence Tuesday morning					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240289			Christine Allen [RN - Registered Nurse]	16/09/2024 20:59:01	Current
Category	Wound care				
Note Body					
New Wound Reported					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240156			Frank Reed [Doctor - GP]	15/09/2024 17:38:48	Current
Category	*Doctor				
Note Body					
To add to Betty's woes her FOB test x2 were positive. Has had haemorrhoids in the past but they have never bled. Unlikely to be fit enough for scopes etc. Will think about it. Will start new antidepressant tomorrow or Tues. Feels a little better after iron injection - not as faint. For further discussion.					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6240061			Christine Allen [RN - Registered Nurse]	14/09/2024 21:55:10	Current
Category	Communication,Infection,Medication				
Note Body					
Betty remains quite teary and depressed Feels her moods have not improved at all MO suggests that her moods may be exacerbated by UTI Betty had a reaction to Cephalexin which made her itch all over MO changed the antibiotic and scripted Alprim for UTI Ward stock for same commenced this evening RN sat with Betty and discussed her feelings Betty remains very teary Comforted by staff this evening					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6239962			Frank Reed [Doctor - GP]	14/09/2024 11:17:15	Current
Category	*Doctor				
Note Body					
Reacted to Cephalexin with rash - cease and try Trimethoprim for UTI.					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6239895			Frank Reed [Doctor - GP]	13/09/2024 17:37:58	Current
Category	*Doctor				
Note Body					
UTI on last MSU last week .Dens to all A/B's. Still feeling depressed - ?exacerbated by UTI. Start: Citalopram 20mg daily and a 6/7 course of Cefalexin					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238819			Rebecca Phillips [RN - Registered Nurse]	06/09/2024 13:02:35	Current
Category					
Note Body					
Betty was at the dinning table this morning and tolerated her breakfast					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238713			Agency RN [RN - Registered Nurse]	05/09/2024 22:52:34	Current
Category	Infection				
Note Body					
UA collected this PM MSU in fridge (front office collection fridge) Awaiting collection from pharmacy					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238578			Rebecca Phillips [RN - Registered Nurse]	05/09/2024 09:10:27	Current
Category					

Note Body

The following details are saved through the form - Clinical Pathway for Older People in aged care homes: Suspected Urinary Tract Infections (UTI)

Frequency on passing urine : Yes
Final Interpretation : Betty requested a U/A

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238573			Rebecca Phillips [RN - Registered Nurse]	05/09/2024 08:19:49	Current
Category					

Note Body

The following details are saved through the form - Pain Record

Date Abbey pain scale scored:
Pain Assessment / Management Records

Record ID: 64318206 - New
Date: 05/09/2024
Hour: 0800
Minutes: 18
PAINAD / Verbal Rating: 0
Resident's response to action taken (If not resolved, continue assessment): Denied pain

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238572			Rebecca Phillips [RN - Registered Nurse]	05/09/2024 08:18:47	Current
Category					

Note Body

The following details are saved through the form - Weight & Vital Signs

Pulse (bpm) : 76.0
BP - Systolic (mmHg) : 147.0
BP - Diastolic (mmHg) : 76.0
Temp (°C) : 36.3
Resps. (pm) : 20.0
SO2 : 97.0
Time : 08:18

Commented By : Rebecca Phillips [RN - Registered Nurse] on 05/09/2024 09:09:

Betty had a shower this morning and got dressed
She c.o feeling dizzy so went back to bed
She told me she always gets spasms in her lower back but they are more frequent

At present no spasms
Denied dysuria but stated she had frequency of urine
For U/A

Commented By : Rebecca Phillips [RN - Registered Nurse] on 05/09/2024 09:10:

Betty requested a U/A

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238512			Frank Reed [Doctor - GP]	04/09/2024 20:01:53	Current
Category	*Doctor				
Note Body					
Faint feelings this a.m. not long after getting out of bed. felt off most of the day. Unlikely to be related to the Fe injection yesterday. Obs have been good through the day. Sitting watching TV when I visited. Rpt bloods if faint feeling persists.					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238441			Rebecca Phillips [RN - Registered Nurse]	04/09/2024 11:59:13	Current
Category					
Note Body					
The following details are saved through the form - Pain Record Pain Assessment / Management Records Record ID: 64314297 - New Date: 04/09/2024 Hour: 1100 Minutes: 59 PAINAD / Verbal Rating: 0 Resident's response to action taken (If not resolved, continue assessment): Denied pain					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238440			Rebecca Phillips [RN - Registered Nurse]	04/09/2024 11:58:54	Current
Category					
Note Body					
The following details are saved through the form - Weight & Vital Signs Pulse (bpm) : 76.0 BP - Systolic (mmHg) : 148.0 BP - Diastolic (mmHg) : 76.0 Temp (°C) : 36.3 Resps. (pm) : 16.0 BGL (mmol/l) : 5.9					

Time : 11:57

Commented By : Rebecca Phillips [RN - Registered Nurse] on 04/09/2024 12:02:

Betty informed staff she was not well asking if it is related to her IRON infusion tomorrow
Normally Betty walks to dinning room for breakfast but she is staying in her room in her recliner
Betty showered and dressed but thought she was going to go out of it she described
Betty tolerated toast and tea for breakfast and morning cup of tea and water
BNO X 2 DAYS
Betty stated last evening she had wind pain but not now
Advised to rest and press bell when wanting to go to toilet as she will need assistance
CNM notified
Dr Reed is coming in today so to review Betty

Commented By : Rebecca Phillips [RN - Registered Nurse] on 04/09/2024 12:37:

Betty is eating her lunch sitting in her recliner chair

Commented By : Rebecca Phillips [RN - Registered Nurse] on 04/09/2024 14:32:

Betty is asleep in her recliner

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238172			MV AIN [NA - Nurse Assistant]	03/09/2024 05:37:13	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64310200 - New
Date: 03/09/2024
Hour: 0500
Minutes: 00
Code: A - Awake

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238130			MV AIN [NA - Nurse Assistant]	03/09/2024 04:27:48	Current
Category					

Note Body

The following details are saved through the form - Bowel Chart

Bowel Records

Record ID: 64309807 - New
Date: 03/09/2024
Hour: 0400
Minutes: 00

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238094			MV AIN [NA - Nurse Assistant]	03/09/2024 04:24:14	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64309735 - New
Date: 03/09/2024
Hour: 0400
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238058			MV AIN [NA - Nurse Assistant]	03/09/2024 03:14:23	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64309599 - New
Date: 03/09/2024
Hour: 0300
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6238019			MV AIN [NA - Nurse Assistant]	03/09/2024 02:15:59	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64309213 - New
Date: 03/09/2024
Hour: 0200

Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6237980			MV AIN [NA - Nurse Assistant]	03/09/2024 01:16:40	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64309135 - New
Date: 03/09/2024
Hour: 0100
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6237942			MV AIN [NA - Nurse Assistant]	03/09/2024 00:38:38	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64308933 - New
Date: 03/09/2024
Hour: 0000
Minutes: 00
Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6237904			MV AIN [NA - Nurse Assistant]	02/09/2024 23:47:54	Current
Category					

Note Body

The following details are saved through the form - Sleep Assessment

Sleep Assessment Records

Record ID: 64308731 - New
Date: 02/09/2024
Hour: 2300

Code: S - Sleeping

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6237509			Anita Thornton [NA-AR - Nurse Assistant (Advance Role)]	31/08/2024 11:27:51	Current
Category	Communication				
Note Body					
FOB specimen collected and placed in fridge behind reception.					

Note ID	Resident	Facility / Unit / Room	By	Created	Status
6237496			Locum Allied [Allied Health]	31/08/2024 10:00:55	Current
Category	Allied Health,Mobility,Physiotherapy,Transfers				
Note Body					

Physiotherapy Note
S: Physio CP and Ax update.
Consent gained.
O: Betty was sitting in her room upon PT arrival.
Betty was alert, conversant and was cooperative.
Betty was able to push herself up using her hands from sitting to standing
Betty was also able to ambulate with her 4ww with Physio assistance.
Manual handling as follows
Bed Mobility: SV + bed mechanics
Transfers: SV + 4ww
Mobility: SV + 4ww
A: Manual Handling updated.
Physio Ax/ Demmi updated.
Settled well post assessment.
P: Will review accordingly.
Marvin Manucan