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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  |  |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  |  |  |  |
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|  | **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:** | | |  | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 Durolax supp given awaiting effect | | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 1 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 (Had the pos FOB's x2) ?CT abdomen ?trial of Prednisolone | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 of Wound Review (This will be the date you update every time you check or change the dressing).: 25/09/2024 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 2 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | 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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 3 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 4 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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 WNR for Betty | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 5 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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. | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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  - Implement proper Perineal care and promote Hygiene Practice | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 6 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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. Resident transferred to hospital: No | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 7 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 8 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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. | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 9 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | **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. | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 10 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 11 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  |  |  | Progress Notes | | | | | | |  |  | |  |  |
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|  | |  | | --- | | 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 | | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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. | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 SO2 : 95.0 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 12 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | 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  Alert and orientated | | | | | | | | | | | | | | | | | | | | | | |  |  |
|  | |  | | --- | | 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 | | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 Continence: BNO- Bowel Not Open | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 13 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 Minutes: 00 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 14 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | Code: S - Sleeping | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 Minutes: 00 | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 15 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | Code: S - Sleeping | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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. | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **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 Jasda Locum Physio | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 16 | of |  | 17 |  |  |
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|  |  |  | Roshana Care Group - Macleay Valley House Nursing Home | | | | | | |  |  | |  |  |
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|  | Printed By : Process X [RN - Registered Nurse] on 30/09/2024 1:10 PM | | | | | | | | | | | |  |  | Page | |  |  | 17 | of |  | 17 |  |  |