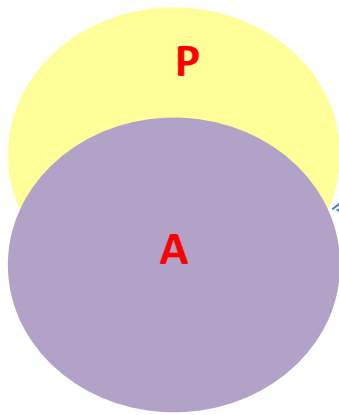


Recording care process

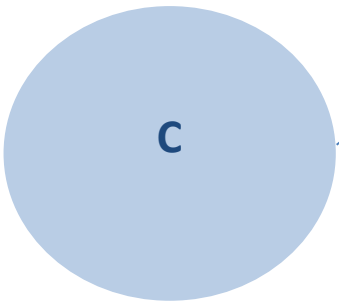
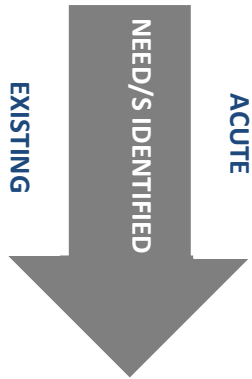


INITIAL

on admission

ONGOING

duration of stay in hospital

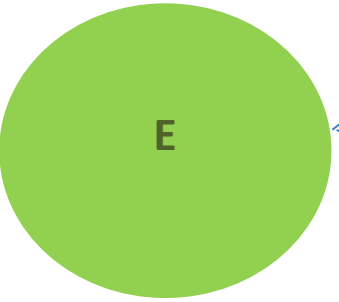
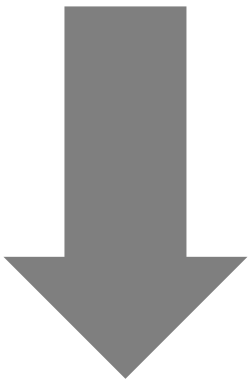


ACUTE

COMPLETE  
Plan of care/treatment/support  
*as need/s identified*

EXISTING

COMPLETE  
*maintenance*  
Plan of care/treatment/support



ACUTE

Continual/contemporaneous  
throughout each shift

EXISTING

Daily (every 24 hours)

## Recording care process for existing needs

- Begins with initial assessment identifying acute and existing needs

*Record in first section of booklet*

- Summarise:

- existing needs & reason for admission highlight the persons baseline - **A**

*Record in – RECORD OF PERSON CENTRED ASSESSMENT, CARE AND EVALUATION*

- Record:

- a maintenance plan to prevent deterioration with the person and obtain consent – **C**
- Evaluate daily (24hours) - **E**

*Record in - RECORD OF PERSON CENTRED ASSESSMENT, CARE AND EVALUATION*

- Record:

- a plan of nursing care for acute needs with the person and obtain consent - **C**
- Evaluate each shift - **E**

*Record in - RECORD OF PERSON CENTRED ASSESSMENT, CARE AND EVALUATION*

- Record ongoing needs as they arise:

- Put a plan of nursing care in place - **C**
- Evaluate the plan – **E**

*Record in - RECORD OF PERSON CENTRED ASSESSMENT, CARE AND EVALUATION*