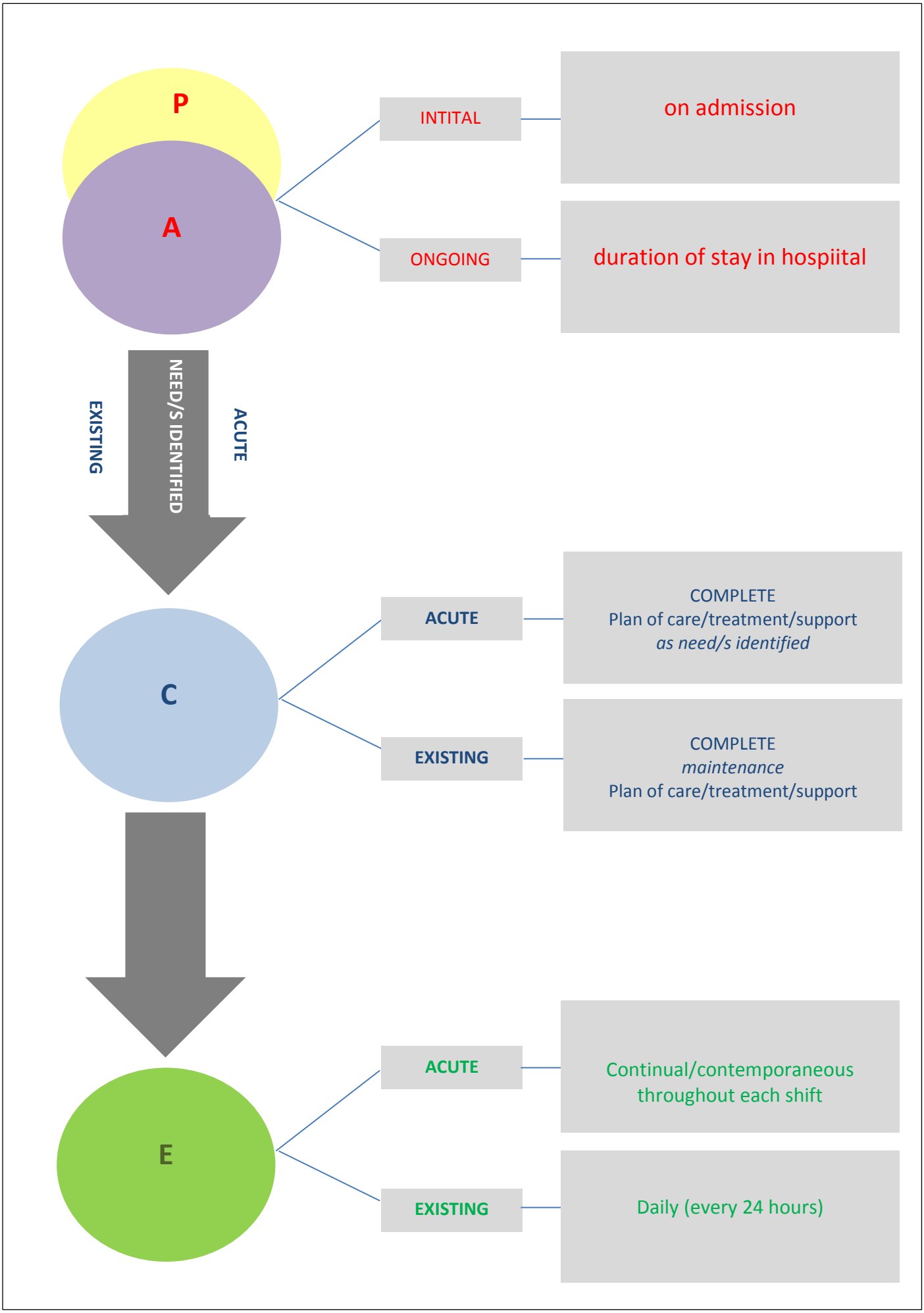
Recording care process



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