

Documentation Assignments

1. Document your initial focused assessment of Jackson Weber.
Jackson was awake, alert, and oriented x4. He had a complaint of no pain on the FACES scale. Jackson stated he felt “dizzy” but denied difficulty breathing or the need to vomit. Vital signs were within normal ranges and phenobarbital 50 mg was given.
2. Identify and document key nursing diagnoses for Jackson Weber.
Impaired gas exchange, risk for aspiration, risk for injury/fall
3. Referring to your feedback log, document the nursing care you provided and Jackson Weber’s response.
I provided pain assessment, education, and administering of scheduled medication. Jackson was compliant with each step.
4. Document the teaching that you would provide for Jackson Weber and his mother before discharge.
I would provide teaching of continuing medications as scheduled, and the importance of getting the phenobarbital levels checked regularly to prevent seizures. I would also teach important safety measures like positioning and measuring the length of time the seizure lasts.
5. Document your handoff report in the situation-background-assessment-recommendation (SBAR) format to communicate what further care Jackson Weber needs.
Dr. ____, this is Cristen Moreno RN, I am calling from ____ hospital about your 5 year old patient Jackson Weber.
He has a history of generalized tonic-clonic seizures and is prescribed oral phenobarbital. He also needed supplemental oxygen via non-rebreather mask at 12 L due to a drop in O2 saturation to 86. He complained of dizziness prior to the seizure. My assessment of the situation concludes that he is currently unconscious due to a 3 minute long seizure and is breathing without difficulty with the supplemental oxygen. I recommend that you see him immediately due to his altered level of consciousness.