## **A-to-Z Documentation Form for Residential Assisted Living**

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| **Resident Information** |
| Name: |  |
| Room Number: |  |
| Date of Incident: |  |
| Time of Incident: |  |
| **A: Alert and Initial Observation** |
| Description of Incident/Observation: |  |
| Immediate Response Taken: |  |
| Staff Member Reporting**:**  |  |
| **B: Brief Assessment** |
| Initial Assessment Findings:  |  |
| Symptoms Observed:  |  |
| Potential Causes Identified (if any): |  |
| **C: Communication and Immediate Actions** |
| Notified Personnel (Physician, Nurse, Supervisor):  |  |
| Family Notified (Yes/No): |  |
| Date/Time of Notifications: |  |
| Immediate Care Actions Taken: |  |
| **D to Y: Detailed Actions, Observations, and Follow-Ups** |
| Medical Interventions (Medications, Treatments): |  |
| Non-Medical Interventions (Comfort Measures, Environment Adjustments.): |  |
| Further Observations (Change in Condition, Responses to Interventions, etc.): |  |
| Consultations (With Healthcare Professionals, Family Discussions, etc.): |  |
| Updates to care Plan:  |  |
| Continued Monitoring Log: |  |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Observation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Actions Taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Additional Notes: |  |
| **Z: Zeroing in on Resolution** |
| Date of Resolution:  |  |
| Summary of Resolution: |  |
| Outcome for Resident: |  |
| Changes to Long-Term-Plan: |  |
| Lessons Learned/Preventive Measures Implemented: |  |
| **Staff Member Completing the Form:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |