DATE:Click here to enter a date. Pt. Initials: RM# Click here to enter text.

Student:Click here to enter text. Allergies:Click here to enter text.

C**heck your assessment data. When you see \*\* you need to document in a narrative note for the patient’s chart further details of the assessment or problem identified, the treatment and the patient’s response to that treatment.**

**Physiologic needs: Oxygenation Glasgow Coma Scale (GCS)**

**Neurological assessment (3-8 Coma severe TBI)(9-12 mod. Disability TBI) (13-15 mild TBI)**

|  |  |  |
| --- | --- | --- |
| **Eye Opening Response** | Spontaneous--open with blinking at baseline | 4 points ☐ |
| Opens to verbal command, speech, or shout | 3 points ☐ |
| Opens to pain, not applied to face | 2 points ☐ |
| None | 1 point ☐  |
| **Verbal Response** | Oriented | 5 points ☐ |
| Confused conversation, but able to answer questions | 4 point s☐  |
| Inappropriate responses, words discernible | 3 points ☐ |
| Incomprehensible speech | 2 points ☐ |
| None | 1 point ☐  |
| **Motor Response**Usually record best arm response | Obeys commands for movement | 6 points ☐ |
| Purposeful movement to painful stimulus | 5 points ☐ |
| Withdraws from pain | 4 points ☐  |
| Abnormal (spastic) flexion, decorticate posture | 3 points ☐  |
| Extensor (rigid) response, decerebrate posture | 2 points ☐ |
| None | 1 point ☐ |



|  |  |
| --- | --- |
| **Pupil Reaction** | B-brisk ☐Equal ☐ Unequal ☐S-Sluggish ☐NR - no reaction ☐C-eye closed by swelling ☐ |
| **Pupil size****(mm)** | **Right** Click here to enter text.**Left** Click here to enter text. |
| **Mentation** | 4-Alert ☐ 3-lethargic ☐ 2-Stuporous ☐ 1-Comatose ☐  |
| **Emotional state** | CA-Calm ☐AN-Anxious ☐CO-Combative ☐AG-agitated ☐ |

 **Total of each section**

 **GCS Total** Click here to enter text.

**2.) Cardio Vascular Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Temp site – record with temp measurement**O-oralR-rectalA-axillaryT-Tympanic | **BP SITE – record where taken**RUA-right upper arm LUA –left upper armRLA-right lower armLLA-left lower armRLL-right lower legLLL-left lower leg**PULSE SITE – record where taken** R-Radial B-Brachial F-femoralA-Apical O-other (location) | **SKIN COLOR**N-Normal for ethnicityF-FlushedP-PaleC-CyanoticM-MottledJ-Jaundice | **SKIN TEMP**H-HotW-warmC-CoolO-Cold | **SKIN PALPATION**D-DryM-MoistC-Clammy/Diaphoretic |
| **TIME** | **Temp** | **BP/Site** | **Pulse rate/site** | **Skin color** | **Skin Temp** | **Skin palpation** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **PULSE SITES – record which pulse sites assessed for pulse strength on each extremity****Upper** : R-radial U-ulnar B-brachial**Lower**: F-femoral P-popliteal DP-dorsalis pedis PT-posterior tibial |  **PULSE STRENGTH**3+Bounding2+Normal1+ WeakD-DopplerA-Absent |  **EDEMA**0-None **Location**TR-Trace H-Hand1+ 3+ A-Arm2+ 4+ F-FootG-Generalized A-AnkleW-\*\* Skin Weeping T-Thigh\*\*Requires further documentation | **CAPILLARY REFILL**B- Brisk (< 3 sec)M- Moderate (>3 sec, <5 sec)S – Sluggish (>5 sec) |
| **Right upper** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Left upper** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Right lower** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Left lower** | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**3.) Pulmonary Assessment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **AIRWAY CODE**N-No Artificial AirwayTR-TracheostomyL-LaryngectomyETT – Endotracheal tube**Trach/ET Tube size:** Click here to enter text.**ET tube placement**Click here to enter text.**cm @ lip line** |  **OXYGEN THERAPY:**NV-Non-Invasive ventilatorTC-Trach CollarNC-Nasal CannulaVM-Venti-MaskNRB-Non-Rebreather MaskRA-Room AirO-Other( requires comment)V – Vent (If vent complete below)**Mode** Click here to enter text. **Rate:** Click here to enter text.**Tidal volume** Click here to enter text.**Peep/pressure support** Click here to enter text. | **SECRETIONS:**S-Small W-WhiteM-Moderate Y-YellowC-Copious G-GreenTN-Thin T-TanTK-Thick F-Foul BT-Blood-Tinged N-None | **Breath Sounds\*\***CL-ClearCR CracklesW-WheezeR-RhonchiD-Diminished**\*\*** Note required to describe breath sounds if other than clear | **INTERVENTION** CPT-Chest PhysiotherapyIS-Incentive SpirometryS-SuctionTC - Trach care (requires note) | **Chest Tube****Lt ☐ RT ☐** Chest tube to suction: ☐No ☐Yes Click here to enter text.cm H20Drainage:Color:Click here to enter text. |
| **TIME** | **RR** | **Air-way** | **O2 therapy** | **O2 Flow** | **Pulse Ox** | **Cough** | **Secretions** | **Breath Sounds** | **Intervention** | **Hx. of SMOKING** |
|  |  |  |  |  |  | ☐No ☐Yes |  |  |  | ☐No ☐Yes |
|  |  |  |  |  |  | ☐No ☐Yes |  |  |  | Packs per dayClick here to enter text. |

**4.) Fluid and Electrolytes Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Skin Turgor: MUCOUS MEMBRANES**N-Normal TD-Tongue Dry P-Poor LD- Lips Dry/Cracked TM – Tongue Moist LM - Lips Moist | **Fluid Intake**Thirst-Presence of thirst Yes ☐No ☐Nausea/ Vomiting\*\*Yes ☐No ☐NPO Yes ☐No ☐Fluid Intake previous 24 hrs. Click here to enter text.\*\*Requires note | **Fluid Restriction Previous 24 hrs.**Yes ☐ No ☐ **Fluid Restriction amt. for 24 hrs. and distribution every shift.** **Total mL** Click here to enter text.**Day shift** Click here to enter text.**Night shift** Click here to enter text. | **IV Infusion****Yes ☐ No ☐****Site Flush****Yes ☐ No ☐****IV D/C \*\*****Yes ☐ No ☐****\*\* Note needed****Continuous medication drip\*\*****Yes ☐ No ☐****\*\* Note needed** |
| **Time**  | **Skin Turgor** | **Mucous Membranes** | **Fluid Intake for shift** | **Fluid allowed for shift** | **IV site location/ Condition/****Pain\*\* Note needed** | **IV Solution and rate** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**5.)** **Nutrition Assessment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ordered Nutrition**R-Regular T-TPN/PPNS-soft P-PureedCL-Clear liquidNPO-Nothing by mouthE-Enteral feeding (type)O-other (specify) | **Dentures**U-UpperL- LowerB- BothO-OwnN-Nonep-Partial | **Nutrition Problems**E-EatingS-SwallowingH-HeartburnT-TasteC-chewingN☐-None | **Change in Weight**Yes\*\* ☐No ☐\*\* Note needed | Other information if needed:**Click here to enter text.** | **Dietary Supplement type**Click here to enter text. |
| **% of meal consumed** | **Ordered nutrition** | **Dentures** | **P**roblems | **Weight** | **Height** | **Dietary Supplement****(Amount taken)** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**6.) Elimination Assessment: 6a. GI Assessment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ABDOMEN INSPECTION:**F-FlatD-DistendedO-ObeseC-Concave **Colostomy**  ☐ Yes\*\* requires note ☐ No |  **BOWEL SOUNDS**3+ Hyperactive2+ Normal1+ Hypoactive0-Absent | **PALPATION**S-SoftF-FirmR-RigidN-GuardingNT-Non-TenderT-Tender | **Bowel movement****Size**S-smallM-mediumL-largeFormedDiarrhea☐ \*\*Bedpan☐Commode☐ | **DRAINAGE COLOR:**G-GreenBR-BrownBL-BlackY-YellowR-RedCG-Coffee GroundN/A-Not applicable | **Nasogastric Tube type:**Salem sump ☐Feeding tube ☐PEG ☐ J-Tube ☐**Placement confirmation method:** Aspiration ☐Air bolus☐ X-ray☐ Date Click here to enter text. | **TUBE SUCTION:**LIS-Low Intermittent SuctionLCS-Low Continuous SuctionG-Gravity DrainageC-Clamped |
| **Time** | **Inspection** | **Bowel****Sounds** | **Palpation** | **BM****(Size, Color****Consistency**) | **Drainage****Color** | **Tube type** | **Tube Location:****(e.g., left nare, RUQ)** | **Tube suction** | **Residual/ amount of drainage or vomit** |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**6b.) GU Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GU CATHETER: type**I-IndwellingS-StraightSP-SuprapubicN-NephrostomyN/A-not applicable |  **URINE COLOR:**Y-Yellow A-Amber N-Colorless B-Brown O-Orange R-RedP-Pale D-Dark | **CLARITY:**C-ClearT-Turbid | **SEDIMENT**P-Present0- None | **TOILETING**S-Self U- Urinal BP- BedpanA-BRP w/assistC-Bedside commodeI-Incontinent @ timesB-incontinence brief |
| **TIME** | **Catheter type** | **Days in place** | **Urine Color** | **Amount voided/emptied** | **Clarity** | **Sediment** | **Toileting** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**7.) Mobility & Activity**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **ROM: RANGE OF MOTION:**A-ActiveP-Passive | **Strength**0-No movement1-Trace2-Movement but not against gravity3-Movement against gravity but NOT against resistance4-Movement against Gravity AND against some resistance5-Full power | **AMBULATION:**S-SelfA-AssistW-WalkerCR-CrutchesCA-CanePT-Physical therapy | **RVS-REDUCED VENOUS STASIS INTERVENTIONS**S-Elastic Stockings onO-Elastic Stockings offA-Ace wrapsM-Sequential Compression Machine F-Foot Pump On | **REPOSITIONING:**R-Right SideL-Left SideS-SupineP-ProneO-OOB to chair | **BED POSITION:**F-FlatL-Low Fowler’sSF-Semi-Fowler’sHF-High-Fowler’sT-TrendelenburgRT-Reverse Trendelenburg |
| **TIME** | **ROM** | **Strength****RU/LU/RL/LL** | **Ambulation** | **Reduced Venous Stasis Interventions** | **Repositioning & time** | **Bed Position** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**8.) Rest and Sleep (Check mark response)**

|  |  |  |
| --- | --- | --- |
| **Assessment of Sleep Pattern**Difficulty falling asleep☐Difficulty staying asleep longer than 4 hrs.☐Uses a prescription sleep aide nightly☐ Drug name: Click here to enter text.Uses an OTC sleep aide, nightly☐ Drug name:Click here to enter text.Denies sleep disturbance.☐ | **Sleep Aides/Methods tried with or without success.** Click here to enter text. | **Patient’s rest, sleep goal:**Click here to enter text. |

**9.) Pain**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DESCRIPTION of PREDOMINANT PAIN:**P-Prickling SH-SharpA-Aching ST-StabbingB-Burning PR-PressureT-Throbbing O-Other | **Pain scale used:****N-Numeric****F-Faces****P- PAINAD****V-Verbal descriptor** | **FREQUENCY of Pain:** C-ConstantE-EpisodicWM with MovementWB with breathing | **What worked in the past?**Click here to enter text. |  **INTERVENTIONS:** P-Pharmacological H-Heat R -Relaxation C-Position for comfort I-Imagery E-Emotional Support D-Distraction Q-Quiet EnvironmentM-Massage O-Other  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TIME** | **Location** | **Description** | **Intensity (0-10) and scale used** | **Frequency** | **Intervention****\*\* Note required** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |



 0 1 2 3 4 5 6 7 8 9 10

 No Pain Mild Pain Moderate Pain Severe Pain Worse possible pain

**PAINAD scale (Pain Assessment in Advanced Dementia) Use as necessary only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | 1 | 2 | 3 | Score |
| **Breathing independent of vocalization** | **Normal** | **Occasional labored breathing. Short period of hyperventilation** | **Noisy labored breathing. Long period of hyperventilation. Cheynes-Stokes respirations** | Click here to enter text. |
| **Negative vocalization** | **None** | **Occasional moan or groan. Low level speech with a negative or disapproving quality** | **Repeated troubling calling out. Loud moaning or groaning. Crying.** | Click here to enter text. |
| **Facial expression** | **Smiling or inexpressive** | **Sad, frightened, frown** | **Facial grimacing** | Click here to enter text. |
| **Body language** | **Relaxed** | **Tense. Distressed pacing. Fidgeting** | **Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.** | Click here to enter text. |
| **Consolability** | **No need to console** | **Distracted or reassured by voice or touch** | **Unable to console, distract or reassure** | Click here to enter text. |

 **Total** Click here to enter text.

**10.) Safety and Security needs - Skin and Safety Assessments (Describe wound dressings in note)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SKIN CONDITION:**I-IntactN-Non-Intact \* \*(Requires further documentation)**WOUND TYPE:**P-Pressure ulcer S-Surgical woundL-Laceration A-AbrasionE-Ecchymosis R-Rash **SURGICAL DRAINS**Yes\*\* ☐ \*\* Note neededNo ☐ | **DESCRIPTION**B-Blanching ErythemaStage I (Non-Blanching Erythema )Stage II: (Skin open to superficial layer)Stage III (Skin open to SC tissue layer)Stage IV (Skin open to muscle or bone)U-Unstageable – Eschar presentDTI-Deep tissue injury | **BATH**C-CompleteP-PartialS-SelfA-Assist | **SIDE RAILS:**4-4 Rails Up3-3 Rails Up2-2 Rails Up1-1 Rail Up0- Side Rails   | **\*\*BRADEN SCALE SCORE#\_\_\_\_\_** **HIGH ☐****MED ☐****LOW ☐****\*\*FALL RISK Score # \_\_\_\_\_****HIGH ☐** **MED ☐** **LOW ☐****Fall risk scale used** Click here to enter text. |
| **Wound type/Size (cm)/Location** | **Surgical drain type and location** | **Description (wound and drainage)** | **Bath** | **Side rails** |  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Love and Belonging needs**

**11.) Psychosocial Assessment**

|  |
| --- |
| **Client report of Family/Friends:**Click here to enter text. **Next of Kin (Ask)\_**Click here to enter text.**Religious Affiliation\_**Click here to enter text. **Indicators—Cards ☐ Flowers ☐ Family Photos☐ Additional Data**Click here to enter text. |

**Self-Esteem needs**

|  |
| --- |
| **Family Role\_**Click here to enter text. **Grooming equipment at bedside:** **Occupation**Click here to enter text. **Brush/Comb ☐ Toothbrush ☐ Toothpaste☐ Other** Click here to enter text. **Toiletries:**Click here to enter text. **Interest in appearance\_**Click here to enter text.**Additional Data:**Click here to enter text. |

**Self-Actualization needs**

|  |
| --- |
| **Client report of satisfaction with life:** Click here to enter text.**Independence:**Click here to enter text.**Creativity:**Click here to enter text.**Additional Data:** Click here to enter text. |
| **ERICKSON’S STAGE OF DEVELOPMENT: (1) State the Developmental Stage the client is exhibiting. (2) Include what part of the stage best represents the client’s behavior and WHY you feel this is the part of the stage the client is exhibiting? (**Make sure you explain your decision process in your explanation.)Click here to enter text. |