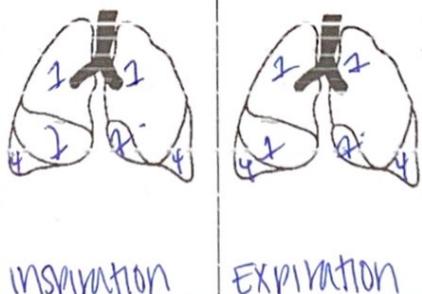


PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+-Bounding unable to occlude 2+-Strong able to occlude 1+-Weak palpable 0-Non palpable Extremities: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>53</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>1+</u> L <u>1+</u> Post. Tib. R _____ L _____ Comments: _____	Family at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Drowsy Cough Reflex <input type="checkbox"/> Y <input type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt <u>W</u> Lt <u>W</u> Pushes: Rt <u>W</u> Lt <u>W</u> Comments: _____ Response to Questions: <input type="checkbox"/> Readily <input checked="" type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input type="checkbox"/> Friendly <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry <input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned Facial expressions: <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Seizure Treatment Done for Neuro Assessment Comments: _____	Edema: <input type="checkbox"/> Generalized <input checked="" type="checkbox"/> Dependent Pitting: <input checked="" type="checkbox"/> 0 Y <input type="checkbox"/> N <input checked="" type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> PPM Site: <u>left subclavian</u> Rhythm: <u>irregular</u> PACER SETTINGS <input type="checkbox"/> None Rate _____ MA: A _____ Y _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N Permanent Pacemaker Site <input checked="" type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular INCISIONS/WOUNDS/DRAINS <input type="checkbox"/> None #1 Location: <u>left hand</u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input checked="" type="checkbox"/> Dressings: <u>alexym</u> <input type="checkbox"/> Comments _____ #2 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #3 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #4 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ CHEST TUBES <input checked="" type="checkbox"/> None #1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____
GASTROINTESTINAL	SKELETAL	ARTERIAL AND VENOUS SITES
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color _____ Consistency _____ Abdomen: <input checked="" type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding Bowel Sounds: <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent X <u>4</u> Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHI R or L Comments: _____	Moves Extremities: <input checked="" type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> Pain <input checked="" type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis <input type="checkbox"/> Amputation _____ Gait <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady Comments: <u>Edema LLE + RLE, rt sided weakness, parkinsons</u> _____	<input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input type="checkbox"/> L <u>AP</u> Start: <u>1/17/24</u> <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ Hemodialysis Access Location _____ <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit
GENITOURINARY	EYES, EARS, NOSE, THROAT	PULMONARY
Urine: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input checked="" type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids <input type="checkbox"/> Foley Size <u>16</u> Fr Insertion Date <u>1/12</u> <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: _____	Sclera: <input checked="" type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red Scleral Edema: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Comments: _____	Respirations: <input checked="" type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored <input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> RA O2: <u>2L</u> <input checked="" type="checkbox"/> NC <input type="checkbox"/> Vent Mask <input type="checkbox"/> Trach Collar <input type="checkbox"/> Non rebreather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator: <input type="checkbox"/> BiPAP/CPAP # _____ ETT @ _____ cm # _____ Shiley Trach BVM at bedside <input type="checkbox"/> Y <input type="checkbox"/> N Obturator at bedside <input type="checkbox"/> Y <input type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input checked="" type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: _____
SKIN ASSESSMENT	LUNGS	ARTERIAL AND VENOUS SITES
<input type="checkbox"/> Skin Intact Skin assessment codes: 1. Abrasions 2. Decubitis 3. Bruises 4. Incision 5. Redness 6. Edema 7. Rash 8. Lacerations 9. Petechiae 10. Hematoma 11. Blister, 12. Stoma 13. Sutures 14. Staples 15. Other: <u>mothling</u> Skin Color normal for patient <input checked="" type="checkbox"/> <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice <input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic Braden Scale Score _____ <input type="checkbox"/> If Braden Scale $\leq$ 18 initiate Skin Care Protocol Comments: _____	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub 	<input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input type="checkbox"/> L <u>AP</u> Start: <u>1/17/24</u> <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ Hemodialysis Access Location _____ <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit

COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

Initial Assessment  See Narrative for Additional Information Signature: V. paretet Date: 1/19/24 Time: 0900  
 No Changes to initial assessment  See Narrative for s Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 No Changes to previous assessment  See Narrative for s Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PERIPHERAL VASCULAR	NEUROLOGY/PSYCHOSOCIAL	CARDIOVASCULAR
3+-Bounding unable to occlude 2+-Strong able to occlude 1+-Weak palpable 0-Non palpable Extremities: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Icd Hose <input type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>&lt;3</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Distal R <u>1+</u> L <u>1+</u> Post. Tib. R _____ L _____ Comments: _____	Family at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Drowsy Cough Reflex <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>W</u> Lt. <u>W</u> Pushes: Rt. <u>W</u> Lt. <u>W</u> Comments: _____ Response to Questions: <input type="checkbox"/> Readily <input checked="" type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input type="checkbox"/> Friendly <input type="checkbox"/> Restless <input type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry <input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned Facial expressions: <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Severe Painful <input type="checkbox"/> Severe Painful Neuro Assessment Comments: _____	Edema: <input type="checkbox"/> Generalized <input checked="" type="checkbox"/> Dependent Pitting: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> PPM Site: <u>left subclav</u> Rhythm: _____ PACER SETTINGS <input type="checkbox"/> None Rate _____ MA: A _____ Y _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Permanent Pacemaker Site <input checked="" type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular INCISIONS/WOUNDS/DRAINS <input type="checkbox"/> None #1 Location: <u>left hand</u> <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input checked="" type="checkbox"/> Dressings <u>attempt</u> <input type="checkbox"/> Comments _____ #2 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #3 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #4 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____ #5 Location: _____ <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____ <input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____ <input type="checkbox"/> Comments _____
GASTROINTESTINAL	SKELETAL	GENITOURINARY
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color _____ Consistency _____ Abdomen: <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding Bowel Sounds: <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input checked="" type="checkbox"/> Hyper <input type="checkbox"/> Absent X4 Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHI K or L Comments: _____	Moves Extremities: <input type="checkbox"/> AR <input checked="" type="checkbox"/> RA <input type="checkbox"/> RL <input checked="" type="checkbox"/> LA <input type="checkbox"/> LL <input checked="" type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis <input type="checkbox"/> Amputation _____ Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: _____	Urine: <input type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids <input type="checkbox"/> Foley Size <u>165</u> Fr Insertion Date <u>1/12</u> <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: <u>not assessed</u>
ARTERIAL AND VENOUS SITES	PULMONARY	SKIN ASSESSMENT
<input type="checkbox"/> Jugular <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ Hemodialysis Access Location: _____ <input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit	Respirations: <input checked="" type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored <input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> RA <input checked="" type="checkbox"/> NC <input type="checkbox"/> Vent Mask <input type="checkbox"/> Trach Collar <input type="checkbox"/> Non rebreather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator <input type="checkbox"/> BiPAP/CPAP # _____ EIT @ _____ cm # _____ Shiley Trach BVM at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Obturator at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input checked="" type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: _____	<input type="checkbox"/> Skin Intact Skin assessment codes: 1. Abrasions 2. Decubitus 3. Bruises 4. Incision 5. Redness 6. Edema 7. Rash 8. Lacerations 9. Petechiae 10. Hematoma 11. Blister 12. Stoma 13. Sutures 14. Staples 15. Other: <u>nothing</u> Skin Color normal for patient <input type="checkbox"/> <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice <input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic Braden Scale Score _____ <input type="checkbox"/> If Braden Scale $\leq$ 18 initiate Skin Care Protocol Comments: _____
LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub		<input checked="" type="checkbox"/> None #1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____ #3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Suction <input type="checkbox"/> Gravity Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous _____ Air-leak <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____

Initial Assessment  See Narrative for Additional information Signature V. Paredet Date: 1/20/21 Time: 1220  
 No Changes to initial assessment  See Narrative for s Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 No Changes to previous assessment  See Narrative for s Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

midline p/c 1/20/21

Student Name: Victoria Paredes

Date: 1/22/21

### Patient Physical Assessment Narrative

**PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS:** (Complete using assessment check list and reminders below).

**GENERAL INFORMATION** (Time of assessment, admit diagnosis, general appearance)

0900 pt cc dark stool & bloody urine x2 days,  
pt diagnosed acute leukemia, pt drowsy

**Neurological-sensory** (LOC, sensation, strength, coordination, speech, pupil assessment)

pt drowsy but responds to commands, responds  
to questions slowly, facial expressions flat. right  
sided weakness, left arm painful to move/touch.

**Comfort level:** Pain rates at 0 (0-10 scale) Location: /

**Psychological/Social** (affect, interaction with family, friends, staff)

pt calm, relaxed, and friendly. pt wife at  
bedside.

**EENT** (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing)

Sclera white, no drainage. pt denies  
cough, sore throat. no nasal drainage noted.

**Respiratory** (chest configuration, breath sounds, rate, rhythm, depth, pattern)

pt on 2L NC, RR 18, O<sub>2</sub> 93%. no distress noted.  
diminished breath sounds lower lobes on inspiration  
& expiration

**Cardiovascular** (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)

irregular rhythm, radial 2+ bilat, pedal pulse 1+  
bilat, apical 92. pacemaker left subclavian

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

### IM1 Patient Physical Assessment Narrative

**Gastrointestinal** (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) abd firm, active x4 quadrants, appetite is poor, denies pain/tenderness to palpation

\_\_\_\_\_ Last BM 1/17

**Genitourinary-Reproductive** (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) urine amber & clear, 1st Foley inserted 2/12/2021

\_\_\_\_\_ Urine output (last 24 hrs) \_\_\_\_\_ LMP (if applicable) \_\_\_\_\_

**Musculoskeletal** (alignment, posture, mobility, gait, movement in extremities, deformities) pt weak LUE, UE, RUE, RLL. pain in LUE.

**Skin** (skin color, temp, texture, turgor, integrity)

pt has melanoma, spotting & mottling on right & left arms.

**Wounds/Dressings**

left hand - allenvn dressing

**Other**