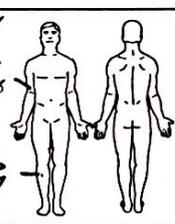
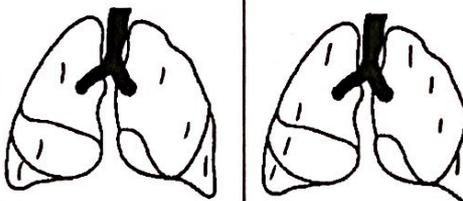


<p>PERIPHERAL VASCULAR ✓</p> <p>3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable</p> <p>Extremities: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input checked="" type="checkbox"/> R <input type="checkbox"/> L Ted 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: 2 < Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R 2+ L - Pedal R - L 2+ Post. Tib. R - L - Comments: Red band on left arm cut cellulitis on right IPS</p>	<p>NEUROLOGY/PSYCHOSOCIAL ✓</p> <p>Family at bedside <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input 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. S Lt. S Pushes: Rt. W Lt. W Comments: weak push due to pain Response to Questions: <input type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Friendly <input checked="" 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 type="checkbox"/> Flat <input type="checkbox"/> Responsive <input checked="" type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments:</p>	<p>CARDIOVASCULAR ✓</p> <p>Edema: <input type="checkbox"/> Generalized <input checked="" type="checkbox"/> Dependent Pitting: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Skin Turgor WNL <input type="checkbox"/> Y <input checked="" 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 type="checkbox"/> PPM Site: - Rhythm: -</p>
<p>GASTROINTESTINAL ✓</p> <p><input checked="" type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color _____ Consistency _____ Abdomen: <input type="checkbox"/> Soft <input 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 X₄ Quadrants Appetite: <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHT R or L Comments:</p>	<p>SKELETAL ✓</p> <p>Moves Extremities: <input type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input 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 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:</p>	<p>PACER SETTINGS ✓</p> <p><input type="checkbox"/> None Rate _____ MA: A _____ V _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular</p>
<p>GENITOURINARY ✓</p> <p>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 _____ Fr Insertion Date _____ <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments:</p>	<p>EYES, EARS, NOSE, THROAT ✓</p> <p>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:</p>	<p>INCISIONS/WOUNDS/DRAINS ✓</p> <p><input type="checkbox"/> None #1 Location: ALE <input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures <input checked="" type="checkbox"/> Reddened <input checked="" type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color - <input checked="" type="checkbox"/> Open to Air <input type="checkbox"/> Dressings <input type="checkbox"/> Comments cellulitis</p>
<p>ARTERIAL AND VENOUS SITES ✓</p> <p>A -Without Redness or Swelling B-Redness C-Swelling D-Dressing</p> <p><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 checked="" type="checkbox"/> PICC <input checked="" type="checkbox"/> R <input type="checkbox"/> L A Start: _____ <input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input type="checkbox"/> L B C 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</p>	<p>PULMONARY ✓</p> <p>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: - <input type="checkbox"/> NC <input type="checkbox"/> Venti 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 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:</p>	<p>CHEST TUBES ✓</p> <p><input 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____</p>
<p>SKIN ASSESSMENT ✓</p> <p><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: 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 ≤ 18 initiate Skin Care Protocol Comments:</p> 	<p>LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub</p> 	<p>CHEST TUBES ✓</p> <p><input 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments _____</p>
<p><input type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature _____ Date: _____ Time: _____ <input type="checkbox"/> No Changes to initial assessment <input type="checkbox"/> See Narrative for _____s Signature _____ Date: _____ Time: _____ <input type="checkbox"/> No Changes to previous assessment <input type="checkbox"/> See Narrative for _____s Signature _____ Date: _____ Time: _____</p>		

COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

Student Name: Greg Kelley

Date: 03/30/2021

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)

08:30, cellulitis in RLE, ~~cellulitis in RLE~~
Alert, mild discomfort

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

Alert & awake, pain in ~~both~~ RLE & RUE, strong
finger grasp & weak push/pull, + pupil reaction and corneal
gaze, speech is fluent and understandable, + toe wiggle

Comfort level: Pain rates at 8 (0-10 scale) Location: RUE & RLE

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

Intros kindly and attentive to staff, no family in room

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

NO drainage of EENT, NO swellings in nodes, effective
swallowing

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

No wounds, scars, or bruising of chest, ~~no~~
~~scars~~, normal breath sounds, 18 breaths per minute, normal
breathing pattern

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

Normal heart sounds at normal rhythm, radial rate
of 80 bpm, +2 pedal & radial pulse

Student Name: _____

Date: _____

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) HAS NOT VOIDED TODAY, NO SCARRING OR GLOWING OF ABDOMEN,
ACTIVE BOWEL SOUNDS IN ALL 4 QUADRANTS, NO HURNESS, PAIN, OR
DISTENTION IN ABDOMEN

Last BM YESTERDAY IN THE AM

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) URINATION TWICE A DAY, URGENT URINATION,
WASHER ACCIDENTS IN BFP AFTER LUNCH, NO VAGINAL BLEEDING
OR DISCHARGE.

Urine output (last 24 hrs) - LMP (if applicable) -

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) LIMITED MOBILITY, CAN MOVE ALL EXTREMITIES, SWELLING IN
LEGS AND ARMS, NEEDS ASSISTANCE TO MOVE.

Skin (skin color, temp, texture, turgor, integrity) SKIN COLOR NORMAL FOR PATIENT, TEMPERATURE OF 97.5 °F,
GOOD SKIN TURGOR, SMOOTH SKIN TEXTURE, WOUNDS ON
RLE DUE TO CELLULITIS. REDNESS, SCABBING, SWELLING, &
WOUND ON RLE

Wounds/Dressings WOUNDS DRY WITH NO DISCHARGE. CURRENTLY NO DRESSING
ON WOUND. RED IN AREA, SWELLING, SCABBING, LOCATED ON
RLE

Other