

Adult/Geriatric Critical Thinking Worksheet

<p><b>1. Disease Process &amp; Brief Pathophysiology-</b></p> <p>Pt experienced a hip fracture. A fracture can be caused by a multitude of factors but ultimately a hip fracture occurs when there is a break in the proximal end of the femur.</p>	<p><b>2. Factors for the Development of the Disease/Acute Illness-</b></p> <p style="text-align: center;"><small>Nonmodifiable Risk Factors</small></p> <ul style="list-style-type: none"> <li>• Previous history of fractures</li> <li>• Low level physical activity</li> <li>• Age</li> <li>• Diabetes</li> <li>• Rheumatoid arthritis</li> <li>• Steroids</li> </ul>	<p><b>• Signs and Symptoms-</b></p> <ul style="list-style-type: none"> <li>• External Rotation</li> <li>• Muscle spasm</li> <li>• Shortening of the affected extremity</li> <li>• Severe pain and tenderness (P)</li> <li>•</li> </ul>
<p><b>3. Diagnostic Tests pertinent or confirming of diagnosis-</b></p> <ul style="list-style-type: none"> <li>• MRI</li> <li>• CT scan</li> <li>• Bone scans</li> <li>• X-rays</li> </ul>	<p><b>4. Lab Values that may be affected-</b></p> <ul style="list-style-type: none"> <li>• Vitamin D levels</li> <li>• Calcium levels</li> </ul>	<p><b>5. Current Treatment-</b></p> <ul style="list-style-type: none"> <li>• Postoperative care</li> <li>• Ambulatory and Home care</li> <li>• Pain management</li> <li>• Neurovascular checks</li> </ul>

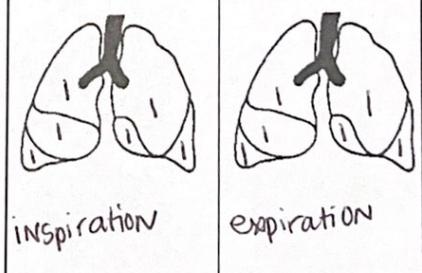
<p><b>6. Focused Nursing Diagnosis:</b> Ineffective Health maintenance</p>	<p><b>11. Nursing Interventions related to the Nursing Diagnosis in #7:</b></p> <p>1. Pt will explain how rugs, clutter and other things on the floor can be a hazard</p> <p><b>Evidenced Based Practice:</b></p> <p>By understanding the safety risk of having clutter and rugs the pt. will demonstrate understanding of why she needs to keep her floors free of anything that she could trip on.</p> <p>2. Pt will explain how having a chair to her shower and an elevated toilet seat will decrease her risk of falling in the bathroom</p> <p><b>Evidenced Based Practice:</b></p> <p>By understanding how <u>a</u> elevated toilet seat and a chair in the shower can decrease her risk of falling the pt. will be able to eliminate a safety hazard that is in her ADL.</p> <p>3. Pt will be able to show the proper technique to using a walker</p> <p><b>Evidenced Based Practice:</b> By performing the proper walker usage the pt. will reduce her risk of falling when using her walker.</p>	<p><b>12. Patient Teaching:</b></p> <p>1. Teach the importance of keeping her house Clean to prevent falls</p> <p>2. Teach <u>pt</u> about benefits of using assistive devices In the bathroom</p> <p>3. Teach <u>pt</u> how to properly use walker</p>
<p><b>7. Related to (r/t):</b> Pt fell while using walker incorrectly</p>		<p><b>13. Discharge Planning/Community Resources:</b></p> <p>1. Consult SNF and/or rehab center for <u>pt</u> to stay after discharge</p> <p>2. Send <u>pt</u> with pamphlet over common home safety hazards</p> <p>3. Send <u>pt</u> home with instructions on how to properly use walker to prevent future fall</p>
<p><b>8. As evidenced by (aeb):</b> Pt has fractured hip</p>		
<p><b>9. Desired patient outcome:</b> Pt will be able to list three safety hazards in her home by 6/1/22 1500.</p>		

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Work Cited

Fractures. Johns Hopkins Medicine. (2020, February 28). Retrieved May 31, 2022, from <https://www.hopkinsmedicine.org/health/conditions-and-diseases/fractures>



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 checked="" 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"/> Hxipulses Capillary Refill: <u>3</u> Seconds Affected extremity pulse verified with Doppler <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R _____ L _____ Comments: _____	Family at bedside <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated <input type="checkbox"/> Drowsy Cough Reflex <input checked="" 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>S</u> Lt. <u>S</u> Pushes: Rt. <u>S</u> Lt. <u>S</u> Comments: _____ Response to Questions: <input checked="" type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Appr. 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 checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments: _____	Edema: <input type="checkbox"/> Generalized <input 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 PPM Site: _____ Rhythm: _____
GASTROINTESTINAL	SKELETAL	PACER SETTINGS
<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u>brown</u> Consistency <u>type 2</u> Abdomen: <input checked="" 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 X/L 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"/> DHT 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 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 checked="" type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: <u>gait not assessed</u>	<input checked="" type="checkbox"/> None Rate _____ MA: A _____ V _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular
GENITOURINARY	EYES, EARS, NOSE, THROAT	INCISIONS/WOUNDS/DRAINS
Urine: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input checked="" 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 checked="" type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent Comments: <u>BRP w/ assistance</u>	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: _____	<input checked="" type="checkbox"/> None #1 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 _____ 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 _____ 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 _____ 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 _____ Comments: _____
ARTERIAL AND VENOUS SITFS	PULMONARY	CHEST TUBES
A-Without Redness or Swelling B-Redness C-Swelling D-Dressing <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 checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L <u>20g AD</u> Start: <u>5/24</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	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 checked="" 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 checked="" type="checkbox"/> Y <input type="checkbox"/> N Obturator at bedside <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Cough: <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Non Productive <input type="checkbox"/> None Secretions: Color _____ Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: _____	<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: _____
SKIN ASSESSMENT	LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub	
<input checked="" 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 <u>19</u> <input type="checkbox"/> If Braden Scale $\leq$ 18 initiate Skin Care Protocol Comments: _____		
<input checked="" type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature <u>Aubree Thomas</u> Date: <u>05/31/22</u> Time: <u>0901</u> <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: _____		

Student Name: Aubree Lomax

Date: 5/31/22

IM1 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)

Time: 0901

Admit dx: lt pubic symphysis fx

General appearance: Pt appears alert, friendly, and responds readily to questions

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

LOC - alert & oriented x4 pupils - equal, round, and

sensation - sharp/dull intact 3mm reactive to light

Strength - equal & strong bilaterally

coordination - coordinated movements

Speech - not slurred

Comfort level: Pain rates at 0 (0-10 scale) Location: NONE

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

affect - expresses pleasant emotions

interaction with staff: Pt is very pleasant and is very friendly, and family / polite to staff.

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) EENT - symmetrical, no drainage

Nodes - no nodes palpable mouth - oral mucosa, pink & moist

dentition - dentures at bedside, clean

swallowing - swallows w/ no difficulty

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

chest configuration - symmetrical

breath sounds - clear in all lobes, inspiration & expiration

Rate - #16 Rhythm - equal depth - equal

pattern - equal

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

Heart sounds - S1 & S2 auscultated, no murmur

Apical & radial rate - 78

Rhythm - regular

Radial & Pedal pulse - 2+ pattern - regular

Student Name: Aubree Lomax

Date: 5/31/22

IM1 Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) bowel habits - normal for pt  
appearance abdomen - soft  
bowel sounds - active x4  
tenderness to palpation - none Last BM 5/29/22 PM

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Frequency - regular vag bleeding - none observed  
Urgency - no urgency odor - no odor  
Continence - continent discharge - none observed  
Color - yellow/clear (not observed) Clarity - clear  
Urine output (last 24 hrs) 4x LMP (if applicable) Post

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities)  
SKIN - alignment - symmetrical deformities - none  
posture - upright  
mobility - ~~no~~ assistance w/ walker  
Gait - not assessed  
movement in extremities - moves all

Skin (skin color, temp, texture, turgor, integrity)  
SKIN - appropriate for race Integrity - not intact  
Color - appropriate for race  
temp - warm  
texture - smooth turgor - not elastic

Wounds/Dressings  
Lt peripheral 20g, clean, dry, intact started 5/24

Other

## Adult/Geriatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
INT	Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Click here to enter text.	Click here to enter text.	Click here to enter text.

<b>Student Name:</b> Aubree Lomax		<b>Unit:</b> S6	<b>Patient Initials:</b> Moreno		<b>Date:</b> 5/31/2022	<b>Allergies:</b> Statins	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List diluent solution, volume, and rate of administration  IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Clopidogrel	Platelet aggregation inhibitor	Antiplatelet drug	75mg, daily PO	Yes  Click here to enter text.	N/A	GI bleeding, dyspnea, chest pain, abdominal pain	1. Monitor for bleeding 2. Monitor platelet count before administration (hold if <100) 3. Avoid ginkgo and garlic can cause increased bleeding 4. Avoid alcohol can cause increased bleeding
Docusate sodium	Emollient	Stool softener	100mg, PO, daily	Yes  Click here to enter text.	N/A	Throat irritation, mild cramps, decreased appetite	1. Encourage pt to increase fluids 2. Advise pt that prolonged use may lead to dependence 3. Instruct pt to increase fiber to increase digestion 4. Withhold medication if pt has diarrhea
Enoxaparin	Anticoagulant	Prevent DVT, stroke, or pulmonary embolus	30mg/0.3 mL inj. Sub-Q Daily	Yes  Click here to enter text.	N/A	Hemorrhage, renal failure, pulmonary edema	1. Report fever, nausea, SOB, or bleeding 2. Do not rub injection site to prevent bleeding and bruising 3. Report dark stools

## Adult/Geriatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Student Name: Aubree Lomax		Unit: S6	Patient Initials: Moreno		Date: 5/31/2022	Allergies: Statins	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List diluent solution, volume, and rate of administration  IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
							4. Inform HCP and dentist when taking
Metoprolol tartrate	Beta-adrenergic blocker	Antihypertensive	50mg, PO, BID	Choose an item.  Yes	N/A	Hypokalemia, Hyernatremia, dehydration, hyperglycemia	<ol style="list-style-type: none"> <li>1. Report muscle cramps or weakness</li> <li>2. Report changes in mental status</li> <li>3. diabetic pt. monitor glucose</li> <li>4. Monitor electrolytes for increase in potassium or calcium</li> </ol>
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item.  Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> <li>1. Click here to enter text.</li> <li>2. Click here to enter text.</li> <li>3. Click here to enter text.</li> <li>4. Click here to enter text.</li> </ol>
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item.  Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> <li>1. Click here to enter text.</li> <li>2. Click here to enter text.</li> <li>3. Click here to enter text.</li> <li>4. Click here to enter text.</li> </ol>
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item.  Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> <li>1. Click here to enter text.</li> <li>2. Click here to enter text.</li> <li>3. Click here to enter text.</li> <li>4. Click here to enter text.</li> </ol>