

Student Name: Ashley S. Barraza

Date: 01/31/2023

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)

0700 received report from Tammie RN. 70y/o Male, admitted from the ED due to aspiration pneumonia & COPD Exacerbation. NKDA, pt. is a DNR, under fall risk & seizure precautions. Pt. in room, on bed, HOB elevated 90°, eating breakfast, denies further needs at this time.

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

Alert, oriented to person, place, time & situation. Pupils 3mm PERRLA. Does not respond to sharp/dull sensations on R upper & lower ext. R hand grasp / toe wiggle absent. Moves LVE/LLE on command, responds appropriately to sharp/dull sensations. D Hand grasp / D toe wiggle strong. mild Slurred speech noted. pt. denies pain or discomfort.

Comfort level: Pain rates at 0 (0-10 scale) Location: denied pain

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

Cheerful affect, interacts appropriately with staff when making direct eye contact & pt. is approached with a slow & low tone of voice. Pt. begins to withdraw & not interact with staff when eye contact is lost & pt's verbal responses are misunderstood.

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

EENT with no drainage noted. Nasal septum midline, ears symmetrical, Hears spoken voice with mild difficulty. Oral mucosa pink, moist & intact. No missing teeth noted. No palpable lymph nodes noted. Pt. denied difficulties swallowing, pt. able to swallow all PO meds without difficulties.

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

Chest symmetrical, trachea midline. Respirations 18 & shallow. Breath sounds diminished on all lung fields with expiratory wheezes. O₂ 3LNC with O₂ sat 97-99%. Pt. reports mild discomfort when asked to take a deep breath & refused to use incentive spirometer. Stated "I do not like that thing". pt. educated on the benefit outcomes of IS. use.

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

S1 & S2 audible with regular rate & rhythm. Apical pulse 68, bilateral radial pulses 2+ with rate of 74. Bilateral pedal pulses 2+ with rate of 104, no edema noted. BP 110/54 (75). Bilateral upper/lower ext. cap. refill < 3 seconds. Denies chest pain or discomfort.

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Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Abd. flat, soft & nontender. Active bowel sounds x4 quadrants. Stated last BM on 1/29 "brown, soft, formed stool"

Last BM 1/29

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) voids clear yellow, adequate amount, denies odor, pain upon voiding. Pt. is male, no penile discharge noted.

x3 **Urine output** (last 24 hrs) 400mL **LMP** (if applicable) None

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) R side hemiplegia, pt. does not ambulate. pt. able to perform most ADL's independently. Full ROM of L upper/lower ext. requires assistance when repositioning in bed. States "I can do everything on my left side, my right side is dead. Let me do it on my own, I'll tell you when you can start helping me just have patience with me."

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

skin warm, dry & intact. color appropriate to race. Turgor elastic.

Wounds/Dressings

20g L wrist-INT placed on 01/26/23. IV site clean, dry, & intact.

18g L AC-INT placed on 01/26/23. IV site clean, dry & intact

Other

1030: 20g L wrist INT removed, catheter tip intact, pt. tolerated well. applied pressure for 5min. & covered with cotton ball & secured with tape. advised pt. to leave dressing to avoid bleeding, pt verbalized understanding.

Adult/Geriatric Medication Worksheet – Current Medications & PRN from 12pm prior day to 12pm current day

Date: 01/31/2023

Student Name: Ashley's, Barraza

Patient Allergies: NKDA

Primary IV fluid and rate: INT

Patient specific reasoning for IV fluids (including type isotonic, hypotonic, hypertonic): N/A

Methylprednisolone Sodium Succinate	40mg/mL IVP Q12H	IVP: undiluted Rate: Over 3 min.	helps reduce the symptoms of swelling & pain.	• Avoid drinking grapefruit juice • May cause dizziness & visual changes use call-light
Piperacillin-tazobactam	3.375g IVPB Q8H	3.375g/100mL 0.9% NaCl Rate: 25 mL/hr	Hx. of COPD, chronic pain, monoarthralgia pt. admitted for pneumonia; will help stop infection	• May cause CDAD; report diarrhea • May cause pain; report any discomfort
Vancomycin	1250mg IV Q18H	1250mg/250mL 0.9% NaCl Rate: 100 mL/hr	pt. admitted for pneumonia; will help stop infection	• May cause ringing in the ears, report any hearing change ASAP • Report edema in lower ext. • Report blood in urine
Atorvastatin	20mg tablet PO Bedtime	PO	helps decrease cholesterol levels & slows down the progression of CAD	• Advise pt. to avoid drinking grapefruit juice • May cause abd. cramps, report any changes in BM such as constipation, diarrhea
Fenofibrate	54mg tab PO Bedtime	PO	helps decrease levels of cholesterol	• May cause fatigue/weakness • May cause rash, report sudden skin rash

Medication reference: Micromedex

Adult/Geriatric Medication Worksheet – Current Medications & PRN from 12pm prior day to 12pm current day

Student Name: Ashley S. Barraza

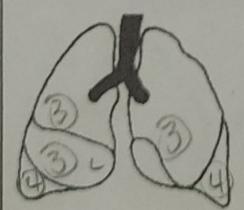
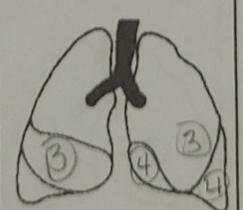
Date: 01/31/2023

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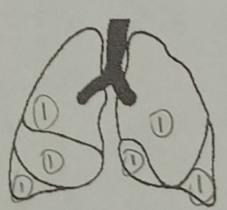
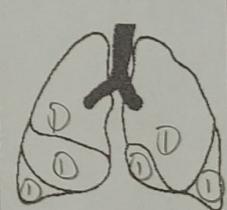
Generic Name	Dosage with route and schedule	IVP-List diluent solution, volume, and rate of administration IVPB- List concentration and rate of administration	Patient specific therapeutic reasoning	Patient specific teaching with reasoning
Apixaban	5mg tablet 2 times daily PO	PO	(A-fib) helps reduce risk of stroke *Hx. of strokes, Afib, CAD helps prevent/stop seizures	<ul style="list-style-type: none"> Instruct pt. not to eat/drink large quantities of grapefruit or grapefruit juice Report any unusual bleeding such as gums or nose bleeds Report any sudden bruises
Phenytoin	300mg ER capsule PO Bedtime	PO	* Hx. of tonic-clonic seizures helps decrease musculoskeletal pain * Hx. of mono-neuropathy, chronic pain	<ul style="list-style-type: none"> Report worsening depression USE CALL-LIGHT Advise pt. against sudden D/C due to potential for seizure recurrence Report any nausea may cause dizziness & weakness USE CALL-LIGHT
Baclofen	5mg tablet PO 2x daily	PO	PT admitted for pneumonia; will help decrease secretions & reduce cough * Hx. of COPD, HLD	<ul style="list-style-type: none"> Instruct pt. to cough effectively Assist pt. to sit upright & take several breaths before attempting to cough Encourage use of Incentive Spirometer May cause sedation; use call-light Report worsening depression May cause dizziness or drowsiness USE CALL-LIGHT
Dextromethorphan guaifenesin	30-60mg tablet PO daily	PO	* Hx. of seizures, mono-neuropathy, chronic pain	
Gabapentin	100mg capsule PO 2x daily	PO		

<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 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 type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: _____ 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> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R <u>2+</u> L <u>2+</u> Comments: _____</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. <u>N</u> Lt. <u>S</u> Pushes: Rt. <u>N</u> Lt. <u>S</u> Comments: <u>R Side hemiplegia</u> 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"/> 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 checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input checked="" 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 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 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 PPM Site: _____ Rhythm: _____</p>
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u>Brown</u> Consistency <u>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 <u>4</u> 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: <u>LBM 42g</u></p>	<p>SKELETAL</p> <p>Moves Extremities: <input type="checkbox"/> All <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input checked="" 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 type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: _____</p>	<p>PACER SETTINGS</p> <p><input checked="" 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 checked="" 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"/> Ovoids <input type="checkbox"/> Foley Size _____ Fr Insertion Date _____ <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input checked="" 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 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 _____ <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 _____</p>
<p>ARTERIAL AND VEINUS 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 type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input checked="" type="checkbox"/> Peripheral <input type="checkbox"/> R <input checked="" type="checkbox"/> LA, D Start: <u>1/20</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</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 checked="" type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> RA O2: <u>3L</u> <input 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 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: _____</p>	<p>CHEST TUBES</p> <p><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 _____</p>
<p>SKIN ASSESSMENT</p> <p><input checked="" 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: 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>15</u> <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: _____</p>	<p>LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub</p> <div style="display: flex; justify-content: space-around;">   </div> <p style="text-align: center;">Inhale Exhale</p>	

Initial Assessment See Narrative for Additional information Signature Ashley S. Barraza Date: 1/31/23 Time: 1000
 No Changes to initial assessment See Narrative for _____s Signature _____ Date: _____ Time: _____
 No Changes to previous assessment See Narrative for _____s Signature _____ Date: _____ Time: _____

Secondary

Rm#88

<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 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</p> <p>Ted Hose <input type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Plexipulses Capillary Refill: <u>> 3</u> Seconds Affected extremity pulse verified with Doppler <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Pulses: Radial R <u>2+</u> L <u>2+</u> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R <u>2+</u> L <u>2+</u></p> <p>Comments: _____</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 type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>S</u> Lt. <u>S</u> Pushes: Rt. <u>W</u> Lt. <u>W</u> Comments: _____</p> <p>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"/> 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 checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment</p> <p>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 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 PPM Site: _____ Rhythm: _____</p>	
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color: <u>Brown</u> Consistency <u>4</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 <u>4</u> 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: <u>1/30</u></p>	<p>SKELETAL</p> <p>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 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 checked="" type="checkbox"/> Steady <input type="checkbox"/> Unsteady Comments: _____</p>	<p>PACER SETTINGS</p> <p><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</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 checked="" type="checkbox"/> Voids <input type="checkbox"/> Foley Size _____ Fr Insertion Date _____ <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input checked="" 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: <u>D Hip</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>FOAM</u> <input type="checkbox"/> Comments _____</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 type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____ <input checked="" type="checkbox"/> Peripheral <input type="checkbox"/> R <input checked="" type="checkbox"/> L <u>A, D</u> Start: <u>1/21</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</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 checked="" type="checkbox"/> RA O2: <u>94%</u> <input 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 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 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 _____</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: _____</p> <p>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>20</u> <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol</p> <p>Comments: _____</p>	<p>LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub</p> <div style="display: flex; justify-content: space-around;">   </div>		<p>#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 _____</p> <p>#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 _____</p>

Initial Assessment See Narrative for Additional information Signature Ashley S. Barraza Date: 1/31/23 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: _____