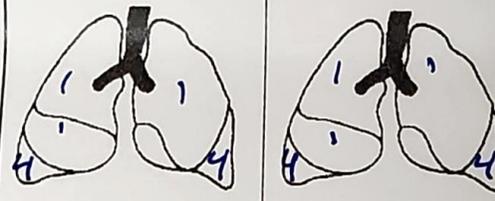


| PERIPHERAL VASCULAR | NEUROLOGY/PSYCHOSOCIAL | CARDIOVASCULAR |
|--|--|---|
| 3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable Extremities: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Call Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input checked="" type="checkbox"/> Y <input type="checkbox"/> N SCDs <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Plex/pulses Capillary Refill: <u>2</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 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 checked="" type="checkbox"/> Y <input type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grips: Rt. <u>5</u> Lt. <u>5</u> Pushes: Rt. <u>5</u> Lt. <u>5</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 Withdrawn 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"/> Appro. for age <input type="checkbox"/> Hostile/Angry <input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input checked="" 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 checked="" 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 checked="" type="checkbox"/> Y <input type="checkbox"/> N <u>70 bpm</u> Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PPM Site: _____ Rhythm: <u>Afib</u> |
| GASTROINTESTINAL | SKELETAL | PACER SETTINGS |
| <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u>Brown</u> Consistency <u>4/25</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 <input checked="" type="checkbox"/> 4 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: _____ | Moves Extremities: <input 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: _____ | <input checked="" type="checkbox"/> None Rate _____ MA: A _____ V _____ Sensitivity _____ Mode _____ Transvenous @ _____ cm Site _____ <input type="checkbox"/> Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Permanent Pacemaker Site <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular |
| GENITOURINARY | EYES, EARS, NOSE, THROAT | INCISIONS/WOUNDS/DRAINS |
| Urine: <input type="checkbox"/> Clear <input type="checkbox"/> Sediment <input type="checkbox"/> Cloudy <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input checked="" 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: <u>Cath removed 8/19 accidentally</u> | Sclera: <input 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: <u>4mm → 3mm</u> | <input type="checkbox"/> None #1 Location: <u>@ anterior lateral thigh</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>CDI</u> <input type="checkbox"/> Comments: _____ #2 Location: <u>@ lower shin</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 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: _____ |
| ARTERIAL AND VENOUS SITES | 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: <u>4/16</u> <input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L <u>AD</u> Start: <u>9/16</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 type="checkbox"/> No Distress <input type="checkbox"/> SOB <input checked="" 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>3L</u> <input checked="" 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 checked="" type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None Secretions: Color <u>green</u> Consistency _____ Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input checked="" 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 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 checked="" type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic Braden Scale Score <u>18</u> <input type="checkbox"/> If Braden Scale ≤ 18 initiate Skin Care Protocol Comments: _____ |  | |

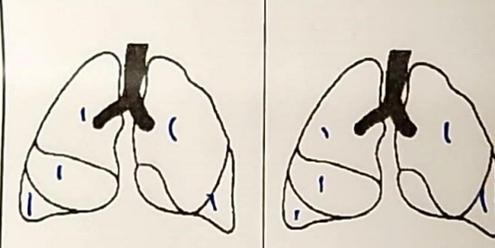
COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

Xavier

@ pain 150ml H₂O

Initial Assessment See Narrative for Additional information Signature _____ Date: _____ Time: _____
 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 |
|---|--|---|
| 34-Bounding unable to occlude 24-Strong able to occlude 14-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 <input type="checkbox"/> Call Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Tail 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"/> Plegipulses Capillary Refill: <u> </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> Pedal R <u>2+</u> L <u>2+</u> Post. Tib. R <u> </u> L <u> </u> Comments: <u> </u> | Family at bedside <input checked="" 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 <input type="checkbox"/> Cough Reflex <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Follows Simple Commands: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Grag <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Muscle Strength: (S-Strong, W-Weak, N-None) Grip: Rt. <u>S</u> Lt. <u>S</u> Pushes: Rt. <u>S</u> Lt. <u>S</u> Comments: <u> </u> Response to Questions: <input checked="" 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 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 checked="" type="checkbox"/> Responsive <input type="checkbox"/> Grimace <input checked="" type="checkbox"/> Seizure Precaution <input type="checkbox"/> Sedation Vacation Done for Neuro Assessment Comments: <u>PT says yes to all 3's</u> | 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 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: <u> </u> Rhythm: <u> </u> |
| GASTROINTESTINAL | SKELTAL | PACER SETTINGS |
| <input checked="" type="checkbox"/> Nausea <input checked="" type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u> </u> Consistency <u>type 5</u> 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 type="checkbox"/> Hyper <input type="checkbox"/> Absent X <u> </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> </u> | 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 <u> </u> Gait: <input type="checkbox"/> Steady <input checked="" type="checkbox"/> Unsteady Comments: <u> </u> | <input checked="" type="checkbox"/> None Rate <u> </u> MA: A <u> </u> V <u> </u> Sensitivity <u> </u> Mode <u> </u> Transvenous @ <u> </u> cm Site <u> </u> Epicardial wires <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Permanent Pacemaker Site <u> </u> <input type="checkbox"/> Left subclavicular <input type="checkbox"/> Right subclavicular |
| ARTERIAL AND VENOUS SITES | 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 <u> </u> Fr Insertion Date <u> </u> <input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input checked="" type="checkbox"/> Incontinent Comments: <u> </u> | Sclera: <input 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 checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N Comments: <u>3-2000</u> | <input type="checkbox"/> None #1 Location: <u>face + lower extremities</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 type="checkbox"/> Dressings <u>from on lower extremities</u> <input type="checkbox"/> Comments: <u>PT has 3-2000</u> #2 Location: <u> </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 type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> #3 Location: <u> </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 type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> #4 Location: <u> </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 type="checkbox"/> Dressings <input type="checkbox"/> Comments: <u> </u> |
| SKIN ASSESSMENT | 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: <u> </u> <input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input type="checkbox"/> L <u>AD</u> Start: <u>9/17</u> <input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> PA @ <u> </u> cm <input type="checkbox"/> R <input type="checkbox"/> L Start: <u> </u> Hemodialysis Access Location <u> </u> <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: <u> </u> <input type="checkbox"/> NC <input type="checkbox"/> Ventri 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 # <u> </u> ETT @ <u> </u> cm # <u> </u> 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 checked="" type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None Secretations: Color <u> </u> Consistency <u> </u> Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal Comments: <u> </u> | <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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> |
| 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> </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 <u>18</u> <input type="checkbox"/> If Braden Scale \leq 18 initiate Skin Care Protocol Comments: <u>Burns</u> | LUNGS: 1. Clear (Normal) 2. Crackles 3. Wheezes 4. Diminished 5. Absent 6. Rub  | <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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> #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 <u> </u> Air-leak <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal Comments: <u> </u> |
| <input type="checkbox"/> Initial Assessment <input type="checkbox"/> See Narrative for Additional information Signature <u> </u> Date: <u> </u> Time: <u> </u> <input type="checkbox"/> No Changes to initial assessment <input type="checkbox"/> See Narrative for <input type="checkbox"/> s Signature <u> </u> Date: <u> </u> Time: <u> </u> <input type="checkbox"/> No Changes to previous assessment <input type="checkbox"/> See Narrative for <input type="checkbox"/> s Signature <u> </u> Date: <u> </u> Time: <u> </u> | | Date: <u> </u> Time: <u> </u> Date: <u> </u> Time: <u> </u> Date: <u> </u> Time: <u> </u> |

VENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT

Kawer