

Student Name: Kim Zarkulhe

Date: 2/14/24

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: 0900

Admit diagnosis: Small bowel obstruction

Appearance: pt presenting in good spirits with clear and well kept appearance

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

LOC: AAOx4, GIS: 15, PERRLA

Sensation: Sensation x4 sharp and dull to bilateral cheeks and all extremities
BUE

Strength: equal grip strength, strong reflexes in BUE, weak BLE

Coordination: coordinated movement in all extremities

Speech: _____

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

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

pt presenting with good affect, interacting age appropriate with staff, family not at bedside.

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

EENT Symmetrical, no drainage noted to eyes, ears, nose, throat, mouth. Nodes non-palpable.

Some difficulty swallowing when drinking fluids

"Too fast" reported. Oral mucosa moist and pink, negative for oral trauma

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

Chest symmetrical, clear breath sounds bilaterally, breath sounds diminished in lower lobes and both R upper and lower lobes. RR 12, adequate depth with Reg pattern of breathing.

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

Heart sounds heard in S₁ and S₂ upon auscultation.

Apical and radial rate equal, HR 74 with regular rhythm. Radial and pedal pulses present. Regular pulse pattern.

Student Name: _____

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Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) Pt has not had BM as of now, abdomen soft negative for distention or obvious visual trauma. Pt denies pain or tenderness upon palpation. Bowel sounds active in all quadrants. Last BM N/A

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) Pt denies frequency or urgency. Description of pt's urine not documented; two occurrences since admission

Urine output (last 24 hrs) 2x LMP (if applicable) N/A

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) Alignment and posture symmetrical. Pt has not ambulated this morning but gait reported to be steady. Pt has strong and coordinated movements in all extremities. Negative for obvious deformities

Skin (skin color, temp, texture, turgor, integrity) Skin color is appropriate for a race, warm and dry. Elastic appropriate skin turgor for age. Skin not intact, laceration to forehead from previous injury

Wounds/Dressings Laceration with controlled bleeding to forehead, open to air, no dressing

Other

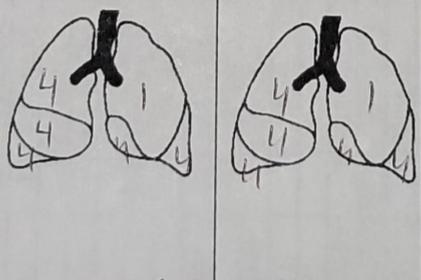
<p>PERIPHERAL VASCULAR</p> <p>3+ Bounding unable to occlude 2+ Strong able to occlude 1+ Weak palpable 0-Non palpable</p> <p>Extremities: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Cyanotic <input type="checkbox"/> Warm <input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L Ted Hose <input type="checkbox"/> Y <input 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 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 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 type="checkbox"/> N Follows Simple Commands: <input 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 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 type="checkbox"/> Responsive <input 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 <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ Pitting: _____ Skin Turgor WNL <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Sounds <input type="checkbox"/> Y <input type="checkbox"/> N Murmur <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> PPM Site: _____ Rhythm: _____</p>
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent Stool Color <u>black</u> Consistency <u>soft</u> Abdomen: <input type="checkbox"/> Soft <input 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 <input checked="" type="checkbox"/> X <input type="checkbox"/> U Quadrants Appetite: <input 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 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 <input type="checkbox"/> 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 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 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 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 type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red Scleral Edema: <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input type="checkbox"/> N Nasal Drainage: <input type="checkbox"/> Y <input 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 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 type="checkbox"/> LA, CDI Start: <u>2/14/24</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</p>	<p>PULMONARY</p> <p>Respirations: <input 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 # <u>N/A</u> AETT @ <u>N/A</u> cm # <u>N/A</u> 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 <u>N/A</u> Consistency <u>N/A</u> 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 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>22</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>	

Initial Assessment See Narrative for Additional information Signature [Signature] Date: 2/14/24 Time: 0830
 No Changes to initial assessment See Narrative for s Signature _____ Date: _____ Time: _____
 No Changes to previous assessment See Narrative for s Signature _____ Date: _____ Time: _____

DAILY ASSESSMENT



62, 63, 64, 66

<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</p> <p><input type="checkbox"/> Cool Calf Tenderness/Swelling <input type="checkbox"/> R <input type="checkbox"/> L</p> <p>Ted Hose <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N SCDs <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p><input type="checkbox"/> Plexipulses Capillary Refill: <u>3</u> Seconds</p> <p>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></p> <p>Pedal R <u>2+</u> L <u>2+</u></p> <p>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</p> <p><input checked="" type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Comatose</p> <p><input type="checkbox"/> Sedated <input type="checkbox"/> Drowsy Cough Reflex <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Follows Simple Commands: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gag <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Muscle Strength: (S-Strong, W-Weak, N-None)</p> <p>Grips: Rt. <u>S</u> Lt. <u>S</u> Pushes: Rt. <u>W</u> Lt. <u>W</u></p> <p>Comments:</p> <p>Response to Questions: <input type="checkbox"/> Readily <input type="checkbox"/> Slowly <input type="checkbox"/> None</p> <p><input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Withdrawn <input type="checkbox"/> Friendly</p> <p><input type="checkbox"/> Restless <input type="checkbox"/> Appro. for age <input type="checkbox"/> Hostile/Angry</p> <p><input type="checkbox"/> Crying <input type="checkbox"/> Anxious <input type="checkbox"/> Concerned</p> <p>Facial expressions: <input type="checkbox"/> Flat <input type="checkbox"/> Responsive <input type="checkbox"/> Grimace</p> <p><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 type="checkbox"/> Dependent</p> <p>Pitting: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+</p> <p>Skin Turgor WNL <input checked="" type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Abnormal Heart Sounds <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Murmur <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>PPM Site: _____ Rhythm: _____</p>
<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent</p> <p>Stool Color _____ Consistency _____</p> <p>Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Guarding</p> <p>Bowel Sounds: <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>X <input checked="" type="checkbox"/> Y <input type="checkbox"/> N Quadrants Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p><input type="checkbox"/> PEG <input type="checkbox"/> NGT <input type="checkbox"/> DHT R or L</p> <p>Comments: <u>Clear liquids, no BM</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</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness <input type="checkbox"/> Weak</p> <p><input type="checkbox"/> Deformities <input type="checkbox"/> Contractures <input type="checkbox"/> Spasms <input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Amputation <input type="checkbox"/> Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady</p> <p>Comments: <u>fall risk</u></p>	<p>PACER SETTINGS</p> <p><input type="checkbox"/> None</p> <p>Rate _____ MA: A _____ V _____</p> <p>Sensitivity _____ Mode _____</p> <p>Transvenous @ _____ cm Site _____</p> <p>Epicardial wires <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Permanent Pacemaker Site</p> <p><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</p> <p><input type="checkbox"/> Amber <input type="checkbox"/> Bloody <input type="checkbox"/> Voids</p> <p><input type="checkbox"/> Foley Size _____ Fr Insertion Date _____</p> <p><input type="checkbox"/> Urostomy <input type="checkbox"/> BRP <input type="checkbox"/> Urinal/Bedpan <input type="checkbox"/> BSC <input type="checkbox"/> Incontinent</p> <p>Comments: <u>no description noted</u></p>	<p>EYES, EARS, NOSE, THROAT</p> <p>Sclera: <input checked="" type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Red</p> <p>Scleral Edema: <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat: <input type="checkbox"/> Y <input checked="" type="checkbox"/> N</p> <p>Nasal Drainage: <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Comments:</p>	<p>INCISIONS/WOUNDS/DRAINS</p> <p><input type="checkbox"/> None</p> <p>#1 Location: <u>anterior frontal region</u></p> <p><input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p><input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color <u>none</u></p> <p><input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings</p> <p><input type="checkbox"/> Comments</p> <p>#2 Location: _____</p> <p><input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p><input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p><input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____</p> <p><input type="checkbox"/> Comments _____</p> <p>#3 Location: _____</p> <p><input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p><input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p><input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____</p> <p><input type="checkbox"/> Comments _____</p> <p>#4 Location: _____</p> <p><input type="checkbox"/> Sutures <input type="checkbox"/> Staples/Clips <input type="checkbox"/> Retention Sutures</p> <p><input type="checkbox"/> Reddened <input type="checkbox"/> Swollen <input type="checkbox"/> Drainage/Color _____</p> <p><input type="checkbox"/> Open to Air <input type="checkbox"/> Dressings _____</p> <p><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: _____</p> <p><input type="checkbox"/> Subclavian <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> PICC <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input checked="" type="checkbox"/> Peripheral <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> L A, COT Start: <u>2/13/24</u></p> <p><input type="checkbox"/> Peripheral <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> Arterial Line <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p><input type="checkbox"/> Femoral <input type="checkbox"/> Radial</p> <p><input type="checkbox"/> PA @ _____ cm <input type="checkbox"/> R <input type="checkbox"/> L Start: _____</p> <p>Hemodialysis Access Location _____</p> <p><input type="checkbox"/> Graft <input type="checkbox"/> AV Fistula <input type="checkbox"/> Thrill <input type="checkbox"/> Bruit</p>	<p>PULMONARY</p> <p>Respirations: <input type="checkbox"/> No Distress <input type="checkbox"/> SOB <input type="checkbox"/> Labored</p> <p><input type="checkbox"/> Accessory Muscles <input type="checkbox"/> Shallow <input type="checkbox"/> Apnea <input type="checkbox"/> Tachypnea</p> <p><input type="checkbox"/> RA O2: _____ NC <input type="checkbox"/> Venti Mask <input type="checkbox"/> Trach Collar</p> <p><input type="checkbox"/> Non rebreather <input type="checkbox"/> T-Piece <input type="checkbox"/> Ventilator: <input type="checkbox"/> BiPAP/CPAP</p> <p># <u>NAETT</u> @ <u>NA</u> cm # <u>NA</u> Shiley Trach</p> <p>BVM at bedside <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Obturator at bedside <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Cough: <input type="checkbox"/> Productive <input type="checkbox"/> Non Productive <input type="checkbox"/> None</p> <p>Secretions: Color <u>N/A</u> Consistency <u>N/A</u></p> <p>Amt. <input type="checkbox"/> Copious <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal</p> <p>Comments:</p>	<p>CHEST TUBES</p> <p><input checked="" type="checkbox"/> None</p> <p>#1 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal</p> <p>Comments _____</p> <p>#2 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal</p> <p>Comments _____</p> <p>#3 <input type="checkbox"/> Pleural <input type="checkbox"/> Mediastinal <input type="checkbox"/> L <input type="checkbox"/> R</p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Gravity</p> <p>Drainage Color: <input type="checkbox"/> Serous <input type="checkbox"/> Sanguinous <input type="checkbox"/> _____</p> <p>Air-leak <input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pleuravac <input type="checkbox"/> Thoraseal</p> <p>Comments _____</p>
<p>SKIN ASSESSMENT</p> <p><input type="checkbox"/> Skin Intact</p> <p>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: _____</p> <p>Skin Color normal for patient <input checked="" type="checkbox"/></p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Shiny <input type="checkbox"/> Clammy <input type="checkbox"/> Cool</p> <p><input type="checkbox"/> Diaphoretic</p> <p>Braden Scale Score <u>15</u></p> <p><input checked="" 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> 	<p>Date: <u>2/14/24</u> Time: <u>09:00</u></p> <p>Date: _____ Time: _____</p> <p>Date: _____ Time: _____</p>

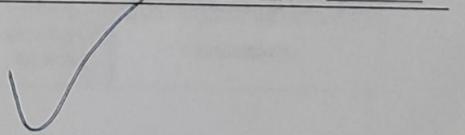
Initial Assessment See Narrative for Additional information Signature: [Signature]

No Changes to initial assessment See Narrative for _____s Signature _____

No Changes to previous assessment See Narrative for _____s Signature _____

COVENANT SCHOOL OF NURSING STUDENT DOCUMENTATION

DAILY ASSESSMENT



VIM DEPARTMENT

Diagnostic Worksheet

Mark high / low values with (↑ or ↓)	Covenant Normal Values	Dates	
		Admit day	Most Recent
WBC	3.6-10.8 K/uL	12/21	11/05
HGB	14-18 g/dL	9.5	9.0
HCT	42% - 52%	30.1	29.1
RBC	4.7-6.1 m/uL	3.8	3.8
PLT	150 - 400 K/uL	400	379
Glucose	70-110 mg/dL	97	94
Sodium	134 - 145 mmol/L	141	141
Potassium	3.5 - 5.3 mmol/L	3.5	3.5
BUN	9-21 mg/dL	13	14
Creatinine	0.8-1.5 mg/dL	1.1	1.1
Chloride	98 - 108 mmol/L	110	114
Calcium	8.4 - 11.0 mg/dL	8.7	8.3
Mg++	1.6 - 2.3 mg/dL	1.1	1.3
Total Protein	5.5 - 7.8 g/dL	7.1	7.3
Albumin	3.4 - 5 g/dL	3.0	2.7
Total Bilirubin	0.1 - 1.3	0.4	0.5
AST (SGOT)	5 - 45 U/L	15	10
ALT (SGPT)	7-72 U/L	18	11
Alk Phos (ALP)	38 - 126 U/L	120	132
Cholesterol	200mg/dL		
TRIG	0-150 mb/dL		
HDL	>60mg/dL		
LDL	0-100 mg/dL		
GFR	Refer to lab specific data	>60	>60
TSH	0.35 - 5.5 U/L		
Digoxin	0.8 - 2 ng/dL		
PT	10.0 - 12.9 secs	1.0	
INR	Therapeutic 2 - 3		
PTT	25.3 - 36.9 secs		
BNP	5 - 100 pg/dL		
CKMB	0 - 5 ng/dL		
Troponin	neg = < 0.07 ng/mL		

Mark high / low values with (↑ or ↓)	Covenant Normal Values	Dates	
		Admit day	Most Recent
Sp Gravity	1.005-1.030	1.021	
Protein	neg trace	neg	
Glucose	neg	neg	
Ketone	neg trace	1 smudgy	
Nitrite	neg	pos	
Leukocytes	neg	mod	
Bilirubin	neg	neg	
Blood	0-2/HPF	neg	
pH	5.0-7.00	5.5	
Other Labs			
Date	Culture	Site	Result
	Blood		
	Urine		
	Wound		
	Wound		
Other Diagnostic / Procedures Examples: CT/Xray/MRI/Paracentesis			
Date	Type	Result	
2/19/21	Abd pelvic w/ACR	SMALL & FEWER STAINS	
Point of Care Glucose Results			
Date	Time	Result	

VIM 22/2/2016

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

Allergies: Levofloxacin, Augmentin (amoxicillin), iodine, morphine, heparin, sulfa

Primary IV fluid and rate: D5 + NaCl 0.45% (DS 1/2 NS) @ 50ml/hr

Patient specific reasoning for IV fluids (including type isotonic, hypotonic, hypertonic): hypotonic - isotonic for hypotension

Generic Name	Dosage with route and schedule	IV-List diluent solution, volume, and rate of administration IVPB- List concentration and rate of administration	Patient specific therapeutic reasoning	Patient specific teaching with reasoning
Clonidine	75mg PO daily	IVP-Ø		<ol style="list-style-type: none"> 1. Report all meds to DR 2. Many meds can interact 3. Can affect thyroid levels 4. Can affect weight gain or loss 5. Can decrease liver function 6. Report any change in health
Diltiazem	180mg PO daily	IVP-Ø	Calcium channel blocker, antiarrhythmic	<ol style="list-style-type: none"> 1. Can cause hypotension, report all decrease in BP 2. Can cause adverse reactions if taken with beta-blockers 3. Can cause liver problems, report any pain, dark urine or jaundice 4. Can cause stomach ulcers, avoid taking other NSAIDs 5. Can cause stomach ulcers and bleeding, report dark stool or hematemesis
Donepezil	10mg PO daily	IVP-Ø	Alzheimer's	

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

Allergies:

Primary IV fluid and rate:

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

Generic Name	Dosage with route and schedule	IV-List diluent solution, volume, and rate of administration NVP- List concentration and rate of administration	Patient specific therapeutic reasoning	Patient specific teaching with reasoning
Famotidine	20mg po daily	IVP-0 IVPB-0	heartburn	1. may require other lifestyle changes to take full effect, including diet + exercise 2. can cause prolonged QT syndrome, tell your Dr if any heart concerns 3. avoid other acid reducers, can increase risk for stomach damage 1. can cause heart arrhythmias, report any heart concerns 2. can cause high B/L, may require frequent sugar checks 3. can cause dizziness side effects leading to death if mixed with weight loss meds
Levothyroxine	125mcg po oral daily before breakfast	IVP-0 IVPB-0	hypothyroidism	1. can increase BP, do not take with uncontrolled HTN 2. can cause HTN, report headaches, blurred vision or pounding in neck/ears 3. can affect liver reactivity, report swelling or painful enlargement
Mirabegron	5mg po daily	IVP-0 IVPB-0	over active bladder	1. tell your Dr if you take anti coagulants, can increase risk of bleeding 2. can cause hypokalemia may require frequent labs 3. can increase bleeding in renal failure, report renal conditions
Piperacillin-Tazobactam	3.375g in NaCl 0.9% Q8	IVP-0 IVPB-3375g in NaCl 0.9% 100ml over 4hrs	antibiotic	

Med Reference: with prescription drug interactions, side effects, drugs.com. published 2023.
<https://www.drugs.com/>