

# BASELINE NURSING ASSESSMENT

 Date 3-21-2011

 Time of Assessment 0745

|                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                                                                                                                                                                                                                                                        |       |           |          |
|----------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------|----------|
| NEURO                      | Mentation/LOC          | Oriented to: <input checked="" type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input checked="" type="checkbox"/> Situation/Event<br><input checked="" type="checkbox"/> Alert <input type="checkbox"/> Sedated <input type="checkbox"/> Restless <input type="checkbox"/> Sleepy/arousable <input type="checkbox"/> Lethargic<br><input type="checkbox"/> Unresponsive <input type="checkbox"/> Responds only to pain<br><input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Combative <input type="checkbox"/> Hallucinating <input type="checkbox"/> Other<br><input checked="" type="checkbox"/> Pain Level 0 (none) to 10 (maximum) |                |                                                                                                                                                                                                                                                        |       |           |          |
| SKIN                       | Skin Integrity         | <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Ulcer/Purpura/Skin tears/Locations: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Wound/Abrasion         | Drainage: <input type="checkbox"/> None <input type="checkbox"/> Other _____ Size: _____ Depth/Stage: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Surgical incision/Site | Drainage: <input checked="" type="checkbox"/> None <input type="checkbox"/> Other _____ Dressing: <input type="checkbox"/> Clean <input type="checkbox"/> Dry <input type="checkbox"/> Intact                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Other:                 | <input checked="" type="checkbox"/> Air mattress <input type="checkbox"/> Specialty bed <input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                                                                                                                                                                                                                                                        |       |           |          |
| CARDIAC                    | Equipment              | <input checked="" type="checkbox"/> None +1/+2/+3/+4 <input type="checkbox"/> Location _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Edema                  | <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Faint <input type="checkbox"/> Absent CMS: <input type="checkbox"/> WNL <input type="checkbox"/> Other: <u>Pedal Pulses +1</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Arterial Pulses/CMS    | <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Clammy <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Skin Temperature       | <input checked="" type="checkbox"/> Pink/Natural <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced <input type="checkbox"/> Mottled <input type="checkbox"/> Cyanotic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Skin Color             | <input checked="" type="checkbox"/> Normal (1-2 seconds) <input type="checkbox"/> Delayed (>3 seconds)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Capillary Refill       | <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |                                                                                                                                                                                                                                                        |       |           |          |
| RESP                       | Rhythm/Heart Sounds    | <input checked="" type="checkbox"/> No distress <input type="checkbox"/> SOB <input type="checkbox"/> Shallow <input type="checkbox"/> Labored                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Respirations           | <input type="checkbox"/> Clear <input checked="" type="checkbox"/> Crackles <input type="checkbox"/> Fine <input type="checkbox"/> Coarse <input type="checkbox"/> Wheezes: Insp./Exp. <input type="checkbox"/> Diminished                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Breath Sounds          | <input type="checkbox"/> Absent <input type="checkbox"/> Productive <input type="checkbox"/> Non-productive <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Cough                  | Color: <u>Clear</u> Consistency: <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Suctioned:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Sputum/Secretions      | <input checked="" type="checkbox"/> None <input type="checkbox"/> S _____ TCDS _____ <input type="checkbox"/> IPPB <input type="checkbox"/> Neb/MDI <input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Respiratory Rx         | <input type="checkbox"/> None <input type="checkbox"/> O2 @ <u>2</u> L/min <input type="checkbox"/> FiO2 _____ %per <u>Nasal Cannula</u> <input type="checkbox"/> BPAP/CPAP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | O2 Therapy             | <input type="checkbox"/> None <input type="checkbox"/> Intermittent <input checked="" type="checkbox"/> Continuous Probe Location: <u>R Index</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Oximetry               | <input checked="" type="checkbox"/> N.A. Waterseal/ _____ cm suction Drainage: <input type="checkbox"/> Air leak                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                |                                                                                                                                                                                                                                                        |       |           |          |
| GI                         | Chest Tube             | <input type="checkbox"/> NPO <input type="checkbox"/> Reg <input type="checkbox"/> CL <input type="checkbox"/> ADA <input type="checkbox"/> Other <input type="checkbox"/> Aspiration Precautions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Diet                   | Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Nausea <input type="checkbox"/> Emesis <u>Refused</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Appetite               | <input checked="" type="checkbox"/> N.A. <input type="checkbox"/> NG/NJ @ _____ <input type="checkbox"/> GT @ _____ <input type="checkbox"/> Clamped <input type="checkbox"/> Int. Suction <input type="checkbox"/> Cont. Suction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | NG Tube                | <input type="checkbox"/> Other <input type="checkbox"/> T.F. <input type="checkbox"/> Gravity <input type="checkbox"/> Bag/Btl. change                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Feeding Tube           | <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Hard <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Girth: _____ cm <u>See Notes</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Abdomen                | <input type="checkbox"/> Normal <input type="checkbox"/> Hyperactive <input checked="" type="checkbox"/> Hypoactive <input type="checkbox"/> Absent <input type="checkbox"/> Flatus <u>See Notes</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                                                                                                                                                                                                        |       |           |          |
| GU                         | Bowel Sounds           | <input checked="" type="checkbox"/> None <input type="checkbox"/> Formed <input type="checkbox"/> Soft <input type="checkbox"/> Liquid Color: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Stool                  | <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Condom Cath <input type="checkbox"/> Foley <input type="checkbox"/> Straight Cath _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Urine                  | Color: <u>Amber</u> Character: <u>Clear</u> <input type="checkbox"/> Bladder Scan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                        |       |           |          |
| ACTIVITY                   | Discharge              | <input checked="" type="checkbox"/> None <input type="checkbox"/> Menses <input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Drains                 | <input checked="" type="checkbox"/> None <input type="checkbox"/> _____ Drainage: _____<br><input type="checkbox"/> V.A.C. _____ Setting: _____ mm Hg <input type="checkbox"/> Cont. <input type="checkbox"/> Int.<br><input type="checkbox"/> V.A.C. Dressing change _____ <input type="checkbox"/> Canister change                                                                                                                                                                                                                                                                                                                                                                                                     |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Traction               | <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Skeletal/Skin Site: _____ # of pounds _____<br><input type="checkbox"/> Bath: Complete <input checked="" type="checkbox"/> Partial <input type="checkbox"/> Shower <input checked="" type="checkbox"/> Oral Care <input type="checkbox"/> Pericare <input type="checkbox"/> Back Care <input type="checkbox"/> Hair Wash<br><input type="checkbox"/> Other: _____ <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Total                                                                                                                                                                                          |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Hygiene                | <input checked="" type="checkbox"/> TEDS <u>Race</u> off x <u>30 min</u> <input type="checkbox"/> SCD _____ off x _____<br><input checked="" type="checkbox"/> Bedrest <input type="checkbox"/> HOB @ _____ degrees Turned x _____ Dangled x _____<br><input type="checkbox"/> BRP <input type="checkbox"/> Commode <input type="checkbox"/> Chair x <input type="checkbox"/> Amb.x <input type="checkbox"/> Indep. <input type="checkbox"/> With assist                                                                                                                                                                                                                                                                 |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Activity               | <input type="checkbox"/> Low <input type="checkbox"/> High (For details see Fall Risk Assessment)<br><input checked="" type="checkbox"/> Call Light in reach/pt. able to use <input checked="" type="checkbox"/> Bed low/brakes on # of siderails up: <u>2</u><br><input type="checkbox"/> Seizure Precautions <input type="checkbox"/> Overbed Frame: <input type="checkbox"/> Safety <input checked="" type="checkbox"/> complete<br><input checked="" type="checkbox"/> ID Band on <input checked="" type="checkbox"/> Allergy Band on/ <input type="checkbox"/> N.A. Other: _____                                                                                                                                    |                |                                                                                                                                                                                                                                                        |       |           |          |
| LINES                      | Fall Risk              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Patient Safety Needs   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                |                                                                                                                                                                                                                                                        |       |           |          |
|                            | Invasive Lines         | <input type="checkbox"/> None<br><input checked="" type="checkbox"/> Pump x <u>1</u><br><input checked="" type="checkbox"/> Peripheral <u>Tetacath</u><br><input type="checkbox"/> Peripheral <u>#20</u><br><input type="checkbox"/> Central<br><input type="checkbox"/> PICC                                                                                                                                                                                                                                                                                                                                                                                                                                            | Size/Size/Type | Size Inspection Description                                                                                                                                                                                                                            | Flush | Site Care | Tbg<br>△ |
|                            |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                | <input checked="" type="checkbox"/> WNL <input type="checkbox"/> <u>WNL</u><br><input type="checkbox"/> WNL <input type="checkbox"/><br><input type="checkbox"/> WNL <input type="checkbox"/><br><input type="checkbox"/> WNL <input type="checkbox"/> |       |           |          |
| ISO                        | Isolation Precautions  | <input type="checkbox"/> Std <input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Special Resp <input type="checkbox"/> Neg. pressure monitor <input checked="" type="checkbox"/> complete<br><input type="checkbox"/> Droplet <input type="checkbox"/> Neutropenic <input type="checkbox"/> Time Initiated/Discontinued: _____                                                                                                                                                                                                                                                                                                                                                   |                |                                                                                                                                                                                                                                                        |       |           |          |
| Nurse <u>McKamaleki RN</u> |                        | Nurse <u>Tisha Jones LVN</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | HCA/NA <u>Sarah Decker CNA</u>                                                                                                                                                                                                                         |       |           |          |

# Admission Charting For Nurses

**Lippincott**



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information on documentation issues including electronic medical records legal and ethical implications and documentation in acute cases along with a variety of charting examples **Fundamental Nursing Skills and Concepts** Barbara Kuhn Timby, 2009 Now in its Ninth Edition this full color text combines theoretical nursing concepts step by step skills and procedures and clinical applications to form the foundation of the LPN LVN course of study This edition features over 100 new photographs exciting full color ancillaries end of unit exercises and extensively updated chapters on nursing foundations laws and ethics recording and reporting nutrition fluid and chemical balance safety asepsis infection control and medication administration Coverage includes new information on cost related issues emerging healthcare settings concept mapping malpractice documentation and reporting HIPAA and more All Gerontologic Considerations sections have been thoroughly updated by renowned experts A Guide for International Nursing Students in Australia and New Zealand - E-Book

Bernadette Hally, 2008-11-01 Please note that this eBook does not include the DVD accompaniment If you would like to have access to the DVD content please purchase the print copy of this title This new book is an essential resource for overseas nurses and international students studying nursing in Australia and New Zealand It provides clear concise information about health care and nursing practice in our region and assists the reader to develop essential communication skills for practice

*The Nursing Student's Guide to Clinical Success* Lorene Payne, 2010-01-08 The Nursing Student's Guide to Clinical Success is the perfect resource for undergraduate nursing students entering the clinical side of their education This text helps students better understand their role as a health care provider by preparing them for what they will encounter on the clinical floor in hospital or other health care setting The first text of its kind this shows students how to get the most out of a clinical experience **Clinical Skills in Children's Nursing** Imelda Coyne, Fiona Timmins, Freda Neill, 2010-04-29

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Rebar,2009-04-10 The perfect guide to charting The popular Davis s Notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and thorough but also meets the highest ethical and legal standards You ll even find coverage of the nuances that are relevant to various specialties including pediatric OB GYN psychiatric and outpatient nursing     **Lippincott's Nursing Procedures** ,2009 The newly revised fifth edition of this popular reference is a start to finish guide for more than 400 basic to advanced nursing procedures It provides step by step instructions for each procedure and explains how to use and troubleshoot equipment     Study Guide to Accompany Rosdahl & Kowalski's Textbook of Basic Nursing Lazette Nowicki,Caroline Bunker Rosdahl,Eileen Klein,Mary T. Kowalski,2002-11-21 This excellent study guide helps LPN LVN students get the most out of the Textbook of Basic Nursing Eighth Edition This concise learning tool allows students to review all the key material from the Eighth Edition and features a self study CD ROM they can use to help prepare for class or examinations     *Charting Made Incredibly Easy!*

Lippincott,2012-03-29 In its Fourth Edition *Charting Made Incredibly Easy* provides up to the minute guidelines on documentation in a comprehensive clear concise practical and entertaining manner The book reviews the fundamental aspects of charting such as the medical record the nursing process and legal and professional requirements guidelines for developing a solid plan of care and the variety of charting formats currently being used It also addresses the specific requirements for charting in acute care home care and long term care and rehabilitation settings Special elements found throughout the book make it easy to remember key points This edition includes new information on cultural needs assessment HIPAA National Patient Safety Goals and electronic health records

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korea remains weaker on both small and medium enterprise and employment fronts but government

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