

# NURSING ASSESSMENT

HOSPITAL \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ MEDICAL RECORD NUMBER: \_\_\_\_\_

DATE:	TIME:					T	NURSES NOTES
NEUROBEHAVIOR							
RESPIRATORY							
CARDIOVASCULAR							
GASTROINTESTINAL							
GENITOURINARY							
SKIN							
MUSCULOSKELETAL							
SAFETY							

INIT	SIGNATURE	INIT	SIGNATURE	INIT	SIGNATURE	INIT	SIGNATURE
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- CHECK ALL THAT APPLY
- LOSS OF APPETITE (50% OR LESS) FOR 3 DAYS OR MORE PRIOR TO ADMISSION
  - UNWANTED WEIGHT LOSS OF 10 POUNDS OR MORE
  - DIFFICULTY SWALLOWING/CHEWING
  - PRESSURE ULCER STAGE 2 OR GREATER
  - RECEIVING TPN, PPN, TUBE FEEDING
  - ADMITTED WITH DX OF CONGESTIVE HEART FAILURE
  - SURGICAL INTERVENTION AND AGE 70
  - NEWLY DIAGNOSED DIABETES MELLITUS
  - CLINSTAR ORDER TO NUTRITION DEPARTMENT - IF ANY OF ABOVE CHECKED

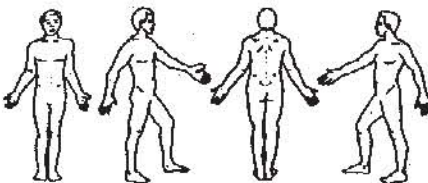
- CALM COOPERATIVE
- UNCOOPERATIVE
- AGITATED/RESTLESS
- ANXIOUS
- SAD/FEARFUL
- CRYING

\_\_\_\_\_ (OTHER)  
 \_\_\_\_\_ (OTHER)  
 CONSIDER CONSULTS/REFERRALS

If answer is: ≤ 14 on Norton Scale, 'Yes' to Fall Risk Assessment, or 'Yes' to Assistance or Dependence to Self Care Ability question, alert Physician and Case Management.

NORTON SCALE						Circle number at each parameter. Score of 14 or less indicate a patient at risk for altered skin integrity.			(add circled numbers)		
Physical Condition	Mental Condition	Activity	Mobility	Incontinent		NORTON SCALE	ADMIT DATE:	SCORE:			
Good = 4	Alert = 4	Walks = 4	Full	Does not have = 4							
Fair = 3	Apathetic = 3	Walks w/help = 3	Slightly limited = 3	Has occasionally = 3							
Poor = 2	Confused = 2	Chairbound = 2	Very limited = 2	Usually urinary = 2							
Very bad = 1	Stuporous = 1	Bedfast = 1	Immobile = 1	Double = 1							

Number and circle location of each pressure score.



PLEASE DOCUMENT ON ADMISSION, WEEKLY, AND IF ANY CHANGES OCCUR, AND ON DISCHARGE.

STAGE I: Erythema not resolving within (30) minutes of pressure relief. Epidermis remains intact. REVERSIBLE WITH INTERVENTION.

STAGE II: Partial thickness loss of skin layers involving epidermis and possible penetrating into but not through dermis. May present as blistering with erythema and/or induration; wound base moist and pink; painful; free of necrotic tissue.

STAGE III: Full-thickness tissue loss extending through dermis to involve subcutaneous tissue. Presents as shallow crater unless covered by eschar.\* May include necrotic tissue, undermining sinus tract formation, exudate, and/or infection. Wound base is usually not painful.

STAGE IV: Deep tissue destruction extending through subcutaneous tissue to fascia and may involve muscle layers, joint, and/or bone. Presents as a deep crater, unless covered by eschar.\* May include necrotic tissue, undermining, sinus tract formation, exudate, and/or infection. Wound base usually not painful.

\* If wound involves necrotic tissue staging cannot be confirmed until wound base is visible.

Date/Time	Length Width Depth	in cm.	Stage	Site	Appearance P = Pink S = Slough E = Eschar	Drainage + *0 = None 1 = Serous 2 = Purulent 3 = Bloody	Comments (odoc, etc.)	Treatment	Osteomy Notified
									<input type="checkbox"/> Yes

Fall Prevention Program implemented?  YES  N/A

HIGH RISK FACTORS: Implement if any one present

- History of fall within 3 months
- Impaired mobility, including use of assistive devices (cane, walker, etc.)
- Dizziness/sensory deficits
- Frail elderly (65+ with multiple co-morbidities)
- Incontinence, frequency, urgency
- Impaired mental status/confusion

MODERATE RISK FACTORS: Implement if any two or more present

- Post-Op 1st 24 hours
- Medications:
  - Diuretic/Laxatives
  - Anti-Hypertensives
  - Sedatives/Narcotics/CNS Depressants
- History of dysrhythmias
- Morbid Obesity

CHECK ALL THAT APPLY:

- INDEPENDENT
- SOME ASSISTANCE
- DEPENDENT
- BEDSIDE COMMODE
- OTHER \_\_\_\_\_
- CANE
- CRUTCHES
- WALKER
- WHEELCHAIR

ARE YOU AFRAID OF OR HAVE YOU BEEN THREATENED BY A CURRENT OR FORMER PARTNER?  YES  NO

WITHIN THE LAST YEAR, HAVE YOU BEEN HIT, SLAPPED, KICKED, FORCED INTO SEXUAL ACTIVITY OR OTHER WISE PHYSICALLY HURT BY A CURRENT OR FORMER PARTNER?  YES  NO

INTERVENTION: \_\_\_\_\_

SIGNATURE	TIME/DATE	INIT	SIGNATURE	TIME/DATE	INIT
	/ /			/ /	
	/ /			/ /	

HOSPITAL  
**ADMISSION/DISCHARGE DATABASE**  
 (NURSING)  
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- HOME WITH FAMILY (SPOUSE, SO, FRIEND, ETC)
- HOME ALONE/INDEPENDENT
- HOME ALONE/WITH INTERMITTENT ASSISTANCE
- SHORT TERM REHABILITATION FACILITY
- ASSISTED LIVING FACILITY - DESCRIBE LEVEL: \_\_\_\_\_
- SKILLED NURSING FACILITY (NURSING HOME)
- OTHER: \_\_\_\_\_

- CARDIAC REHABILITATION                 NUTRITION
- ENTEROSTOMAL SERVICES               PAIN CLINIC
- HOME CARE                                 PHARMACY (MEDICATION EDUCATION)
- HOSPICE                                     PT/OT/SPEECH THERAPY
- INFECTION CONTROL                    PULMONARY REHABILITATION
- IV THERAPY                               SOCIAL SERVICES/CASE MANAGEMENT
- OTHER: \_\_\_\_\_

- HOME WITH FAMILY (SPOUSE, SO, FRIEND, ETC)
- HOME ALONE/INDEPENDENT
- HOME ALONE/WITH INTERMITTENT ASSISTANCE
- SHORT TERM REHABILITATION FACILITY
- ASSISTED LIVING FACILITY - DESCRIBE LEVEL: \_\_\_\_\_
- SKILLED NURSING FACILITY (NURSING HOME)
- UNABLE TO IDENTIFY AT THIS TIME
- OTHER: \_\_\_\_\_

- NPO SINCE: \_\_\_\_\_ (TIME/DATE)     N/A COMMENTS: \_\_\_\_\_
- LAST DOSE THROMBOLYTIC: \_\_\_\_\_ (TIME/DATE)    \_\_\_\_\_ (DRUG/DOSE)
- N/A                                        \_\_\_\_\_ (TIME/DATE)    \_\_\_\_\_ (DRUG/DOSE)
- \_\_\_\_\_ (TIME/DATE)    \_\_\_\_\_ (DRUG/DOSE)
- \_\_\_\_\_ (TIME/DATE)    \_\_\_\_\_ (DRUG/DOSE)
- PRE-ADMIT PREOPERATIVE PREPS DONE (ie-BOWEL, SKIN, ETC)-LIST: \_\_\_\_\_
- NA
- PREOPERATIVE EDUCATION COMPLETED TO: \_\_\_\_\_
- PATIENT    SO    OTHER: \_\_\_\_\_ (RELATIONSHIP)
- PREOPERATIVE EDUCATION RESPONSE (CHECK ALL THAT APPLY):
- DEMONSTRATED KNOWLEDGE    VERBALIZED KNOWLEDGE    NO QUESTIONS    OTHER: \_\_\_\_\_
- IV ACCESS:    PERIPHERAL/SITE/GAUGE: \_\_\_\_\_
- CENTRAL/SITE/TYPE: \_\_\_\_\_
- IV ACCESS-PERIPHERAL-STARTED BY: \_\_\_\_\_ (UNIT) STAFF NAME IF ASD: \_\_\_\_\_
- NA

MAMMOGRAPHY EDUCATIONAL MATERIALS PROVIDED IF MEDICALLY APPROPRIATE

PATIENT ADMISSION ASSESSMENT/SYSTEM REVIEW COMPLETED

PLAN OF CARE INITIATED

SIGNATURE	TIME/DATE	INIT	SIGNATURE	TIME/DATE	INIT
	/			/	
	/			/	
	/			/	
	/			/	