GRAYSON COLLEGE
ASSOCIATE DEGREE
NURSING PROGRAM

NURSING 1

RNSG 1360

Course Information: ***RNSG 1360,***
Introduction to Professional Nursing for Integrated Programs,

Professor Contact Information:

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Course Description:
(0-0-12-192-3) A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional.

Course Pre-requisites, Co-requisites, and/or Other Restrictions

Pre-requisites: BIOL 2301/2101 or 2401 & 2302/2102 or 2402; MATH 1314 or MATH 1342.

Co-requisites: RNSG 1360 must be taken concurrently with RNSG 1119 and RNSG 1423.

Restrictions: A grade of "Pass" (75%) or better is required to progress to Nursing 2 courses.

Course Placement: First semester of the nursing program. Acceptance to the nursing program required.

End-of-Program Student Learning Outcomes:

Member of the profession
1.1 Demonstrate professional attitudes and behaviors.
1.2 Demonstrate personal accountability and growth.
1.3 Advocate on behalf of patients, families, self, and the profession.
Provider of patient-centered care
2.1 Use clinical decision-making skills to provide safe, effective care for patients and families.
2.2 Develop, implement, and evaluate teaching plans to meet the needs of patients and families.
2.3 Integrate a caring approach in the provision of care for diverse patients and families.
2.4 Perform skills safely and correctly in the provision of patient care.
2.5 Manage resources in the provision of safe, effective care for patients and families.
Patient safety advocate
3.1 Implement measures to promote a safe environment for patients, self, and others
3.2 Formulate goals and outcomes to reduce risk using evidence-based guidelines.
Member of the health care team
4.1 Initiate and facilitate communication to meet the needs of patients and families.
4.2 Collaborate with patients, families, and health care team members to promote quality care.
4.3 Function as a member of the interdisciplinary team.

Course Outcomes:

- Demonstrate professional attitudes and behaviors
- Demonstrate personal accountability and growth
- Identify the role of the nurse as a patient advocate
- Use clinical decision-making skills to provide safe, effective care for one patient
- Apply basic teaching/learning principles to develop individualized teaching plans
- Provide considerate and respectful care to diverse patients
- Perform skills safely and correctly in the provision of patient care
- Use appropriate resources to safely provide basic patient care
- Implement measures to promote a safe environment for patients, self, and others
- Implement risk reduction strategies
- Convey information in an accurate and timely manner

- Elicit participation of patients, families, and healthcare team members to meet patient needs
- Describe the roles of the members of the interdisciplinary team

SCANS Skills:

When taken concurrently with RNSG 1423 and RNSG 1119, the following skills will be achieved:

Workplace Competencies

1. Resources: Identifies, organizes, plans, and allocates resources
   Students in RNSG 1360 must be able to manage the care of one client and organize their time in the clinical setting to complete the objectives of the clinical assignment.
2. Interpersonal: Works with others
   Students in RNSG 1360 must learn to work in groups for the achievement of goals. This learning is also reflected in the student's ability to work with the healthcare team.
3. Information: Acquires and uses information
   Students in RNSG 1360 must learn to access all available information sources in order to collect data including the Internet, patient records, physician records and peer reviewed nursing journals. They must be able to evaluate what information is pertinent to solve patient problems and deliver appropriate nursing care. Students must learn to use the information for communicating therapeutically to clients and documenting in client records and clinical assignments.
4. Systems: Understands complex inter-relationships
   Students in RNSG 1360 must be able to demonstrate understanding of the operations of various healthcare delivery systems, especially nursing services. Students must become familiar with managed care defined as a system of health care that provides a generalized structure and focus when managing the use, cost, quality and effectiveness of health care services.
5. Technology: Works with a variety of technologies
   Students in RNSG 1360 are introduced to a variety of technology in the healthcare system. They must learn to use information technology for information handling. Students must analyze, store, retrieve and/or manage data and information needed by nurses in providing care to individual clients.

Foundations Skills

1. Basic Skills: Reading, Writing, Math, Listening and Speaking
   Students in RNSG 1360 are required to complete nursing care plans and physical assessments. Students must also demonstrate mastery with dosage calculations by completing an exam with 90% accuracy.
2. Thinking Skills: Creative thinking, problem solving, visualizing relationships, reasoning and learning
   Students in RNSG 1360 are required to demonstrate reflective and critical thinking by being inquisitive, honest in facing personal biases, and prudent in making judgments. The students must develop a value system of right and wrong that helps the student with affective behavioral skills.
3. Personal Qualities: Responsibility, Sociability, self-management, integrity and honesty
   Students in RNSG 1360 must learn to actively participate in the process of gaining knowledge. They must transition from the passive to active learner role. They must come to class prepared to engage with the content while interacting with faculty and fellow students in planned learning activities.

Methods of Instruction:

1. Required textbooks
2. Instructor – Student Conferences
3. Written assignments
4. Weekly discussion forums
5. Supervised care of selected clients in the clinical setting
6. Daily clinical evaluations
7. Lecture/Discussion
8. Audio-Visual or Computer materials
9. Weekly PrepU assignments in The Course Point
10. Weekly journaling

Methods of Evaluation:

1. A student must pass theory, lab and clinical courses to progress to the next nursing level.
2. The clinical grade is based upon clinical performance and written assignments.
   A. Clinical performance will be evaluated by the clinical professor on a daily evaluation sheet, and on the *Clinical Performance Evaluation Tool* at mid-semester and upon completion of the semester.
   B. Clinical performance is evaluated as a "Pass" or "Fail" grade. To receive a clinical grade of "Pass", the student must, at the completion of the clinical course, exhibit a satisfactory level of 75% (3.0) or better on all starred (*) criteria (behaviors) on the *Clinical Performance Evaluation Tool*.
   C. All assignments listed in the syllabus as well as any additional assignments given by the clinical professor must be satisfactorily completed and submitted to the clinical professor by the designated deadline date in order to receive a grade of "Pass." All online assignments for the Clinical Canvas Course are in Microsoft Office format. No other type of submission will be accepted. Assignments include returning the signed daily evaluation back to the instructor by the designated deadline.
   D. Continued failure to turn in assignments by the designated deadline will result in an "Unsatisfactory" (2.0) for each day / week that the assignment is late.

Course Grading:

1. RNSG 1360 is a pass/fail course.

Course & Instructor Policies

Attendance:
The ADN program adheres to the Grayson College Student Handbook attendance policy. Should absences occur which do not allow for full evaluation of student performance (quality and consistency) faculty will be unable to assign a passing grade. In addition, the following policies are specific to the clinical course.

1. Attendance on the assigned clinical day is mandatory. Any missed clinical time must be made up. More than one clinical absence during the entire program may be grounds for dismissal based on the recommendation of the Admission, Retention and Graduation Committee.
2. A student must notify the clinical instructor if he/she is going to be late to any clinical experience. Failure to notify the professor or an unexcused tardiness, per the instructor's discretion, will result in an absence for the clinical day.
2. Students must attend all pre and post-conferences either in the clinical setting or on campus (i.e., guest speakers, lab practices, etc.).
3. Students are expected to remain on the clinical campus during the entire clinical day. If a student must leave the clinical campus during a designated meal or break time, the student must have permission of the clinical instructor and is responsible to ensure that there is adequate coverage to meet the needs of assigned clients.
4. Students must notify the professor or a designated alternate at least one hour prior to time scheduled for clinical if they are going to be absent. Failure to notify the professor will be reflected on the final clinical evaluation and may result in a clinical failure.

Please refer to your Grayson Nursing Student Handbook for additional information/policies on attendance.

In case of inclement weather, emergency closings, or other unforeseen disruptions to scheduled classes, student must log onto their Canvas accounts for directions on where or how to continue their coursework. The schedule is subject to change with fair notice and will be made through Announcements in the Canvas Course.

The student is highly encouraged to subscribe to GC alert at grayson.edu for GC closings, delay in class time and weather/emergency related issues.

Clinical Procedures Policy

1. Medications may be administered only after satisfactory completion of a campus laboratory student demonstration (check-off).
2. Procedures not marked may be performed independently by the student following satisfactory lab check-off.
3. All procedures marked with a **(*)** must be supervised by a faculty member until released for supervision by a designated Registered Nurse.
4. If an error is made while completing a procedure, the student must follow the *Procedure Variance Policy.*
5. Removal of any medical device must be approved or supervised by the clinical instructor or approved Registered Nurse.
6. During Role Transition, the clinical preceptor is the "designated RN
7. Documentation of all procedures as appropriate.

Nursing 1	Nursing 2	Nursing 3	Nursing 4
Vital signs	Vital signs	Vital signs	Vital signs
Bed making	Bed making	Bed making	Bed making
Bed bath	Bed bath	Bed bath	Bed bath
ROM exercises	ROM exercises	ROM exercises	ROM exercises
Transfers / positioning	Transfers / positioning	Transfers / positioning	Transfers / positioning
Health assessment	Health assessment	Health assessment	Health assessment
Glucometer check	Glucometer check	Glucometer check	Glucometer check
		Basic EKG interpretation	Basic EKG interpretation
Dressing change Non-sterile dressing	Dressing change Non-sterile dressing Sterile dressing * Central line dressing *	Dressing change Non-sterile dressing Sterile dressing * Central line dressing *	Dressing change Non-sterile dressing Sterile dressing * Central line dressing *
	NG tube insertion *	NG tube insertion *	NG tube insertion *
	Gastric tube feeding *	Gastric tube feeding *	Gastric tube feeding *
	Urinary catheterization *	Urinary catheterization *	Urinary catheterization *
Medication administration	Medication administration	Medication administration	Medication administration
Oral *	Oral *	Oral *	Oral *
Intramuscular *	Intramuscular *	Intramuscular *	Intramuscular *
Intradermal *	Intradermal *	Intradermal *	Intradermal *
Subcutaneous *	Subcutaneous *	Subcutaneous *	Subcutaneous *
Suppository *	Suppository *	Suppository *	Suppository *
Topicals *	Topicals *	Topicals *	Topicals *
Inhalers *	Inhalers *	Inhalers *	Inhalers *
Eye / ear meds *	Eye / ear meds *	Eye / ear meds *	Eye / ear meds *
	NG / PEG tube meds *	NG / PEG tube meds *	NG / PEG tube meds *
	IV push / IV piggyback *	IV push / IV piggyback *	IV push / IV piggyback *
	Venipuncture / IV insertion*	Venipuncture / IV insertion *	Venipuncture / IV insertion *
	Blood specimen collection*	Blood specimen collection *	Blood specimen collection*
	Access implanted venous port*	Access implanted venous port*	Access implanted venous port*
		Nasotracheal suctioning *	Nasotracheal suctioning *
		Tracheostomy suctioning *	Tracheostomy suctioning *
		Tracheostomy care *	Tracheostomy care *

Student Conduct & Discipline

Refer to ADN Student Handbook for policies

Grayson College campus-wide student policies may be found on our Current Student Page on our website: http://grayson.edu/current-students/index.html

Academic Integrity

Refer to the Grayson Nursing Student Handbook for policies

The faculty expects from its students a high level of responsibility and academic honesty. Because the value of an academic degree depends upon the absolute integrity of the work done by the student for that degree, it is imperative that a student demonstrate a high standard of individual honor in his or her scholastic work.

Scholastic dishonesty includes but is not limited to cheating, plagiarism, collusion, and the submission for credit of any work or materials that are attributable in whole or in part to another person, taking an examination for another person, any act designed to give unfair advantage to a student or the attempt to commit such acts. Plagiarism, especially from the web, from portions of papers for other classes, and from any other source is unacceptable and will be dealt with under the college's policy on plagiarism (see GC Student Handbook for details). Grayson College subscribes to turnitin.com, which allows faculty to search the web and identify plagiarized material.

Plagiarism is a form of scholastic dishonesty involving the theft of or fraudulent representation of someone else's ideas or words as the student's original work. Plagiarism can be intentional/deliberate or unintentional/accidental. Unintentional/Accidental plagiarism may include minor instances where an attempt to acknowledge the source exists but is incorrect or insufficient. Deliberate/Intentional plagiarism violates a student's academic integrity and exists in the following forms:

- Turning in someone else's work as the student's own (such as buying a paper and submitting it, exchanging papers or collaborating on a paper with someone else without permission, or paying someone else to write or translate a paper)
- Recycling in whole or in part previously submitted or published work or concurrently submitting the same written work where the expectation for current original work exists, including agreeing to write or sell one's own work to someone else
- Quoting or copy/pasting phrases of three words or more from someone else without citation, • Paraphrasing ideas without citation or paraphrasing incompletely, with or without correct citation, where the material too closely matches the wording or structure of the original
- Submitting an assignment with a majority of quoted or paraphrased material from other sources
- Copying images or media and inserting them into a presentation or video without citation,
- Using copyrighted soundtracks or video and inserting them into a presentation or video without citation
- Giving incorrect or nonexistent source information or inventing source information
- Performing a copyrighted piece of music in a public setting without permission
- Composing music based heavily on someone else's musical composition.

- **Student Responsibility**

You have already made the decision to go to college; now the follow-up decisions on whether to commit to doing the work could very well determine whether you end up working at a good paying job in a field you enjoy or working at minimum wage for the rest of your life. Education involves a partnership that requires both students and instructors to do their parts. By entering into this partnership, you have a responsibility to show up for class, do the assignments and reading, be engaged and pay attention in class, follow directions, and put your best effort into it. You will get out of your experience here exactly what you put into it – nothing more and nothing less.

Disability Services

The ADN faculty recognizes that, in specific circumstances, students in the ADN program may require modifications. This policy is consistent with the Rules & Regulations Relation to Professional Nursing Education, Licensure & Practice, Texas Board of Nursing, and with the Americans with Disabilities Act (ADA). Please refer to Grayson College's policy regarding student accommodations, the Grayson College Student Handbook, or refer to the website: www.grayson.edu for more information.

TITLE IX

GC policy prohibits discrimination on the basis of age, ancestry, color, disability, gender identity, genetic information, national origin, race, religion, retaliation, serious medical condition, sex, sexual orientation, spousal affiliation and protected veterans' status.

Furthermore, Title IX prohibits sex discrimination to include sexual misconduct: sexual violence (sexual assault, rape), sexual harassment and retaliation.

For more information on Title IX, please contact:

- Dr. Molly M. Harris, Title IX Coordinator (903)463-8714
- Ms. Logan Maxwell, Title IX Deputy Coordinator - South Campus (903) 415-2646
- Mr. Mike McBrayer, Title IX Deputy Coordinator - Main Campus (903) 463-8753
- Website: http://www.grayson.edu/campus-life/campus-police/title-ix-policies.html
- GC Police Department: (903) 463-8777- Main Campus) (903-415-2501 - South Campus)
- GC Counseling Center: (903) 463-8730
- For Any On-campus Emergencies: 911

**Grayson College is not responsible for illness/injury that occurs during the normal course of classroom/lab/clinical experiences.

**These descriptions and timelines are subject to change at the discretion of the Professor(s).

** Grayson College campus-wide student policies may be found at the following URL on the College website: https://www.grayson.edu/currentstudents/Academic%20Resources/index.html

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Clinical Objectives

May include any of the objectives for previous clinical courses, as well as those listed for each course.

	RNSG 1360	**RNSG 1461**	**RSNG 2462**	**RNSG 2463**
Member of the Profession				
Professionalism	1. Describe professional behaviors and attitudes observed on your assigned unit. 2. Describe a clinical situation you observed which involved an ethical issue. 3. Describe a clinical situation you observed which involved a legal issue	Describe how you demonstrated professional behaviors in the provision of care to your assigned patients. Describe how you used an ethical principle to in planning and implementing care for your assigned patients. Describe how you used a legal principle in planning and implementing care for your assigned patients.	Analyze the impact of professionalism on the outcome of care for your assigned patients. Analyze the impact of ethical principles in the outcome of care for your assigned patients. Analyze the impact of legal principles in the outcome of care for your assigned patients.	Analyze the impact of professionalism on patient care outcomes on your assigned unit. Analyze a clinical situation that involved an ethical dilemma. Analyze legal considerations that impact the outcome of care for patients on your assigned unit.
Personal Accountability	4. Describe a situation where you took personal accountability for you actions within the clin setting.	Analyze the outcome of a situation in which you assumed personal accountability for your actions in the clinical setting.	Implement a plan to address your personal learning needs in the clinical setting.	Evaluate strategies you implemented to address your personal learning needs in the clinical setting.
Advocacy	5. Describe a specific clinical situation which involved advocacy.	Describe how you acted as an advocate for your assigned patient.	Analyze how patient advocacy impacted the outcome of patient care in a clinical situation.	Analyze how you independently advocated on behalf of your patients, families, self, or the profession.

Provider of Patient-Centered Care				
Clinical Decision Making	6. Describe the nursing knowledge needed to plan safe, effective care for your assigned patient.	Describe how your assigned patient's plan of care relates to your assessment findings. Describe a patient care situation in which clinical decision making skills impacted the outcome of patient care.	Analyze a clinical situation in which additional nursing knowledge might have impacted the outcome of patient care. Analyze a clinical situation in which decision making skills impacted the outcome of patient care.	Discuss how the nurse manager on your assigned unit uses nursing knowledge in the management of care for the patients on the unit. Analyze how your use of decision making skills impacted the outcome of patient care for a group of patients.
Patient Teaching	7. Describe your assigned patient's response to the teaching you provided	Discuss the principles underlying your approach to patient teaching for your assigned patients.	Analyze a clinical situation in which the strategies used to provide patient teaching impacted the outcome of patient care.	Analyze how your approach to patient teaching impacted the outcome of patient care.
Caring Approach	8. Describe caring interventions you used in the care of your assigned patient.	Describe a patient care situation in which the implementation of a caring approach impacted the outcome of patient care.	Analyze how a caring approach impacted the outcome of patient care in a clinical situation.	Analyze the utilization of a caring approach to meet the needs of a diverse patient population
Resource management	9. Identify resources available to you in the provision of care for your assigned patient.	Describe how your use of resources impacted the outcome of your patient care.	Discuss the role of the nurse in ensuring adequate resources for patient care.	Analyze how availability of adequate resources impacts outcomes of care on your assigned unit.
Skill Competency	10. Describe skills used to ensure safe, effective care. 11. Discuss the importance of the	Analyze the effectiveness of the skills you used in the care of your patients.	Analyze a clinical situation in which effective time management skills impacted the outcome of patient care.	Analyze the effectiveness of the strategies you used to care for a group of patients.

	rights of medication administration. 12. Identify factors that may impact safe medication administration on your assigned unit.	Analyze the effectiveness of the strategies you used to organize medication administration for your assigned patients.	Evaluate a clinical situation in which the approach to medication administration impacted the outcome of patient care.	Discuss alternate approaches to promote safe medication administration.
Patient Safety Advocate				
Safety	13. Describe measures you used to promote a safe environment for your patient, self, and others.	Discuss measures you used to promote a safe environment for your patients, self, and others.	Analyze measures used to promote a safe environment for patients, self, and others.	Evaluate measures to promote a safe environment for patients, self, and others.
Risk Reduction	14. Describe how abnormal values (vital signs; diagnostic test findings) reflect increased risk for your assigned patient.	Describe the diagnostic test results, prescribed medications and/or treatments for your assigned patients.	Analyze the relationship between the assessment findings, diagnostic test results, and prescribed treatments for your assigned patients. Analyze how the implementation of risk reduction strategies impacted the outcome of care for your assigned patients.	Analyze the impact of evidence-based practice on the outcomes of care on your assigned unit. Describe a clinical situation where failure to rescue could lead to potential harm.
Member of the Health Care Team				
Communication	15. Identify communication skills used in the care of your assigned patient.	Describe a patient care situation in which therapeutic communication skills impacted the outcome of patient care.	Analyze a clinical situation in which therapeutic communication skills impacted the outcome of patient care.	Analyze how your use of therapeutic communication skills impacted the outcome of patient care.
Collaboration & Coordination	16. Describe activities you used to encourage participation of the patient, family,	Describe how varying members of the IDT healthcare team impacted the outcome of care for	Describe how your collaboration with other IDT members impacted the outcome	Analyze strategies you used to promote effective collaboration.

	and/or health care team to meet patient needs. 17. Describe the role of a non-nurse member of the interdisciplinary healthcare team.	your assigned patient.	of care for your assigned patients.	

Grayson College
Associate Degree Nursing
Simulation Lab Specialty Objectives:

1. Completes all applicable components of the daily evaluation form.
2. Actively participates in activities, role playing and simulation scenarios.
3. Contributes to the debriefing process using a positive approach.

CONTENT	LEARNING ACTIVITIES
Simulated Clinical Experiences Basic assessment and treatment of adult patient Focused assessment and treatment of pediatric patient Focused assessment and treatment of adult patient Cardio-pulmonary Resuscitation Scenario vSIM Case Studies Colostomy Assessment and Care	**Prep:** See Clinical Canvas Course

Clinical Readiness Exam (CRE) Requirement

In order to satisfy requirements of the program and clinical facilities, all nursing students must pass a clinical readiness exam before clinical begins in Nursing 1 & 3, or upon re-entry into a previously enrolled semester if it has been more than one semester since the student was in a clinical course. The student will have two attempts to pass the exam with a score of 75%. Students who do not pass with a score of 75% within two attempts will not be able to progress in the clinical component of the program. A *Clinical Readiness Exam* study guide is available to assist the student to prep for this exam.

Topics to be included in the Clinical Readiness Exam may include:

- Nursing Student Practice
- Patient Identification
- Confidentiality
- Patient Rights
- Organization Ethics and Compliance
- Informed Consent/Advance Directives/Do Not Resuscitate
- HCAHPS Customer Service
- Communication Among Caregivers
- Cultural Competence
- Developmental Competence
- Proper Body Mechanics
- Needle Stick Injury
- Latex Allergy
- Sexual Harassment and Workplace Violence
- Medication Safety
- Patient Falls
- Abuse and Neglect
- Patient Safety/National Patient Safety Goals
- Sentinel Events
- Restraints
- Serviceable Medical Equipment/Alarm Systems
- Electrical Safety
- Fire Safety
- Radiation Safety
- Hazardous Materials
- Infection Control/Isolation
- Personal Protective Equipment
- Blood-borne Pathogens
- Hepatitis
- HIV
- Tuberculosis
- Ebola
- Middle East Respiratory Syndrome
- Seasonal Influenza
- Emergency Preparedness/Disaster
- Bioterrorism
- Emergency Medical Treatment & Active Labor Act (EMTALA)

Grayson College
Associate Degree Nursing Program

1360 Clinical Evaluation
Performance Standards which Define Satisfactory Performance of Expected Behaviors

Grade	Criteria
1	● Unprofessional attitudes or behaviors ● Unsafe skill or practice ● Formal, written counseling is required if a 1 is received
2	● Not adhering to program and/or agency policies ● Requires continuous cues from faculty and/or staff ● Demonstrates a lack of skill, clinical judgment, or efficiency ● Failure to recognize an unsafe environment for patient, self, and others ● Demonstrates ineffective communication ● Performs as an ineffective team member
3	● Adheres to program and agency policies ● Demonstrates positive professional behaviors ● Performs nursing care safely and accurately with supportive guidance ● Demonstrates appropriate clinical judgment and efficiency ● Recognizes an unsafe environment for patient, self, and others ● Demonstrates effective communication ● Performs as an effective team member
4	● Adheres to program and agency policies ● Demonstrates positive professional behaviors ● Performs nursing care safely and accurately for 1 or more patients with supportive guidance ● Demonstrates appropriate clinical judgment and efficiency for 1 or more patients ● Recognizes an unsafe environment for patient, self, and others ● Demonstrates effective communication ● Performs as an effective team member ● Has demonstrated an improvement in designated criteria and/or behavior

Grayson College
Associate Degree Nursing Program
Clinical Evaluation
RNSG 1360

Name ____ Dates _____ and

State today's assigned clinical objective(s) and describe how ***you*** met it:
Clinical Objective 1:

Clinical Objective 2:

Please check all skills performed during clinical day:

		Comments
Vital Signs	☐	
Administration of Oral Meds	☐	
Administration of Parenteral Meds	☐	
Dressing Change (Sterile/Non-sterile)	☐	
Discontinued IV or Foley Catheter	☐	
Blood glucose Checks	☐	
Other	☐	

1. Identify ***your*** independent decisions/interventions for each day.

2. Describe specifically what you did to implement "look-check-connect."

3. Describe any clarification ***you*** need about the clinical experience and/or other comments:

Instructor Comments:

Instructor's Signature _____Student's Signature _____
Acknowledges having read instructor's remarks & evaluation criteria

RNSG 1360 – Criteria for Student Clinical Daily Evaluation: 1= Unprofessional/Unsafe; 2= Unsatisfactory; 3=Satisfactory; 4=Above Average

S1	S2	Evaluative Criteria	S1	S2	Evaluative Criteria
		Member of the Profession:			**7. Effective use of resources**
		1. Professionalism			a. Uses appropriate resources to ensure safe, effective care:
		*a. Maintains confidentiality.			Human: faculty, staff, patient, HCP, families
		*b. Seeks appropriate supervision and direction.			Information: medical record, report, current data, policies, references, worksheet
		*c. Adheres to agency policies.			Material: supplies, equipment
		*d. Demonstrates positive, respectful demeanor and approach to others.			**8. Skill Competency**
		1. Personal Accountability			*a. Performs skills/ tasks correctly.
		*a. Demonstrates accountability through insightful self- evaluation.			b. Safe Medication Administration:
		*b. Adheres to ADN program policies.			*1. Demonstrates knowledge of medications being given.
		*c. Meets requirements for attendance.			*2. Identifies unsafe &/or inaccurate drug orders.
		*d Meets requirements for written assignments.			*3. Calculates dosages accurately.
		*e. Implements instructions from instructor and licensed personnel.			*4. Demonstrates use of client's rights.
		*f. Assumes responsibility for achievement of learning outcomes.			*5. Demonstrates correct administration procedures.
		1. Advocacy			*6. Documents medication administration correctly.
		*a. Identifies situations of concern to assigned patients and families.			c. Completes skills/tasks in an organized, efficient manner.
		*b. Reports situations of concern in an effective manner.			*d. Ensures client comfort and privacy during tasks.
		c. Acts on behalf of patients and families in an effective manner.			e. Evaluates and reports patient outcomes following skills.
		Provider of Patient-Centered Care:			**Patient Safety Advocate:**
		4. Clinical decision making in the provision of care			**9. Safety**
		*a. Demonstrates sound clinical reasoning based on accurate, relevant knowledge.			*a. Adheres to recognized safety standards.
		*b. Obtains report/gathers needed information before assuming care of patient.			**10. Risk Reduction**
		* c. Completes focused assessment within one hour of report.			*a. Implements care to reduce patient risk
		*d. Analyzes assessment data to plan and prioritize care.			* b. Uses evidence-based guidelines to impact quality of care.
		*e. Reports abnormal findings to instructor and staff.			**Member of the Health Care Team**
		f. Completes assigned care according to priorities.			**11. Communication**
		g. Evaluates nursing care.			a. Manages information using available technology.
		h. Uses outcomes of care to revise the plan of care.			*b. Communicates information accurately and in a timely manner: Written and Verbal
		i. Documents nursing care Accurate, legible, concise, timely.			*c. Clearly identifies self and student nurse role to patient, family, and healthcare team.
		*j. Reports client's condition and summary of care at end of clinical day.			**12. Collaboration & Coordination**
		k. Organize and manage time effectively.			*a. Negotiates mutually agreeable solutions with others.
		5. Patient Teaching			b. Elicits participation of patient, family, and HC team members.
		*a. Provides appropriate explanations prior to implementing care.			*c. Accepts criticism in a constructive manner.
		b. Implements patient teaching.			
		c. Documents effectiveness of patient teaching.			
		6. Caring approach to diverse patients and families			

		*a. Provides considerate, non-judgmental, and respectful care.			
		*b. Offers self in a therapeutic manner within professional boundaries.			

GRAYSON COLLEGE
ASSOCIATE DEGREE NURSING
CLINICAL PERFORMANCE EVALUATION TOOL
Nursing I - RNSG 1360

Student _____ Term _____ Instructor _____

Clinical Facility _____

I have read this evaluation tool and understand that my clinical performance will be evaluated according to these criteria.

Date: _____ Signature: _____

1. The student shares the responsibility for seeking opportunities for evaluation.
2. Definition for criteria for clinical evaluation:
   S - (Satisfactory) Student demonstrates an average score of 3.0 (75%) on expected behaviors.
   U - (Unsatisfactory) Student demonstrates an average score below 3.0 (75%) on expected behaviors.
3. In order to pass clinical, the student must achieve a satisfactory grade on all items identified with an asterisk at the time of final evaluation.

RNSG 1360	Mid-term		Final		INSTRUCTOR
EXPECTED STUDENT BEHAVIOR	S	U	S	U	COMMENTS
MEMBER OF THE PROFESSION:					
1. Professionalism					
*A. Maintains confidentiality.					
*B. Seeks appropriate supervision and direction.					
*C. Adheres to agency policies.					
*D. Demonstrates positive, respectful demeanor and approach to others.					
2. Personal Accountability					
*A. Demonstrates accountability through insightful self-evaluation.					
*B. Adheres to ADN program policies.					
*C. Meets requirements for attendance.					
*D Meets requirements for written assignments.					
*E. Implements instructions from instructor and licensed personnel.					
*F. Assumes responsibility for achievement of learning outcomes.					
3. Advocacy					
*A. Identifies situations of concern to assigned patients and families.					

*B. Reports situations of concern in an effective manner.					
C. Acts on behalf of patients and families in an effective manner.					
PROVIDER OF PATIENT-CENTERED CARE:					
4. Clinical decision making in the provision of care					
*A. Demonstrates sound clinical reasoning based on accurate, relevant knowledge.					
*B. Obtains report/gathers needed information before assuming care of patient.					
*C. Completes focused assessment within one hour of report.					
*D. Analyzes assessment data to plan and prioritize care.					
*E. Reports abnormal findings to instructor and staff.					
F. Completes assigned care according to priorities.					
G. Evaluates nursing care.					
H. Uses outcomes of care to revise the plan of care.					
I. Documents nursing care. Accurate, legible, concise, timely.					
*J. Reports client's condition and summary of care at end of clinical day.					
K. Organize and manage time effectively.					
5. Patient Teaching					
*A. Provides appropriate explanations prior to implementing care.					
B. Implements patient teaching.					
C. Documents effectiveness of patient teaching.					
6. Caring approach to diverse patients and families					
*A. Provides considerate, non-judgmental, and respectful care.					
*B. Offers self in a therapeutic manner within professional boundaries.					
7. Effective use of resources					
A. Uses appropriate resources to ensure safe, effective care.					
Human: faculty, staff, patient, HCP, families					
Information: medical record, report, current data, policies, references, worksheet					
Material: supplies, equipment					
8. Skill Competency					

*A. Performs skills/tasks correctly.					
B. Safe Medication Administration:					
*1. Demonstrates knowledge of medications being given.					
*2. Identifies unsafe &/or inaccurate drug orders.					
*3. Calculates dosages accurately.					
*4. Demonstrates use of client's rights.					
*5. Demonstrates correct administration procedures.					
*6. Documents medication administration correctly.					
C. Completes skills/tasks in an organized, efficient manner.					
*D. Ensures client comfort and privacy during tasks.					
E. Evaluates and reports pertinent outcomes following skills.					
PATIENT SAFETY ADVOCATE:					
9. Safety					
*A. Adheres to recognized safety standards.					
10. Risk Reduction					
*A. Implements care to reduce patient risk.					
*B. Uses evidence-based guidelines to impact quality of care.					
MEMBER OF THE HEALTHCARE TEAM					
11. Communication					
A. Manages information using available technology.					
*B. Communicates information accurately and in a timely manner: Written and Verbal					
*C. Clearly identifies self and student nurse role to patient, family, and healthcare team.					
12. Collaboration & Coordination					
*A. Negotiates mutually agreeable solutions with others.					
B. Elicits participation of patient, family, and HC team members.					
*C. Accepts criticism in a constructive manner.					

RNSG 1360

Date_____ Mid-Rotation Grade _____ Absences _____

Instructor Comments:

Vital Signs _____
Oral Meds _____
Parenteral Meds _____
Dressing
Change _____
DC IV/Foley _____
Blood Glucose _____
Other _____

Student Signature: _____ Instructor Signature: _____

****
****

Date _____ Final Grade _____ Absences _____

Instructor Comments:

Vital Signs _____
Oral Meds _____
Parenteral Meds _____
Dressing
Change _____
DC IV/Foley _____
Blood Glucose _____
Other _____

Student Signature: _____ Instructor Signature: _____

Grayson College
Associate Degree Nursing
Unit Orientation / Scavenger Hunt

Objectives:

Identify supplies needed to provide efficient care of your patient.
Identify resources available for use to provide care for your patient.

1. You need to take and record vital signs on your patient. What will you need and where is it located?

	Item	Location
1.		
2.		
3.		
4.		
5.		
6.		
7.		

2. You are preparing to give a complete bed bath, shampoo and linen change to a bedfast, incontinent patient who has just been admitted to your unit. There are no supplies in the room. What personal care items will you need and where are they located?

	Item	Location
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

3. A patient that you are not assigned to asks for a cup of coffee.

	Item/Information	Answer
1.	What type of information will you need before you get the coffee?	
2.	Where is this information located?	

4. You are assigned to administer oral medications to your patient. List and give the location of all the items you will need.

	Item	Location
1.		
2.		
3.		
4.		
5.		

5. The physician has just ordered a dressing change for a patient with a large draining wound. A) What and where are the supplies you will need? B) Where and how will you dispose of the old dressing?

	Item	Location
A 1.		
2.		
3.		
4.		
5.		
6.		
B 1.		
2.		

6. As you enter your patient's room, you observe that smoke and flames are coming out of the bedside trash can. A) List the steps you would follow and give the rationale. B) What and where are the resources / equipment available on the unit to be used in resolving this situation?

	(A) Steps	(B) Equipment & Location
1.		
2.		
3.		
4.		
5.		
6.		

7. As you enter your patient's room, you discover he is unresponsive with no pulse or respirations. List the steps you should follow.

	Steps	Rationale
1.		
2.		
3.		
4.		

8. Your patient wants to take a shower. He has a saline lock and telemetry leads. What do you need to do before he gets in the shower?

	Steps	Rationale
1.		
2.		
3.		
4.		

Grayson College
Associate Degree Nursing Program

Chart Discovery Form

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Use a client's chart to answer the following questions:

1. List the client's medical diagnoses.

2. List the client's allergies to food and medications.

3. Determine the client's resuscitation status (Advanced Directives, Living Will, etc.)

4. List the client's current medications (use the MAR)

5. List the client's last vital signs

6. List the date, type and the results of the most recent diagnostic lab test.

7. Compare the nurse's admission assessment to the most recent assessment in two areas (i.e., cognitive level, ADL support, skin integrity)

8. Physician progress notes: Summarize the last entry

9. History and Physical: Write the physician's impression

12 Hour
Clinical Worksheet

0800	**Temp._____ Pulse_____ Resp_____ BP_____O2 sat_____** **Pain _____** **Report_____ Medication Check _____FSBS_____**
0900	**Bed Bath/Shower_____ Oral Care_____**
1000	
1100	
1200	**Temp._____ Pulse_____ Resp_____ BP_____O2 sat_____** **Pain _____** **Report_____ Medication Check_____ FSBS_____**
1300	**Medication check _____**
1500	
1600 - 1700	**Temp._____ Pulse_____ Resp_____ BP_____O2 sat_____** **Pain _____** **FSBS_____ MEDS_____**

Student_____ Client Age._____ Staff RN_____

Diagnosis_____ HCP_____

Code Status _____ Allergies_____

Diet _____ IV Fluid _____Rate_____

IV Site Location/Type_____ Appearance_____ Date Inserted_____

VS Q_____Hrs FSBS_____ O2 @ _____lpm via _____

Tele_____Activity_____ Bath_____

Foley Catheter / Voids

Wound Care/Drsg Change/Drains_____

Special Instructions_____

_____

Medication Times _____ _____ _____ _____

Diagnostic Testing/Labs: WBC_____ H/H ____/_____ BUN _____ CRT_____ K+_____

Albumin _____ Glucose_____

Notes-Patient teaching

_____

Intake	**Output**	% Meal
	BM:	Breakfast _____ Lunch _____ Dinner _____

Grayson College

RNSG 1360

- Apply medical/surgical concepts to clinical patient assignments
- Connect diagnostics, treatments, presentations, situations, procedures, and nursing situations to care for specific disease processes.

Name _____ Date: _____

Clinical Picture: Medical or Surgical Diagnosis

Directions: Please complete the left-hand side of the page based on textbook information. An example source for this information is Lewis Medical-Surgical textbook. Please complete the right-hand side of the page based on the client being cared for in clinicals.

Diagnosis:

_____

Definition:

_____

_____

_____

Clinical Manifestations:

_____

_____

_____

Manifestations the client exhibits related to diagnosis:
(Include subjective & objective assessment findings)

_____

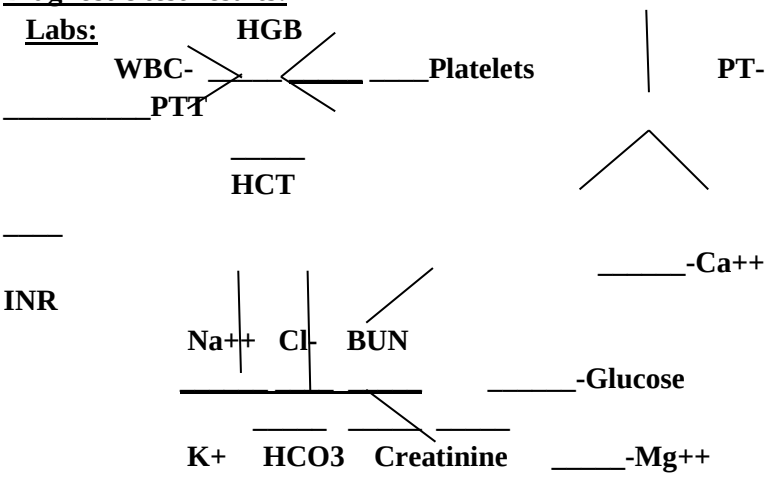
_____

_____

Diagnostic Studies:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Diagnostic test results:



Radiology: _____

_____
_

Other:

_____
_
_____
_

Interdisciplinary therapy:

_____
_____
_____
_____
_____
_____

Current treatment for your client:

_____
_____
_____
_____
_____
_____

Nursing & Interprofessional Management:

Client Planning- (list three):

Client will….. (specify time)

1. _____
2. _____
3. _____

Nursing Implementation (list five):

1. _____
2. _____
3. _____
4. _____
5. _____

Nursing care provided by you OR the nursing staff:

_____
_____
_____
_____
_____

Client/Family Teaching & Discharge Planning:

_____
_____
_____
_____
_____
_____
_____

Client Teaching provided:

(Be sure to include the client's response to teaching)

_____
_____
_____
_____
_____

Other diagnoses for your client:

_____

References used in preparation:

(Be sure to list author and title of source)

_____

SHIFT ASSESSMENT

Student Name: _____ **Date:** _____

Rm # _____ DOB: _____ Sex: ☐ Male ☐ Female Date of admission: _____

Chief Complaint (client's own words):_____ Informant: ☐ Patient ☐ Other _____

Onset & Duration: _____

Allergies and Reactions: _____ **Wt:** _____ **Ht:** _____

_____

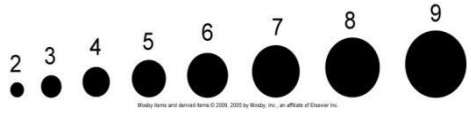
_____

_____

Temp: _____degree C* _____degree F* ☐ Temporal ☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic	**Pulse:** _____ bpm ☐ Reg ☐ Irreg	**SpO_2** _____% ☐ RA ☐ O_2 at l/min ☐ NC ☐ Mask	**Respiration:** _____ breaths/min	**BP:** _____ ☐ Lying ☐Sitting ☐Standing	**Pain** _____/10 Location: _____ Descriptors: _____ _____ _____

Current Medications:	Past Medical History:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Safety	Fall Risk	☐ Low ☐ High ☐ Bed alarm in use Comments_____
	Safety Needs	☐ Call light in reach/ pt able to use ☐ Bed low/brake on # of siderails up: _____ ☐ Seizure precautions ☐ Allergy band on ☐ ID band on ☐ Safety check complete
Ac	Activity	☐ Bedrest ☐ HOB @ _____ degrees ☐ BRP ☐ Self ☐ Assist ☐Total

tivity	Hygiene	☐ Bath: ☐ Complete ☐ Partial ☐ Shower ☐ Oral Care ☐Pericare ☐ Hair care ☐Backrub ☐Other : _____
	Drains	☐ None ☐ Other _____ ☐ Drainage: Amt-_____ Color-_____
Integumentary	Skin Integrity	☐ Intact ☐ Turgor ☐ Ulcer ☐ Skin tear Location: _____ Description: _____ _____
	Open wound/ Surgical Incision	☐ None Location: _____ Size: _____ Description: _____ ☐ Drainage Color: _____ Amount: _____ ☐ Drsg- CDI ☐ Drsg changed Other: _____
	Other	☐ Air Mattress ☐ Specialty bed ☐ Other: _____
Neuro	Mentation LOC	Oriented: ☐ Person ☐ Place ☐ Time ☐ Situation/Event ☐ Disoriented LOC: ☐ Alert ☐ Sedated ☐ Restless ☐ Confused ☐ Sleepy/arousable ☐ Lethargic ☐ Unresponsive ☐ Responds only to pain ☐ Agitated ☐ Hallucinations Speech: ☐ Clear ☐ Slurred ☐ Aphasic ☐ Dysphasia ☐ Non-verbal
	Pupils	Pupils: Right: Size: _____ ☐ PERRLA Left: Size: _____ ☐ PERRLA 
	Grips	Right: ☐ Strong ☐ Weak ☐ Flaccid Left: ☐ Strong ☐ Weak ☐ Flaccid
Respiratory	Respirations	☐ No distress ☐ Dyspnea ☐ Shallow ☐ Labored ☐ Orthopnea ☐ Nasal Flaring
	Breath Sounds	☐ Clear _____ ☐ Wheezes ☐ Crackles ☐ Rhonchi ☐ Diminished Other: _____
	Thorax	☐ Symmetrical expansion ☐ Retractions
	Cough/ Sputum	☐ Absent ☐ Non-productive ☐ Productive Color: _____ Consistency: ☐ Thick ☐ Thin

	Respiratory Rx	☐ None ☐ IS ☐ TCDB _____ ☐ Neb/MDI ☐ Chest tube ☐Drainage _____ ☐ Oxygen therapy @ _____lpm per ☐ NC ☐ Mask ☐ BiPap/CPAP Oximetry: ☐ None ☐ intermittent ☐ continuous
Cardiovascular	Edema	☐ None ☐ Non-pitting ☐ Pitting ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Location: _____
	Heart Sounds	☐ Regular ☐ Irregular ☐ S1 ☐ S2 ☐ Telemetry
	Capillary Refill	UEs x 2: ☐ Brisk, < 3 sec ☐ Sluggish, >3 sec | LEs x 2: ☐ Brisk, < 3 sec ☐ Sluggish, >3 sec
	Periph Pulses	UEs x 2: ☐ Present ☐ Equal Strength: _____ | LEs x 2: ☐ Present ☐ Equal Strength: _____
	Skin Temp	☐ Warm ☐ Cool ☐ Dry ☐ Clammy ☐ Moist ☐ Diaphoretic
	Skin Color	☐ Pink/Natural ☐ Flushed ☐ Pale ☐ Jaundiced ☐ Mottled ☐ Cyanotic
Gastrointestinal	Diet	☐ NPO ☐ Reg ☐ CL ☐ ADA ☐ Cardiac ☐ Other _____ ☐ Swallowing Precautions
	Appetite	☐ Good ☐ Fair ☐ Poor ☐ Nausea ☐ Emesis Amt: _____ Color: _____
	Abdomen	☐ Soft ☐ Firm ☐ Hard ☐ Distended ☐ Guarded ☐ Girth _____
	Bowel Sounds	☐ Present ☐ Hyperactive ☐ Hypoactive ☐ Absent ☐ Flatus ☐ Other _____

<table>
<tr><td></td><td>Stool</td><td>☐ Incontinent ☐ Formed ☐ Soft ☐ Liquid ☐ Constipation ☐ Other _____ LBM _____</td></tr>
<tr><td></td><td>Equipment</td><td>☐ NGT ☐ GT ☐ Other _____ ☐ Clamped ☐ Int. Suction ☐ Cont. Suction</td></tr>
<tr><td>GU</td><td>Urine</td><td>☐ Continent ☐ Incontinent
Color: _____
Characteristics: _____
☐Dysuria ☐ Nocturia</td></tr>
<tr><td></td><td>Discharge</td><td>☐ Foley cath ☐ Straight cath: _____ ☐ None
☐ Menses: _____</td></tr>
<tr><td>Musculoskeletal</td><td>Muscle Strength</td><td>Current Mobility: ☐ amb unassisted ☐ amb assisted ☐ up in chair ☐ not amb
<table>
<tr><td>R. Upper Extremity</td><td>L. Upper Extremity</td></tr>
<tr><td>Strong ☐</td><td>Strong ☐</td></tr>
<tr><td>Moderate ☐</td><td>Moderate ☐</td></tr>
<tr><td>Weak ☐</td><td>Weak ☐</td></tr>
<tr><td>Paralysis ☐</td><td>Paralysis ☐</td></tr>
</table>
☐ Active ROM ☐ Passive ROM
☐Tingling ☐ Numbness ☐ Contracture ☐ Amputation ☐ Inflammation</td></tr>
<tr><td></td><td>Equipment</td><td>☐ Cane ☐ Walker ☐ WC ☐ Crutches ☐ Prosthesis ☐ Brace ☐ CPM
☐ Cast ☐ TED Hose ☐ SCDs ☐ Abduction Pillow</td></tr>
</table>

S S e n s o r y e n s o r y	Eyes	☐ No correction ☐ Correction ☐ Glasses ☐ Contacts ☐ Other _____
	Ears	☐ No deficit ☐ HOH ☐ Hearing Aids: ☐R ☐L
	Lips/Mouth	☐ Discoloration ☐ Moist Membranes ☐ Dry Membranes ☐ Lesions ☐ Other _____

I V T h e r a p y	Location: _____ _____ IV Type: ☐Saline lock ☐ Venous ☐ Central Line ☐ PICC ☐ Arterial Line ☐ PortaCath ☐ Dialysis Cath ☐ Fluids Infusing : Type_____ Rate: _____ ml/hr ☐ Drsg CDI ☐ Edema ☐ Pain ☐ Redness	Location: _____ _____ IV Type: ☐Saline lock ☐ Venous ☐ Central Line ☐ PICC ☐ Arterial Line ☐ PortaCath ☐ Dialysis Cath ☐ Fluids Infusing : Type_____ Rate: _____ ml/hr ☐ Drsg CDI ☐ Edema ☐ Pain ☐ Redness

ISO Precautions	☐ Standard ☐ Contact ☐ Airborne ☐ Droplet ☐ Neutropenic ☐ Other _____

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nurse Signature:	Date/Time of assessment:

Nursing Admission Assessment Student _____

Date: _____ Time: _____

Informant: □ Patient □ Other_____

Reason for Admission (client's own words):_____

_

_____

_____

Onset & Duration_____

Severity 0-10: _____ Region or Radiation: _____

Pt understanding and/or expectation of problem/treatment:_____

Rm #_____ Age _____ Date of admission_____

Advanced directive status: □ Living Will □ DNR □ POA □ None

Current Diagnosis: _____ Other Diagnoses_____

Current Surgery & Date_____

CODE Status: □ Full □ DNR □ Other_____ Isolation Status: _____ Reason_____

ID band present: □ No □Yes Allergy band present □ No □Yes

Allergies	Reaction

Past Medical History:

□ Respiratory Problems_____ □ Cardiovascular Problems_____

□ COPD/Emphysema □ Pneumonia □Hypertension□Heart Disease

□ Peripheral Vascular Disease

□Stroke

□GI problems_____ □Endocrine Problems_____ □ GU problems_____

□Liver disease □Diabetes □Thyroid problems □Kidney disease

□ Integumentary problems_____ □ Neurological Problems_____

□Cancer_____

□Seizures

□ Musculoskeletal problems_____

□ Arthritis/Joint Disease

Past Surgical History and dates (if available)
_____
_____
_____
_____
_____

Family History: □Hypertension_____ □Diabetes_____ □Stroke_____
□Seizures_____ □Kidney disease_____
□Cancer_____
□Liver disease_____ □Thyroid problems_____ □Heart Disease_____`

Vital signs

Temp: O/R/A/T	**Pulse:** Reg/Irreg	**SpO_2:** RA/NC	O_2 **@____LPM**	**Respiration:**	**BP:** Lying/ Sitting/ Standing	**Wt:** **Ht:**

PsychoSocial
□Lives alone □Lives with_____ Ethnic Origin: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed Primary Language: _____
Religion: _____ Education: _____
Immunizations current: □ Flu Vaccine_____ (last date given) □ Pneumonia Vaccine_____ (last date given)
Nicotine Use: □ No □Yes- How much? _____ How Long? _____ What type? _____
Hx of Nicotine Use □ No □Yes Date of Cessation_____
Alcohol Use: □ No □Yes- How much? _____ How Long? _____ Last Drink? _____
Social Drug Use: □ No □Yes- Type? _____ Frequency? _____
Hx of Drug Use □ No □Yes Date of Cessation_____
Support Services: □ No □Yes- Type? □ HHC □ Hospice □ Other_____
Supportive Relationships: □ No □Yes- Type? _____
Additional Help needed? □ No □Yes- Referral made to _____
Erikson's Developmental Stage_____

Safety
Call System in Reach: □ Yes □ No Provide orientation to unit: □ Yes □ No
Wheels Locked: □ Yes □ No Bed in lowest position: □ Yes □ No
Seizure precautions: □ Yes □ No Bed Alarm on: □ Yes □ No
Offer Toileting: □ Yes □ No Side Rails up x2: □ Yes □ No
Fall Precautions: □ Yes □ No Non-skid footwear when out of bed: □ Yes □ No
Keep Floor Clear of clutter: □ Yes □ No Swallow Precautions: □ Yes □ No

Circle the numbers that apply under each heading:

Braden Scale

Sensory Perception (Ability to respond to pressure r/t discomfort)	**Moisture** (Skin exposed to moisture)	**Activity** (Degree of physical activity)	**Mobility** (Ability to change and control body position)	**Nutrition** (Food intake pattern)	**Friction/ Shear**
No impairment (4)	Rarely Moist (4)	Walk Freq. (4)	No Limitations (4)	Excellent (4)	No Problem (3)
Slightly Limited (3)	Occ. Moist (3)	Walk Occ (3)	Slightly Limited (3)	Adequate (3)	Pot. Problem (2)
Very Limited (2)	Very Moist (2)	Chairfast (2)	Very Limited (2)	Inadequate (2)	Problem (1)
Comp. Limited (1)	Const. Moist (1)	Bedfast (1)	Immobile (1)	Very Poor (1)	

Total Score_____ An adult score <18 is at risk for developing pressure sores.

Review of Systems

Sensory

Eyes: PERRLA: □ Yes □ No
Impaired Vision: □ Yes □ No Glasses/Contacts: □ Yes □ No Double Vision: □ Yes □ No
Blurred Vision: □ Yes □ No Pain: □ Yes □ No Inflammation: □ Yes □ No
Itching: □ Yes □ No Color Blind: □ Yes □ No Pupils Abnormal: □ Yes □ No
Drainage: □ Yes □ No Color _____ Amount _____
Ophthalmic Medications
_____
_____
_____
_____
Labs/Diagnostic Tests_____
_____
Comments_____
_____
_____

Ears:
Impaired Hearing: □ Yes □ No R/L/Both Deaf: □ Yes □ No R/L/Both
Hearing Aid: □ Yes □ No R/L/Both
Signs/Symptoms:
Tinnitus: □ Yes □ No ↓ sense of balance: □ Yes □ No Pain: □ Yes □ No
Drainage: □ Yes □ No Color _____ Amount _____
Otic Medications
_____
_____
_____
_____

Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____

Nose:
Signs/Symptoms:
Congestion: □ Yes □ No Pain: □ Yes □ No Sinus problems: □ Yes □ No
Nasal Flaring: □ Yes □ No Alignment: □ Yes □ No Nosebleeds: □ Yes □ No -Frequency_____
Drainage: □ Yes □ No Color _____ Amount _____
Nasal Medications
_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____

Mouth:
Gums: Pink: □ Yes □ No
White: □ Yes □ No
Red: □ Yes □ No
Bleeding: □ Yes □ No
Ulcers: □ Yes □ No
Tongue: Pink: □ Yes □ No
Coated: □ Yes □ No
Swollen: □ Yes □ No
Sore: □ Yes □ No
Signs/Symptoms:
Dentures: □ Yes □ No □ Upper □ Lower □ Partials Poor dentition: □ Yes □ No
Halitosis: ☐ Yes ☐ No Pain: ☐ Yes ☐ No ↓ sense of taste: ☐ Yes ☐ No
Medications
_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____

Throat/Neck:

Signs/Symptoms:

Sore Throat: □ Yes □ No Hoarseness: □ Yes □ No Lumps: □ Yes □ No

Swollen glands: □ Yes □ No Stiffness □ Yes □ No Pain: □ Yes □ No

Dysphagia: □ Yes □ No

Medications

_____

_____

_____

_____

Labs/Diagnostic Tests_____

_____

Comments_____

_____

_____

Neurological:

Oriented: □ Person □ Place □ Time □ Situation □ Disoriented

LOC: □ Alert □ Forgetful □ Confused □ Drowsy □ Lethargic □ Comatose

Speech: □ Clear □ Slurred □ Aphasic □ Dysphasia □ Non-verbal □ Other_____

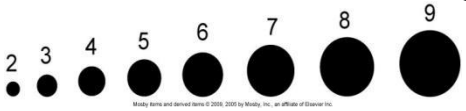
Affect: □ Pleasant □ Cooperative □ Withdrawn □ Flat □ Uncooperative □ Combative

Pupils: Right: Size:_____ □ PERRLA □ Fixed □ Irregular

Reaction □ Brisk □ Sluggish □ No Response

Left: Size:_____ □ PERRLA □ Fixed □ Irregular

Reaction □ Brisk □ Sluggish □ No Response



Grips: Right: □ Strong □ Weak □ Flaccid
Left: □ Strong □ Weak □ Flaccid

Signs/Symptoms:

Cooperative: □ Yes □ No Memory Changes: □ Yes □ No Dizziness: □ Yes □ No

Tingling: □ Yes □ No Diminished sensation: □ Yes □ No - Location_____

Tremors: □ Yes □ No Numbness: □ Yes □ No -Location_____

Seizures: □ Yes □ No Syncope: □ Yes □ No

Neuro Medications:

_____
_____

_____
_____

Labs/Diagnostic Tests_____
_____

Comments_____
_____
_____

Circle the numbers that apply under each heading:

Glasgow Coma Scale Appropriate stimulus for Best Motor Response: verbal command or pain (apply pressure to nail bed) Best Verbal Response: verbal questioning with maximum arousal Best Eye Response: approach to bedside, verbal command, or pain		
Best Motor Response (Record best upper limb response)	**Best Verbal Response** (Record "E" if endotracheal tube in place, "T" if tracheostomy tube in place)	**Best Eye Response** (Record "C" if eyes closed by swelling)
Obeys verbal Command (6)	Oriented x 3 (5)	Spontaneous (4)
Localizes to Pain (5)	Conversation-Confused (4)	On Command (3)
Normal Flexion (withdrawal) (4)	Speech-Inappropriate (3)	To Pain (2)
Abnormal Flexion* (3)	Sounds-incomprehensible (2)	None (1)
Abnormal Extension** (2)	No Response (1)	Unable to test (U)
No Response(1)	Unable to test (U)	
Unable to test (U)		

Total Score_____ (*abnormal flexion-decorticate rigidity) (**abnormal extension-decerebrate rigidity)

Respiratory:

Lung Sounds: □ Clear_____ □ Rales_____ □ Rhonchi_____
□ Wheezing_____ □ Stridor_____ □ Pleural Rub_____ □ Decreased_____
□ Absent

Respirations: □ Even □ Uneven □ Labored □ Unlabored □ Shallow □ Tachypnea

□ Orthopnea □ Bradypnea □ Cheyne-Stokes □ Apnea
□ Retractions
Dyspnea: □ None □ With activity □ At rest □ Lying down
Cough: □ None □ Non-productive □ Productive-Color_____ Amount_____
Consistency_____
Chest Symmetry: □ Yes □ No- □ Barrel □ Funnel □ Other_____
Signs/Symptoms:
Night Sweats: □ Yes □ No Hemoptysis: □ Yes □ No Clubbing: □ Yes □ No
Cyanosis: □ Yes □ No -Location_____
Respiratory Medications:
_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____
Respiratory Equipment:
O2 Device: □ Yes □ No Chest Tube: □ Yes □ No Tracheostomy: □ Yes □ No
□ Room Air □ Location_____ □ Intact
□ Cannula O2 LPM____ □ Fluctuates w/ Resp. □ Care Provided
□ Venti-Mask/ Non-Rebreather □ Air Leak □ Suction _____
□ Trach Collar □ Crepitus
□ CPAP/Bipap □ Suction _____
□ Ventilator □ Secretions: Color_____ Amt_____
□ Home O2

Cardiovascular:

Apical Pulse: □ Regular □ Irregular Heart Sounds: □ S1/S2 Audible □ Murmur
□ Muffled
Nail Beds: □ Normal □ Pale □ Cyanotic □ Clubbing □ Other_____
Capillary Refill: □ Brisk, < 3 sec □ Sluggish, >3 sec.
AV Graft/Fistula: □ Yes □ No Bruit: □ Yes □ No Thrill: □ Yes □ No

Right Upper Extremity	Left Upper Extremity	Right Lower Extremity	Left Lower Extremity
□ Radial □ Brachial	□ Radial □ Brachial	□Dorsalis Pedis □ Posterior Tibial	□Dorsalis Pedis □ Posterior Tibial
□ Normal (2+)	□ Normal (2+)	□ Normal (2+)	□ Normal (2+)
□Weak (1+)	□Weak (1+)	□Weak (1+)	□Weak (1+)
□ Bounding (3+)	□ Bounding (3+)	□ Bounding (3+)	□ Bounding (3+)
□ Doppler	□ Doppler	□ Doppler	□ Doppler
□ Absent	□ Absent	□ Absent	□ Absent

Edema: □ None	Edema: □ None	Edema: □ None	Edema: □ None
□ Non-pitting	□ Non-pitting	□ Non-pitting	□ Non-pitting
□ Pitting	□ Pitting	□ Pitting	□ Pitting
□ 1+ trace	□ 1+ trace	□ 1+ trace	□ 1+ trace
□ 2+ mild	□ 2+ mild	□ 2+ mild	□ 2+ mild
□ 3+ moderate	□ 3+ moderate	□ 3+ moderate	□ 3+ moderate
□ 4+ severe	□ 4+ severe	□ 4+ severe	□ 4+ severe

Signs/Symptoms:

Calf Tenderness: □ Yes □ No Phlebitis: □ Yes □ No Jugular Vein Distention: □ Yes □ No

Palpitations: □ Yes □ No Syncope: □ Yes □ No Dizziness: □ Yes □ No

Chest pain: □ Yes □ No - Location_____ Onset_____ Duration_____ Intensity (1-10) _____

Cardiovascular Medications_____

_____

_____

_____

Labs/Diagnostic Tests_____

_____

Comments_____

_____

_____

Cardiovascular Equipment/Monitors:

Telemetry: □ Yes □ No □ Rhythm_____

Pacemaker: □ Yes □ No Holter Monitor: □ Yes □ No Other: □ Yes □ No_____

Gastrointestinal:

Abdomen: □ Soft □ Firm □ Flat □ Distended □ Round □ Ascites □ Tender □ Rigid □ Obese

Bowel Sounds: □ present x __ quadrants □ Hyperactive □Hypoactive □ Absent

Last BM: Date_____ Freq_____ □ Normal □ Loose □ Hard

Appetite: □ Good □ Poor □ Recent Change_____

Gastrointestinal (cont'd):

Diet: □ Normal (as tolerated) □ Soft □ Low Fat □ Diabetic _____ADA □ Full Liquid

□ Thin Liquid □ NPO □ Other_____

Signs/Symptoms:

Laxative Use □ Yes □ No - Type_____ Freq_____ How long_____
Constipation: □ Yes □ No Diarrhea: □ Yes □ No Nausea: □ Yes □ No
Vomiting: □ Yes □ No Incontinent: □ Yes □ No Hemorrhoids: □ Yes □ No
Heartburn: □ Yes □ No GERD: □ Yes □ No Pain: □ Yes □ No
Rectal bleeding: □ Yes □ No Black Stools: □ Yes □ No
Weight gain/loss: □ Yes □ No -Amt_____ Rectal Tube: □ Yes □ No -Insertion Date_____
Ostomy: □ Yes □ No □ Colostomy □ Ileostomy □ Other_____
GI
Medications_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____
Gastrointestinal Equipment:
NG Tube: □ Yes □ No Feeding Tube: □ Yes □ No Type/Rate Feeding_____
□ Placement verified □ NG Tube Tube Drainage: □ None
□ Low Suction □ Duotube □ Green
□ Continuous □ PEG Tube □ Bloody
□ Intermittent Suction □ Bolus □ Coffee Ground
□ Clamped □ Continuous □ Other_____

Genitourinary:
Urine: Color_____ Amt_____ □ Yes □ No Sediment
Signs/Symptoms:
Frequency: □ Yes □ No Flank pain: □ Yes □ No Incontinent: □ Yes □ No
Retention: □ Yes □ No Burning: □ Yes □ No Stress Incon/Dribbling: □ Yes □ No
Nocturia: □ Yes □ No Hematuria: □ Yes □ No Discharge: □ Yes □ No
Hx of UTI: □ Yes □ No Hx of calculi: □ Yes □ No
GU
Medications_____
_____
_____
_____

Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____

Genitourinary Equipment:
Foley Catheter: □ Yes □ No Bladder Irrigation : □ Yes □ No

Date Inserted_____ Dialysis: □ Yes □ No
Date Changed_____ Urostomy: □ Yes □ No

Reproductive:
Female:
LMP_____ G____ P____ Last Pap_____
Birth Control: □ Yes □ No Menopausal: □ Yes □ No -How long? _____
Vaginal Discharge: □ Yes □ No Hormone Replacement: □ Yes □ No Lesions: □ Yes □ No
Itching: □ Yes □ No Dysmenorrhea: □ Yes □ No Amenorrhea: □ Yes □ No
Hx STD exposure: □ Yes □ No Hysterectomy: □ Yes □ No
Breast Do SBE Monthly: □ Yes □ No Lumps: □ Yes □ No Breast feeding: □ Yes □ No
Nipple Discharge: □ Yes □ No Dimpling: □ Yes □ No Symmetry: □ Yes □ No
Nipple inversion: □ Yes □ No Pain: □ Yes □ No
Last Dr. Exam_____ Last Mammogram_____
Male:
Last Prostate Exam_____ Last PSA_____
Penile discharge: □ Yes □ No Hernias: □ Yes □ No Sores: □ Yes □ No
Do STE Monthly: □ Yes □ No Testicular lumps: □ Yes □ No Hx STD exposure: □ Yes □ No
Scrotal Swelling: □ Yes □ No Scrotal Pain: □ Yes □ No
Breast Pain: □ Yes □ No Lumps: □ Yes □ No Swelling: □ Yes □ No
Discharge: □ Yes □ No
Medications_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____

Hematological:
Signs/Symptoms:

Bruising: □ Yes □ No Anemia-Hx: □ Yes □ No Anemia-Current: □ Yes □ No

Anticoagulant Use: □ Yes □ No Blood Transfusion-Hx: □ Yes □ No

Medications_____
_____
_____
_____

Labs/Diagnostic Tests_____
_____

Comments_____
_____
_____

Endocrine:

Thyroid: □ Hypothyroidism □ Hyperthyroidism

Signs/Symptoms:

Polydipsia: □ Yes □ No Polyuria: □ Yes □ No Polyphagia: □ Yes □ No

Intolerance to heat or cold: □ Yes □ No Excessive bleeding/bruising: □ Yes □ No

Diabetes Mellitus: □ Type I □ Type II - □ Diet Controlled □ None
□ PO meds
□ Insulin

FSBS Range_____ Frequency checked_____ □ FSBS checked performed-result_____

Medications_____
_____
_____
_____

Labs/Diagnostic Tests_____
_____

Comments_____
_____
_____

Musculoskeletal:

Signs/Symptoms:

Fractures: □ Yes □ No Inflammation: □ Yes □ No Swelling: □ Yes □ No

Stiffness: □ Yes □ No Tremors: □ Yes □ No Back Problems: □ Yes □ No

History DVT: □ Yes □ No Crepitus: □ Yes □ No

Joint Replacement: □ Yes □ No Location_____ Date_____

Extremities:

Right Upper Extremity	Left Upper Extremity	Right Lower Extremity	Left Lower Extremity
NSF: □	NSF: □	NSF: □	NSF: □
Weakness: □ Yes □ No	Weakness: □ Yes □ No	Weakness: □ Yes □ No	Weakness: □ Yes □ No
Tingling: □ Yes □ No	Tingling: □ Yes □ No	Tingling: □ Yes □ No	Tingling: □ Yes □ No

Pain: □ Yes □ No	Pain: □ Yes □ No	Pain: □ Yes □ No	Pain: □ Yes □ No
Numbness: □ Yes □ No	Numbness: □ Yes □ No	Numbness: □ Yes □ No	Numbness: □ Yes □ No
Deformity: □ Yes □ No	Deformity: □ Yes □ No	Deformity: □ Yes □ No	Deformity: □ Yes □ No
Contracture: □ Yes □ No	Contracture: □ Yes □ No	Contracture: □ Yes □ No	Contracture: □ Yes □ No
Amputation: □ Yes □ No	Amputation: □ Yes □ No	Amputation: □ Yes □ No	Amputation: □ Yes □ No

Muscle Strength:

Right Upper Extremity	Left Upper Extremity	Right Lower Extremity	Left Lower Extremity
□ Strong	□ Strong	□ Strong	□ Strong
□ Moderate	□ Moderate	□ Moderate	□ Moderate
□ Weak	□ Weak	□ Weak	□ Weak
□ Paralysis	□ Paralysis	□ Paralysis	□ Paralysis
□ ROM-Normal	□ ROM-Normal	□ ROM-Normal	□ ROM-Normal
□ ROM-Impaired	□ ROM-Impaired	□ ROM-Impaired	□ ROM-Impaired
□ Overcomes Resistance	□ Overcomes Resistance	□ Overcomes Resistance	□ Overcomes Resistance
□ Overcomes Gravity	□ Overcomes Gravity	□ Overcomes Gravity	□ Overcomes Gravity
□ Twitch of Muscle	□ Twitch of Muscle	□ Twitch of Muscle	□ Twitch of Muscle

Current Mobility: □ Ambulate w/o help □ Ambulate w/ help □ Up in Chair □ Not Ambulatory

Level of Assistance: □ None needed □ Amb w/ family/friend □ Min assist □ Mod assist

□ Max assist □ Assist x 1 □ Assist x 2 or more

Gait: □ Steady □ Unsteady Balance: □ Steady □ Unsteady

Medications_____

_____

_____

_____

Labs/Diagnostic Tests_____

_____

Comments_____

_____

_____

Musculoskeletal Equipment:

Ambulatory Device: □ Yes □ No Shower Chair: □ Yes □ No Bedside Commode: □ Yes □ No

□ Cane Traction: □ Yes □ No Immobilizer: □ Yes □ No

□ Walker Crutches: □ Yes □ No Brace: □ Yes □ No

□ Wheelchair Prosthesis: □ Yes □ No Cervical Collar: □ Yes □ No

□ Mobilized Scooter Trapeze Bar: □ Yes □ No TED Hose: □ Yes □ No

CPM: □ Yes □ No SCDs: □ Yes □ No

Ice Pack: □ Yes □ No Abduction Pillow: □ Yes □ No

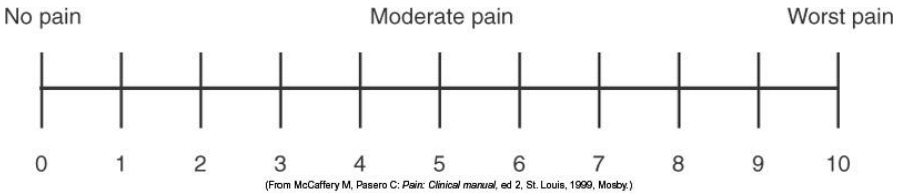
ADLS:

Bathing: □ Self-care □ Supervise □ Assist □ Total □ Shower □ Tub □ Bed bath

Toileting: □ Self-care □ Supervise □ Assist □ Total □ Bedside Comm □ Bedpan □ Urinal □ Bathroom Privileges

Feeding: □ Self-feed □ Assist □ Total

Pain:



Stated Pain level ___ Pain stated location_____ Pain Frequency: □ Constant □ Intermittent

Pain Descriptors: □ Aching □ Burning □ Dull □ Numb □ Pressure □ Radiating □ Sharp □ Throbbing □ Stabbing

Pain Intervention: □ Medication □ Repositioning □ Other_____

Other Nonverbal Pain indicators: □ Grimacing □ Guarding □ Splinting □ Changes in VS

Medications_____
_____
_____
_____

Labs/Diagnostic Tests_____
_____

Comments_____
_____
_____

Intravenous Therapy (IV): □ none present

IV Site #1	IV Site #2	IV Site #3
Location:	Location:	Location:
IV Type: □ Venous □ Central Line □ Arterial Line □ Porta Cath □ PICC Line □ Dialysis Catheter	IV Type: □ Venous □ Central Line □ Arterial Line □ Porta Cath □ PICC Line □ Dialysis Catheter	IV Type: □ Venous □ Central Line □ Arterial Line □ Porta Cath □ PICC Line □ Dialysis Catheter
IV Gauge:	IV Gauge:	IV Gauge:
Date Started:	Date Started:	Date Started:

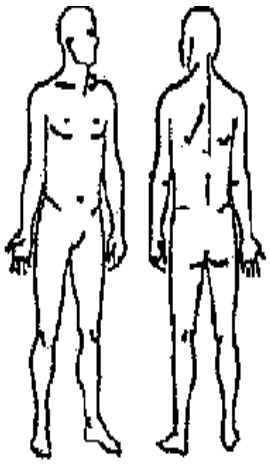
Patent, Fluids Infusing: □ Yes □ No □ N/A	Patent, Fluids Infusing: □ Yes □ No □ N/A	Patent, Fluids Infusing: □ Yes □ No □ N/A
Patent, Saline Lock □ Yes □ No □ N/A	Patent, Saline Lock □ Yes □ No □ N/A	Patent, Saline Lock □ Yes □ No □ N/A
IV Site Dry: □ Yes □ No	IV Site Dry: □ Yes □ No	IV Site Dry: □ Yes □ No
Redness: □ Yes □ No	Redness: □ Yes □ No	Redness: □ Yes □ No
Edema: □ Yes □ No	Edema: □ Yes □ No	Edema: □ Yes □ No
Pain: □ Yes □ No	Pain: □ Yes □ No	Pain: □ Yes □ No
Infiltrated: □ Yes □ No	Infiltrated: □ Yes □ No	Infiltrated: □ Yes □ No
IV Line Flushed: □ Yes □ No □ N/A	IV Line Flushed: □ Yes □ No □ N/A	IV Line Flushed: □ Yes □ No □ N/A
IV Dressing Changed: □ Yes □ No □ N/A	IV Dressing Changed: □ Yes □ No □ N/A	IV Dressing Changed: □ Yes □ No □ N/A
IV Fluid DC'd: □ Yes □ No □ N/A	IV Fluid DC'd: □ Yes □ No □ N/A	IV Fluid DC'd: □ Yes □ No □ N/A
IV Tube Change: □ Yes □ No □ N/A	IV Tube Change: □ Yes □ No □ N/A	IV Tube Change: □ Yes □ No □ N/A
IV Tubing Labeled: □ Yes □ No □ N/A	IV Tubing Labeled: □ Yes □ No □ N/A	IV Tubing Labeled: □ Yes □ No □ N/A
IV Site Discontinued: □ Yes □ No □ N/A	IV Site Discontinued: □ Yes □ No □ N/A	IV Site Discontinued: □ Yes □ No □ N/A

Medications_____
_____
_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____
_____
_____
_____
_____
_____
_____

Integumentary:

Skin: □ Dry □ Intact □ Moist □ Diaphoretic □ Clammy □ Fragile □ Warm
□ Hot □ Cool □ Other_____
Skin Color: □ Pink □ Pale □ Dusky □ Cyanotic □ Jaundice □ Mottled
□ Other _____
Turgor: □ Elastic □ Non-Elastic Mucosa: □ Moist □ Dry □ Intact
□ Other
Signs/Symptoms:
S/s of Infection: □ Yes □ No Bruises: □ Yes □ No Change in Mole: □ Yes □ No
Erythema: □ Yes □ No Petechiae: □ Yes □ No Pruritis: □ Yes □ No
Rash: □ Yes □ No Scar: □ Yes □ No

Medications_____
_____
Labs/Diagnostic
Tests_____
_____
Comments_____



_____
_____
_____
_____

Wounds: □ none present

Please mark an "X" indicating the locations of any wounds or skin problems. Number them as necessary

Wound #1	Wound #2	Wound #3
Location:	Location:	Location:
Measurements: ____cm L x ____cm W x ____cmD	Measurements: ____cm L x ____cm W x ____cmD	Measurements: ____cm L x ____cm W x ____cmD
Drainage Amt: □ None □ Scant □ Minimal □ Moderate □ Heavy	Drainage Amt: □ None □ Scant □ Minimal □ Moderate □ Heavy	Drainage Amt: □ None □ Scant □ Minimal □ Moderate □ Heavy
Drainage Color: □ Serous □ Serosanguineous □ Sanguinous □ Purulent	Drainage Color: □ Serous □ Serosanguineous □ Sanguineous □ Purulent	Drainage Color: □ Serous □ Serosanguineous □ Sanguineous □ Purulent
Odor: □ Yes □ No	Odor: □ Yes □ No	Odor: □ Yes □ No

Approximated: □ Yes □ No □ N/A	Approximated: □ Yes □ No □ N/A	Approximated: □ Yes □ No □ N/A
Dehisced: □ Yes □ No □ N/A	Dehisced: □ Yes □ No □ N/A	Dehisced: □ Yes □ No □ N/A
S/S of Infection: □ Yes □ No	S/S of Infection: □ Yes □ No	S/S of Infection: □ Yes □ No
Redness: □ Yes □ No	Redness: □ Yes □ No	Redness: □ Yes □ No
Edema: □ Yes □ No	Edema: □ Yes □ No	Edema: □ Yes □ No
Dry: □ Yes □ No	Dry: □ Yes □ No	Dry: □ Yes □ No

Drain Present: □ Yes □ No

- □ none
- □ Penrose
- □ Hemovac
- □ Jackson-Pratt (JP)
- □ T-tube
- □ Other_____

Wound Action Taken:

- □ Dressing Change performed
- □ Wound Med applied_____
- □ Drain Device Removed
- □ Drain Emptied
- □ Other_____

Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nurse Signature:_____

Date	Time	Narrative Nursing Notes

Medication Summary Sheet (Example)

Brand Name Generic Name	**Classification**	**Why is client receiving? Give supporting data**	**Side effects**	**Nursin**
Lasix/Furosemide	Loop Diuretic	CHF, Edema, Crackles to BLL	Increased urine output, electrolyte disturbances, H/A, dizziness	Monitor BP for (esp. K), M Moni
Insulin/Humulin R	Antidiabetic	Diabetes, FSBS 168	Hypoglycemia, localized reaction at SQ site	Monitor FSBS, Have food re i
Lanoxin/Digoxin	Antiarrhythmic	CHF, irreg HR	N/V, H/A, light flashes, halos around bright objects, yellow/green color perception	Monitor HR, physician direc Mg,

Medication Summary Sheet

Brand Name Generic Name	Classification	Why is client receiving? Give supporting data	Side effects	Nursin

Grayson College
Associate Degree Nursing Program
Medication Presentation Form

Objectives:

- Identify key components of the assigned medication using the medication presentation form
- Identify common medications, drug indications, mechanism of action, nursing considerations and potential interactions and/or side effects

Drug _____ Generic Name _____

Classification _____

Indications/Therapeutic Effects (How does this drug work? _____

_____

Metabolism & Excretion _____ Half-life _____

Onset/Peak/Duration _____

Adverse Reactions – Side Effects (major) (List by body system) _____

_____

_____

Contraindications (major) _____

Drug Interactions (major) _____

Route _____ Dosage _____

Assessment – Monitoring – Administration Considerations.

(What do you need to check/know before giving this drug? VS; Lab; w/food; Do not crush; etc.) _____

_____

_____

_____

Client Teaching (What does the client need to know about this drug?) _____

_____

_____

Evaluation of desired Effects (How do you know this drug is working?) _____

_____

Grayson College
Associate Degree Nursing Program

RNSG 1360

Interdisciplinary Interview (IDT)

Objectives:

- Discuss activities used to encourage participation of the health care team to meet patient needs.
- Describe the role of a non-nurse member of the interdisciplinary healthcare team.

Instructions:

1. Select an individual, other than a med-surg nurse, who is part of the healthcare interdisciplinary team.

Some examples are listed below:

Physical Therapist, Occupational Therapist, Dietician, ET nurse, Infection Control Nurse, Diabetic Educator, Speech Therapist, Cardiac Rehab Nurse, Physician, Nurse Manager/Director, Nurse Practitioner/PA, Chaplain, Social Worker, Case Manager

2. You must set up a time with this individual to perform a one-on-one interview regarding the questions listed on the next page. You cannot do the interview by phone or social media.

3. Write down what the individual tells you in regards to each question and you will present this in a scheduled post-conference. Please contact the individual ahead of time (preferably 3-4 days prior to visit) to allow for scheduling.

Interdisciplinary Team Interview

Student _____ Date _____

Person Interviewed _____

Discipline Interviewed _____

Facility _____

1. What is the function / purpose of your discipline?

2. How do you collaborate with nursing?

3. What are some of the challenges you face in your profession?

4. What are some of the advantages of your profession?

5. What are some of the challenges and benefits of working with nurses?

6. How do you see your role / profession changing within the next 5 years?

Grayson College
Associate Degree Nursing Program

RNSG 1360

Well Elder Visits

Objectives:

- Discuss communication skills utilized during the interview of the well elder.
- Describe measures implemented to promote a safe environment for the well elder.
- Apply skills to ensure safe, effective care of the well elder in their home.
- Identify caring interventions promoted during the interview of the well elder.

Instructions:

Select a well elder client: over the age of 70, lives in own home or apartment (not in a nursing home setting), self-reliant, does not have any major chronic diseases including dementia. **May not select a relative.**

You must visit the same client for both visits. Therefore, inform the client that you will be visiting him/her twice, approximately 1-2 weeks between each visit. You cannot do the interview by phone or social media. It must be completed in a one-on-one interview with your well elder.

Keep all scheduled visits if possible. Please contact the client ahead of time (preferably 3-4 days prior to visit) if unable to meet at designated time and reschedule the visit.

Grayson College
Associate Degree Nursing Program

RNSG 1360
Well Elder Visit #1

Student: _____ Client Age: _____

Date: _____ Meeting Location: _____

1. How does your client define "health" and "old age"?

2. Describe your client's home and living environment. What factors enhance or enable him/her to maintain independence?

3. Describe your client's nutritional status including their food likes, eating patterns, etc.

4. Identify how your client meets his/her comfort/hygiene, activity/exercise and rest/sleep activities.

5. Describe any GI and GU systems problems your client is experiencing.

6. List medication your client is taking (prescription and over the counter). Determine if he/she has difficulty remembering to take it at the prescribed time. How could you assist in solving this problem?

7. Discuss your impressions, your reactions and your feelings about the visit.

Grayson College
Associate Degree Nursing Program

RNSG 1360
Well Elder Visit #2

Student: _____ Client Age: _____

Date: _____ Meeting Location: _____

1. Describe your client's involvement with family and support systems.

2. Describe the feelings your client expresses regarding aging.

3. Describe any identified physiological and/or psychosocial changes observed in your client that are characteristic of the older adult.

4. Describe any concerns your client expresses in regard to his/her life situation.

5. Describe your client's feelings about death and dying (such as, refusal to discuss; deaths of spouse, parents and other loved ones; funeral arrangements.)

6. Describe how you conducted the termination phase (nurse/client relationship) of your interview.

7. Discuss your overall experience of interviewing an older adult.

CLINICAL DUTY ASSIGNMENTS
(WHAT TO DO)
12-hour clinical schedule

0630-0700 Pre-conference:
1. Clinical preparation
2. Review daily objectives

0700-0830:
1. Introduce yourself to the primary nurse, then request report.
2. Obtain vital signs and perform baseline assessment-report findings to your primary nurse.
3. Correct any safety hazards.
4. Provide warm, wet washcloth if appropriate.
5. Straighten bedding and over bed table, removing trash or unsightly items (urinal).
7. Assist with breakfast as needed
8. Check MAR for meds to be given and note times and notify instructor of times.
9. Mentally plan your day- Ask yourself the following:
    What must be done right away?
    What must be done on a schedule?
    What must be done sometime today?
    What would be good to do if time permits?

0830-0930 Shift Assessment or Admission Assessment:
1. Review chart and plan of care.
2. Perform complete assessment (make brief notes)
3. Record I & O from breakfast
4. Before leaving room, make sure the client is comfortable and make sure call light is in reach. Bed must be lowest position and side rails up X 2.

0930-1100 AM care:
1. Gather supplies needed for AM care.
2. Give AM care, including hair wash, oral care, and peri-care if applicable.

1100-1200
1. Perform other client care procedures as ordered.
2. Perform FSBS (if ordered) and vital signs-report findings to your primary nurse.
3. Visit with your client. Work on clinical assignments (assessment, clinical objectives for the day).
4. Pass noon trays before going to lunch. Assist with lunch if needed.

1230-1300 Student lunch
1. Report off to primary nurse and instructor before lunch.

1300-1600
1. Re-assess client and check for any new HCP orders.
2. Continue completing assessment form (psychosocial, etc.).
3. Keep recording I & O!
4. Make client rounds hourly for client needs.

5. May see additional procedures as given by instructor (PICC line nurse, etc.)

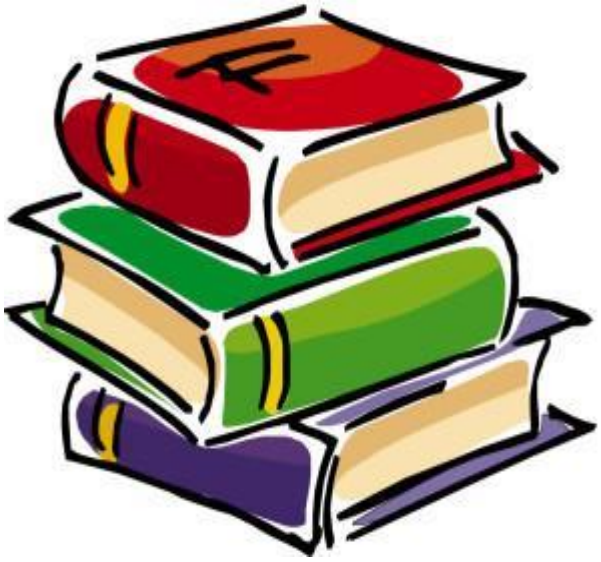
1600-1645
1. Perform FSBS (if ordered) and vital signs- report findings to your primary nurse.
2. Tidy room and give fresh water.
3. Check MAR and make sure all meds have been given.
4. Say good-bye to your client!
5. Report off to primary nurse and nursing instructor.

Things to do when there is “nothing to do”!

1. Help a classmate.
2. Pass trays on ALL patients on the floor.
3. Make sure all rooms are clean, tidy, and stocked.
4. Ask your primary nurse if there is anything you can do for them/ anything you can observe them doing.
5. Ask your instructor- they have PLENTY of ideas!

POST CONFERENCE

Helpful Nursing Resources



Guidelines for Communicating with Physicians Using the SBAR Process

Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.

1. Direct page (if known)
2. Physician's Call Service
3. During weekdays, the physician's office directly
4. On weekends and after hours during the week, physician's home phone
5. Cell phone

Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

Prior to calling the physician, follow these steps:

1. Have I seen and assessed the patient myself before calling?
2. Has the situation been discussed with resource nurse or preceptor?
3. Review the chart for appropriate physician to call.
4. Know the admitting diagnosis and date of admission.
5. Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?

Have available the following when speaking with the physician:

1. Patient's chart
2. List of current medications, allergies, IV fluids, and labs
3. Most recent vital signs
4. Reporting lab results: provide the date and time test was done and results of previous tests for comparison
5. Code status

When calling the physician, follow the SBAR process:

(**S) Situation:** What is the situation you are calling about?

- Identify self, unit, patient, room number.
- Briefly state the problem, what is it, when it happened or started, and how severe.

(B) Background: Pertinent background information related to the situation could include the following:

- The admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Other clinical information
- Code status

(A) Assessment: What is the nurse's assessment of the situation?

(R) Recommendation: What is the nurse's recommendation or what does he/she want?

Examples:

- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

Document the change in the patient's condition and physician notification.

This SBAR tool was developed by Kaiser Permanente. Please feel free to use and reproduce these materials in the spirit of patient safety, and please retain this footer in the spirit of appropriate recognition.

SBAR report to physician about a critical situation

S
Situation
I am calling about <patient name and location>.
The patient's code status is <code status>
The problem I am calling about is _____.
I am afraid the patient is going to arrest.
I have just assessed the patient personally:
Vital signs are: Blood pressure _____/_____, Pulse _____, Respiration_____ and temperature _____
I am concerned about the:
Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual
Pulse because it is over 140 or less than 50
Respiration because it is less than 5 or over 40.
Temperature because it is less than 96 or over 104.

B
Background
The patient's mental status is:
Alert and oriented to person place and time.
Confused and cooperative or non-cooperative
Agitated or combative
Lethargic but conversant and able to swallow
Stuporous and not talking clearly and possibly not able to swallow
Comatose. Eyes closed. Not responding to stimulation.
The skin is:
Warm and dry
Pale
Mottled
Diaphoretic
Extremities are cold
Extremities are warm
The patient is not or is on oxygen.
The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours)
The oximeter is reading _____%
The oximeter does not detect a good pulse and is giving erratic readings.

A
Assessment
This is what I think the problem is: <say what you think is the problem>
The problem seems to be cardiac infection neurologic respiratory _____
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse, we need to do something.

R
Recommendation
I suggest or request that you <say what you would like to see done>.
transfer the patient to critical care
come to see the patient at this time.
Talk to the patient or family about code status.
Ask the on-call family practice resident to see the patient now.
Ask for a consultant to see the patient now.
Are any tests needed:
Do you need any tests like CXR, ABG, EKG, CBC, or BMP?
Others?
If a change in treatment is ordered then ask:
How often do you want vital signs?
How long to you expect this problem will last?
If the patient does not get better when would you want us to call again

Seven-Minute Assessment Manager

Today, nurses are busier than ever, yet even the busiest nurse strives to perform quick and thorough assessment on all assigned patients. Assessment ensures safe care and safety is always #1. Try this focused guide to save time while assessing each patient.

1st Based on patient's history from the chart and report, perform a quick overview. Keep in mind the primary system of concern or reason for admission into the hospital.

Ask the patient what symptoms are most troubling to him/her.
Look for both expected and unusual symptoms.
Specifically inquire about pain, including pain rating, location, and description.
Ask the patient to demonstrate use of the call light.

2nd Check the bedside for assistive equipment.

Is a urinary catheter present?
Assess the appearance of urine? Sediment? Draining properly?
Drainage bag is lower than insertion site?
Is there an IV?
Confirm that the correct solution is infusing at the prescribed rate. Carefully assess the peripheral or central line sites.
Observe for any other tubes.
Track the origin and the insertion of each, as well as the condition of every insertion site and each dressing.
Is equipment functioning properly?
Are each of these appropriate to the patient's diagnosis and condition? Above all else, is the patient comfortable and safe?

3rd As you introduce yourself observe eye contact, facial expressions, the ability to answer questions appropriately and the emotional tone of interactions. Take care to interpret these observations within the appropriate cultural context.

Is the patient up in a chair?
Assess posture.
Is the patient in bed?
Assess ability to change positions during assessment.
Is the patient ambulating?
Observe steadiness of the gait and apparent ease of movement.

4th Examine head and neck. Look for skin lesions, loss of hair, and assess mobility of the neck.

Check the swallow reflex.
Look at the mucous membranes of the mouth, the tongue, and condition of teeth/dentures.
Assess the pupil size and equality.
Check for obvious limitations to sight or hearing.

5th Observe both upper extremities for mobility.

Hold the patient's hands to assess the strength of grip bilaterally.
Assess skin temperature, capillary refill, radial pulses, as well as character and rate of each.
Check skin integrity and look for signs of edema.

6th Inspect the abdomen and the anterior/posterior thorax.

Look for any lesions or apparent structural abnormalities.

Auscultate the heart, lungs, and abdomen.

Note any abnormal sounds.

Palpate the abdomen for tenderness, distention, rigidity, or discomfort.

Remember, as the bladder becomes distended it leaves its place behind the symphysis pubis and may be palpated abdominally.

Carefully inspect the patient's back and sacrum.

7th Inspect legs and feet.

Palpate both pedal pulses.

Assess extremity strength by having the patient plantar flex each foot against your hand and then dorsi flex against resistance.

Check skin integrity, capillary refill, and bony prominences.

Inspect the feet, heels, and legs once again for lesions as well as signs of edema, redness, or dryness.

Invest 7-10 minutes to implement these 7 steps and hopefully the nurse and the patients will reap the rewards of a safe, prioritized, and thorough assessment.

0630-0700	**Comments**
☐ Tab Drug Book ☐ Review 0730-0900 Meds ☐ Review Care for Med DX	
0700	
☐ Get Report from Primary ☐ Familiarize yourself with pt's SBAR ☐ Get MAR from primary nurse	
0730-0830	
☐ VS in computer by 8 ☐ Report VS to primary nurse ☐ Perform Focused Assessment (Focus on admission reason.) ☐ Look, Check, Connect ☐ Check MAR Against Dr Orders ☐ Check Labs in Comp ☐ *Insulin: Ck FSBS, Admin w/ Tray ☐ Chart FSBS in comp ☐ Report FSBS to primary nurse	
0830	
☐ Prepare to Give 0900 Meds (Review Drug Book) ☐ Check Labs That Affect Meds ☐ Check VS That Affect Meds	
0845-0930	
☐ Admin 0900 Meds ☐ Sign MAR in Patients Room ☐ Return MAR to primary nurse	
0930-1000	
☐ Finish Thorough Assessment ☐ Assist With AM Care ☐ Report Bath and Linen change to instructor and primary nurse	
1000-1030	
☐ Finish Assessment on paper	
1030-1130	
☐ Complete Any Other Pt Care Needed ☐ FSBS- ☐ Chart FSBS in comp ☐ Report FSBS to primary nurse ☐ Look Up Any Other Meds ☐ *Admin Insulin w Tray	
1200	
☐ VS- ☐ Chart VS in comp	

☐ Report VS to primary nurse	
1230-1330	
☐ 30 min Lunch ☐ Coordinate w instructor ☐ Report to Primary before leaving floor and upon returning	
1200-1400	
☐ Reassess Pt as Needed ☐ Admin Meds as Scheduled ☐ Sign MAR ☐ Look over Comp Chart and pt's dx, labs, orders, etc… ☐ Look for Skills	
1500	
☐ Look up Any Other Meds	
1600	
☐ Reassess Pt ☐ VS- ☐ Chart VS in comp ☐ Report VS to primary nurse ☐ Admin Meds as Scheduled ☐ Sign MAR	
1600-1700	
☐ Complete Pt Care ☐ FSBS-chart in comp and report to primary ☐ Empty Foley Bags ☐ Verify Comp Charting w Inst ☐ Report Off to Primary & Inst	
1700-???	
Post Conference	

Hourly	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800
Asses s/LCK													
I&O													
Pain													

PAIN SCALE for Alzheimer's/Dementia Patients

PAINAD Scale
(Pain Assessment in Advanced Dementia Scale)

ITEMS	0	1	2	SCORE
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low- level of speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
			TOTAL*	

*** Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").**

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and surrogate report from an individual knowledgeable of the person and their pain behaviors.

Remember that some patients may not demonstrate obvious pain behaviors or cues.

Breathing

Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.

Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.

Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.

Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.

Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.

Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative vocalization

None is characterized by speech or vocalization that has a neutral or pleasant quality.

Occasional moan or groan is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.

Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.

Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.

Loud moaning or groaning is characterized by mournful or murmuring sounds, wails or laments much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.

Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial expression

Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.

Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.

Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.

Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.

Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Body language

Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.

Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).

Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.

Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.

Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).

Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.

Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).

Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.

Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

No need to console is characterized by a sense of well being. The person appears content.

Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.

Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

ALWAYS ASK YOURSELF:

"What did I do to keep my patient safe today?"

…. and then ask

"What could I have done better?"

1. **The <u>six rights</u> for every medication & every procedure?**
2. **For psychological safety…..did I inform my patient about all I was doing and all that I planned to do…..and *why*?**
3. **<u>Did I follow the line</u>, checking the *origin* and the *insertion* of EVERY tube & catheter my patient had?**

   *Remember: **Look….. Check……Connect.**
4. **Did I ask my patient what s/he needed to know about medications and treatments ordered so that I would know what to teach?**
5. **Did I look up all important information and document the patient teaching that I did?**

Verbal Skills

Your words and demeanor have the power to defuse tensions, so be attuned to your tone of voice, choice of words, and body language. Basic guidance includes:

Allow the person to express concern.

- "Please tell me what's bothering you."

Use a shared problem solving approach.

- "How can we correct this problem?"

Be empathic.

- "I understand how frustrating this must be for you."

Avoid being defensive or contradictory. This only exacerbates a tense situation.

Apologize if appropriate.

- "I'm sorry this happened. Let's find a way to fix it."

Follow through with their problem.

- "I'm going to bring this to my supervisor immediately."

Avoid blaming others or "It's not my job".

- "Let me get someone who can help you with this problem."

Be alert to early signs of a patient's rising anxiety; perhaps offer an empathic inquiry such as, "You seem to be upset...can you tell me what's troubling you?"

- Be calm, or at least act calm. Maintain non-threatening eye contact, smile, and keep hands open and visible.
- Listen. Nod your head to demonstrate that you are paying attention.
- Respect personal space. Maintain arm/leg distance away from the individual. Avoid touching the upset individual as it may be misinterpreted.
- Approach the patient from an angle or from the side.
- Convey that you are in control, by demonstrating confidence in your ability to resolve the situation.
- Demonstrate supportive body language. Avoid threatening gestures, such as finger pointing or crossed arms.
- Avoid laughing or smiling inappropriately.

Tips for Narrative Charting

- Assessment data should be stated in 1st or 2nd entry because this is what your day and care depends on. Must have a baseline assessment in order to know when something changes.
- Safety precautions: Side rails up x2 or x3 or x4, call light within reach, and bed in lowest position should be stated in your narrative notes every 1hr – 1 ½ hr.
- Need to have an entry every 1-2 hrs.
- Need to put only what is relevant to patient in narrative notes. Do not give me "play by play" of your actions. It has to be about your patient and only your patient.
- Do not use names or state anything about diagnosis and/or plan of care unless you are providing that intervention at that moment. Never put anything into the chart that the doctor or someone else has said.
- Do not try to justify why something is, just STATE THE FACTS.
- Be objective about your documentation. Do not use words such as "**seems, very**, **appears**." If a patient is sick, how do you know that? Fever is elevated, pallor, nausea/vomiting. These are all observable facts.
- Do not need to chart anything that is on the chart elsewhere. Such as the specific medication names, these are on your MARS and do not require you to restate them. Same with I&O.
- Be as descriptive as possible with wounds, pain, drainage, etc.
- Anytime there is a concern mentioned by your patient, you need to document how you intervened regarding that concern.
- Always state if patient leaves the floor for procedure and when he/she returns
- Do not leave blank lines.

Narrative Charting

Think of your notes as a camera that takes the client's picture.
Be specific enough so that anyone who reads your notes will be able to see that client through your words.
Always review each of your client's problems (Nrsg. Diagnosis) as you consider what to document in the progress notes.

Chart whenever you observe:

- A change in client's condition
- Response to a treatment or medication
- A lack of change in a client's condition
- Teaching done and pt's response

CARE: If you gave: AM care, Oral care, Peri care. Chart if client refuses AM care

Respiratory:

- Respirations describe. Even? Uneven? Labored? Unlabored?
- Describe adventitious breath sounds-what kind? . If heard- note on inspiration &/or expiration? What lobes involved?
- If cough is noted, describe-productive/non-productive? If productive cough noted-need to describe sputum color? Amount? Consistency?
- O2 via NC ____LPM or O2 via mask at ____%.
- Post-op cough, deep breathing &/or Incentive spirometer (teaching, client performance, how often performed, etc)

Cardiovascular:

- Apical pulse rate. Regular? Irregular? Murmur present? S1/S2?
- Jugular Vein Distention(JVD)
- Pedal pulses present?
- Capillary refill?
- Edema-pitting or non-pitting. Describe- ex. If pitting 1+, etc.
- Telemetry in place.

Neurological:

- Awake, alert, drowsy?
- Orientation-describe. Person? Place? Time? Situation?
- Responds to verbal stimuli?
- PERRLA

Gastrointestinal:

- Bowel sounds-present? X 4 quads?
- Soft? Distended? Tenderness? Rigid? Ascites?
- Last bowel movement (LBM)?
- N/G in place. Clamped? Connected to low intermittent suction? NPO or ice chips?
- PEG tube-is it clamped or connected to a pump? Feeding what solution? Via N/G or PEG tube? Infusion rate? Gravity or pump?

Genitourinary:

- If urine observed in urinal, bedpan, or BSC-describe urine.
- Urinary indwelling (or foley) cath- patent?, draining? (describe urine).

Musculoskeletal:

- Extremities ROM-describe? Strong? Weak? Paralysis?
- Grips? Equal?
- Ambulatory or transferred via W/C? If amb, document approximate distance. With or without assist?
- With all activity need to document: How client tolerated the activity. Do not chart "Tolerated well" Document heart rate, shortness of breath, or O2 sat after ambulating. Any pain? Tired?
- If immobile, document when client was turned. If active, &/or passive ROM performed.
- SCDs present? TED hose present?

Integumentary:

- Skin-describe. Warm? Dry? Color? Turgor?
- Mucous membranes-describe. Moist? Pink?
- Nailbeds-describe.
- Note any areas of redness, lesions, etc. Any redness or swelling?
- Document assessment of wounds. Dressing dry and intact? Any drainage? How much drainage? Drsg changed? What cleansing agent and dressing used for dressing change?
- IV site-describe-location? Gauge? Type: Saline lock? IV infusing? If infusing, what type of fluid? How many mL/hr is pump set for?

Pain:

- Rating on pain scale? Location? Description-dull, ache, sharp, shooting, radiating?

Safety Precautions:

After each entry, always document how you left the patient. By doing this, you are stating that when you leave the patient's room, he/she is safe as documented by the following:

- Side rails up x 2
- Bed in lowest position
- Call bell within reach
- Family at bedside

NARRATIVE CHARTING EXAMPLE

Date	Time	Narrative Nursing Notes
10/10/13	0700	*Sitting up in bed, watching TV. Alert, oriented to person, place, situation, and*
		time. No reports of pain or discomfort. VS: T-97.6, P-68, R-16, B/P-110/70,
		O2 sat 98% on RA. Skin pink, warm and dry. No lesions noted. IV site in L
		forearm without redness, tenderness, or swelling. Infusing at 60mL/hr via pump
		TED hose on bilaterally. ----------N. Nurse SN
	0730	*Dr. Pepper in to examine client.---------- N. Nurse SN*
	0800	*Awake. Speech clear. Appropriate verbal responses. Cooperative and calm.*
		PERRLA without discharge. Respirations even and nonlabored. Bilateral
		breath sounds clear to auscultation (CTA). No shortness of air (SOA). Radial
		pulses 2+ bilaterally, Pedal pulses 2+ bilaterally. Capillary refill less than
		3 sec. No difficulty in swallowing or chewing. Mucous membranes pink and
		moist. Bowel sounds present x 4 quads. Abdomen soft without distention and
		non-tender. LBM 10/09/13, soft and brown. Voids on own. Clear, yellow
		urine without sediment. Denies burning, urgency, or incontinence. Full ROM
		x 4 extremities. No joint swelling or crepitus noted. Tubing is free of kinks and
		IV infusing without complications.---------- N. Nurse SN
	0930	*Assisted with am care. Provided assistance with oral care and shave. TED hose*
		removed for 30 minutes and replaced. Assisted client to bedside chair. Call
		bell within reach. ---------- N. Nurse SN
	1030	*Assisted back to bed. Reports pain in lower right back rated 6 on scale of 1-10.*
		"My back is starting to really hurt. Could I get something for pain?" ----------
		----------N. Nurse SN
	1045	*Administered Ibuprofen 800mg PO . Side rails up x 2. Bed in lowest position.*
		Call bell within reach. ---------- N. Nurse SN
	1115	*Reports pain a 2 on scale of 1-10. "My back is feeling much better." ----------*
		----------N. Nurse SN
	1200	*VS- T-98.6, P-72, R-14, B/P 114/72, O2 sat 99% on RA. IV site intact, without*
		redness, edema, or tenderness. Sitting in bed, reading newspaper. Reports no
		pain or discomfort. ----------N. Nurse SN