PATIENT CHART

Chart for Josephine Morrow

STUDENT NAME:	
PATIENT INITIALS:	
CLINICAL DATE(S):	
INSTRUCTOR:	

Josephine Morrow			**Gender:** Female	**Allergies:** Penicillin
DOB: 02/23/XX	**Age:** 80 years	**Height:** 160 cm (63 in.)	**Weight:** 90 kg (198 lb)	**MRN:** 93312065
Diagnosis: Chronic venous insufficiency; venous stasis ulcer		**Adm Date:** 3 days ago		**Adm Provider:** Dr. Alvin Hernandez
Facility: Skilled Nursing Home Care Facility		**Adv Directive:**		**Isolation Precaution:**

PATIENT INFORMATION

Demographics

Marital Status: Widow	**Religion:** Catholic
Next of Kin: Sandra Hughes (daughter)	**Race:** White
Ethnic Category: Not Hispanic or Latino	**Ethnicity:**
Primary Language: English	**Occupation:** Retired waitress

History of Chief Concern: Impaired mobility and overweight with history of varicose veins, leg pain, and swelling. She developed a venous stasis ulcer at home. Duplex ultrasound ruled out peripheral arterial disease.

Past Medical History

☒ **No prior surgical history** ☐ **Denies prior medical problems**

Surgical Procedure:	**Year:**	**Disease/Condition:**	**Date Diagnosed:**
		COPD	10 years ago
		DVT	5 years ago

Notes:

Pain History: Yes **Notes:** Pain in legs related to venous insufficiency	**Transfusion History:** No **Notes:**
Allergies: Penicillin **Substance:** **Category:** Medication **Reaction:** Rash	**Immunizations:** Up to date

Social History

Living situation: Skilled Nursing Home Care Facility
Lives with:

Education: High school

Nicotine Use: Former smoker	Notes: ½ pack-year history. Quit smoking 30 years ago.
Alcohol Use: Former user	Notes: Occasional glass of wine or beer when living at home

Drug Use: Non-user

Violence Screening: NA

Nutritional Screening: Yes. Has been living on high-fat. Low-protein diet at home. She is a bit low on protein, albumin, and prealbumin in her lab results and is now receiving high-fat, low-protein diet at home.

Exercise Screening: No

Mental Health Screening: Yes, forgetful of some recent events. Otherwise, consistent reactions.

Sexual Activity: No

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NURSING ASSESSMENT FLOWSHEET

TIME OF ASSESSMENT: Done at 0730

NEUROLOGICAL

ORIENTATION: ☒ Person ☒ Time ☒ Place ☒ Situation
☐ Disoriented

PUPILS: ☒ PERRLA

Left: Size: _____ Reaction: _____

Right: Size: _____ Reaction: _____

STRENGTH: _____

BEHAVIORAL/EMOTIONAL: ☒ Calm ☐ Cooperative
☐ Restless ☐ Combative ☐ Confused ☐ Agitated ☐ Untestable

GLASGOW COMA SCALE:

Eye Opening: ☒ Spontaneous ☐ Speech ☐ Pain
☐ Non-responsive

Verbal Response: ☒ Oriented x 3 ☐ Confused
☐ Inappropriate ☐ Incomprehensible ☐ No Sounds

Motor Response: ☒ Obeys commands ☐ Localizes pain
☐ Flexion/Withdrawal to Pain ☐ Abnormal Flexion ☐ Extension
☐ No movement

SIGHT: ☒ No Correction ☐ Glasses ☐ Contacts ☐ Blind

HEARING: ☒ WNL ☐ Hard of Hearing ☐ Hearing Aid ☐ Deaf

RESPIRATORY

OXYGEN DELIVERY METHOD: ☒ Room Air ☐ Nasal Cannula
☐ Simple Face mask ☐ Non-Rebreather Mask ☐ CPAP
☐ BiPAP ☐ Other

SPUTUM: _____

RESPIRATORY SYMPTOMS: ☐ Cough ☒ Shortness of Breath
☐ Difficulty Breathing at Rest ☒ Difficulty Breathing with Activity
☒ Use of Accessory Muscles ☐ Cyanosis ☐ Other

BREATH SOUNDS:

Right: ☒ Clear ☐ Crackles ☐ Ronchi ☐ Wheeze
☐ Coarse ☐ Stridor ☐ Inspiratory ☐ Expiratory
☐ Decreased ☐ Absent

Left: ☒ Clear ☐ Crackles ☐ Ronchi ☐ Wheeze ☐ Coarse
☐ Stridor ☐ Inspiratory ☐ Expiratory ☐ Decreased ☐ Absent

RESPIRATIONS: ☐ Regular ☐ Irregular ☒ Labored
☐ Gasping ☐ Grunting ☐ Retraction ☐ Nasal Flaring

THORAX: ☒ Even expansion ☐ Uneven expansion

CARDIOVASCULAR

HEART TONES: ☒ S1, S2 ☒ Regular ☐ Irregular ☐ Murmur
☐ S3 ☐ S4 ☐ Gallop ☐ Muffled ☐ Distant ☐ Radiating

PULSES:

All: ☐ Absent ☐ Intermittent ☐ +1 ☐ +2 ☒ +3
☐ Bounding ☐ Doppler

LUE: ☐ Absent ☐ Intermittent ☐ +1 ☐ +2 ☐ +3
☐ Bounding ☐ Doppler

RUE: ☐ Absent ☐ Intermittent ☐ +1 ☐ +2 ☐ +3
☐ Bounding ☐ Doppler

LLE: ☐ Absent ☐ Intermittent ☐ +1 ☐ +2 ☐ +3
☐ Bounding ☐ Doppler

RLE: ☐ Absent ☐ Intermittent ☐ +1 ☐ +2 ☐ +3
☐ Bounding ☐ Doppler

EDEMA: ☐ None ☒ Generalized

Site #1: _____ ☐ Absent ☐ Trace
☐ 1 + ☒ 2 + ☐ 3 + ☐ 4 + ☐ Non-Pitting ☐ Pitting

Site #2: _____ ☐ Absent ☐ Trace
☐ 1 + ☒ 2 + ☐ 3 + ☐ 4 + ☐ Non-Pitting ☐ Pitting

CAPILLARY REFILL:

LUE: ☒ < 3 sec ☐ > 3 sec ☐ Absent

RUE: ☒ < 3 sec ☐ > 3 sec ☐ Absent

LLE: ☒ < 3 sec ☐ > 3 sec ☐ Absent

RLE: ☒ < 3 sec ☐ > 3 sec ☐ Absent

SKIN COLOR AND DESCRIPTION:

☒ Appropriate for ethnicity ☐ Warm ☐ Dry ☐ Intact
☐ Cool ☐ Clammy ☐ Cyanotic ☐ Diaphoretic
☐ Blotchy ☐ Dusky ☐ Flushed ☐ Fragile ☐ Jaundiced ☐ Moist
☐ Mottled ☐ Pale ☐ Ashen ☐ Other

DEVICES:

☐ Pacer ☐ IABP ☐ CVP ☐ Pulmonary Artery Monitoring
☐ Cardiac Monitor ☐ Arterial line

GASTROINTESTINAL

ABDOMINAL DESCRIPTION: ☐ Soft ☐ Flat ☐ Non-Distended
☐ Distended ☐ Firm ☒ Round ☐ Sunken ☐ Rigid ☐ Guarding
☐ Rebound ☐ Scars ☐ Hernia

PALPATION: ☒ Non-Tender ☐ Tender

Location: _____

GI SYMPTOMS: ☐ Anorexia ☐ Belching ☐ Vomiting
☐ Heartburn ☐ Nausea ☐ Epigastric Pain ☐ Cramping
☐ Constipation ☐ Diarrhea ☐ Abdominal Pain
☐ Flatulence ☐ Hiccup ☐ Early Satiety ☐ Dysphagia
☐ Encopresis ☐ Bloody Stools
☐ Weight Loss ☐ Weight Gain ☐ Other

BOWEL SOUNDS: ☒ Present ☐ Hypoactive ☐ Hyperactive
☐ Absent

DIET TOLERANCE: ☐ Excellent ☐ Adequate ☒ Inadequate
☐ NPO ☐ Other

Diet Type: _____

☐ Impaired swallowing ☐ Choking

DEVICES: ☐ NG Tube ☐ Feeding Tube

NOTES: _____

JOSEPHINE MORROW

NURSING ASSESSMENT FLOWSHEET – CONTINUED

GENITOURINARY

URINARY SYMPTOMS: ☐ Dysuria ☐ Oliguria ☐ Polyuria ☐ Anuria ☐ Hemituria ☐ Nocturia ☐ Urinary Retention ☐ Difficulty Starting Stream ☐ Hesistancy ☒ None

INCONTINENCE: ☐ Frequency ☐ Urgency ☐ Stress ☐ Complete ☐ Daytime ☐ Nighttime

URINE COLOR: ☒ Yellow ☐ Amber ☐ Orange ☐ Red ☐ Brown ☐ Pink ☐ Green ☐ Blue ☐ Not Visualized

URINE CHARACTER: ☒ Clear ☐ Cloudy ☐ Concentrated ☐ Diluted ☐ Sediment ☐ Bloody ☐ Clots ☐ Frothy ☐ Purulent

URINE ODOR: _____

DEVICE: _____

CATHETER: Size: _____ Volume in Balloon: ____

SITE DESCRIPTION: _____

GENITALIA EXAM: _____

SANE EXAM: _____

OTHER/NOTES: _____

MENTAL HEALTH

BEHAVIOR/AFFECT:

☒ Appropriate ☐ Agitated ☐ Anxious ☐ Depressed ☐ Crying ☐ Fearful ☐ Hostile ☐ Inappropriate ☐ Help-rejecting/Complaining ☐ Embarrassed ☐ Evasive ☐ Resentful ☐ Angry ☐ Impulsive ☐ Disturbed Sleep ☐ Nightmares ☐ Night terrors ☐ Regression ☒ Other: Forgetful of resent events

STRESSORS: ☒ Condition ☐ Hospitalization ☐ Diagnosis ☐ Procedure ☐ Surgery ☐ Family Death ☐ Family Illness ☐ Family Problems ☐ Finances ☐ Unknown Causes ☐ Abuse/Neglect ☐ Exposure to Violence ☐ Other: _____

COPING: ☐ Well ☒ Fair ☐ Poor

COPING STYLE: _____

COMMUNICATION: _____

CONSULT: ☐ Chaplain ☐ Social Work ☐ Psychiatry ☐ Child life

COGNITIVE IMPAIRMENT SCREENING:

TOOL USED: _____ Interpretation: _____

PRESENT REGIMEN: _____

THOUGHTS EXHIBITED: ☐ Delusional ☐ Hallucinatory ☐ Depersonalization

REACTION: ☐ Over-reactive ☐ Under-reactive ☐ Purposeful ☐ Disorganized ☐ Stereotypical ☒ Consistent Reactions ☐ Inconsistent Reactions

OTHER/NOTES: _____

INTEGUMENTARY

DATE/TIME: _____

☐ Clean/Dry/Intact Skin Assessment

☒ Site/Wound: _____

REGION: ☐ Head ☐ Neck ☐ Shoulder ☐ Back ☐ Torso ☐ Arm ☐ Hand ☐ Hip ☐ Buttocks ☐ Groin ☒ Leg ☐ Ankle ☐ Foot

TYPE: Venous stasis ulcer on her right medial malleolus

CHARACTERISTICS: Mostly pink to red with small yellow patch, moist with minimal exudate, shallow

LENGTH: 2 inches WIDTH: 1 inch

DEPTH: _____ ACTIONS: _____

NOTES: Irregularly shaped on medial malleolus

BRADEN SCALE SCORE: 16

MUSCULOSKELETAL

MUSCULOSKELETAL SYMPTOMS: ☐ Pain ☐ Joint Swelling ☐ Join Stiffness ☐ Contractures ☐ Deformities ☐ Crepitus ☐ Weakness ☐ Amputation ☐ Fractures ☐ Spasm ☒ None

MOTOR STRENGTH GRADE:

All: ☐ 5/5 ☒ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5
LUE: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5
RUE: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5
LLE: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5
RLE: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

RANGE OF MOTION & CHARACTERISTIC:

All: ☐ Passive ROM ☒ Active Assistive ROM ☐ Active ROM ☐ Spasm ☐ Paralysis ☐ Atrophy

LUE: ☐ Passive ROM ☐ Active Assistive ROM ☐ Active ROM ☐ Spasm ☐ Paralysis ☐ Atrophy

RUE: ☐ Passive ROM ☐ Active Assistive ROM ☐ Active ROM ☐ Spasm ☐ Paralysis ☐ Atrophy

LLE: ☐ Passive ROM ☐ Active Assistive ROM ☐ Active ROM ☐ Spasm ☐ Paralysis ☐ Atrophy

RLE: ☐ Passive ROM ☐ Active Assistive ROM ☐ Active ROM ☐ Spasm ☐ Paralysis ☐ Atrophy

WEIGHT BEARING/GAIT/POSTURE:

☐ Steady ☐ Independent ☒ Unsteady ☐ Dependent ☐ Asymmetrical ☐ Jerky ☐ Shuffling ☐ Spastic ☐ Developmentally Appropriate ☐ Lordosis ☐ Scoliosis ☐ Kypholosis ☐ None

ACTIVITY: ☒ Up ad lib ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair

ASSIST: ☒ x1 ☐ x2 ☐ Lift ☐ Bed Bound

NOTES: _____

PAIN SCALE

LOCATION: _____

ONSET: _____

LAST ASSESSMENT AT: _____

PAIN RATING: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

AGGRAVATING FACTORS: ☐ Movement ☐ Coughing ☐ Breathing ☐ Eating

ALLEVIATING FACTORS: ☐ Rest ☐ Compression ☐ Medication ☐ Ice ☐ Immobility

PAIN CHARACTERISTICS: ☐ Aching ☐ Throbbing ☐ Dull ☐ Stabbing ☐ Burning ☐ Piercing ☐ Sore ☐ Crushing ☐ Radiating

FREQUENCY: ☐ Constant ☐ Intermittent

DURATION: _____

TYPE OF PAIN: ☐ Chronic ☐ Acute ☐ Cancer-related

ACTION: _____

VASCULAR ACCESS

LOCATION: _____ TYPE: _____ SIZE: _____

DOCUMENTED AT: _____

DRESSING: _____

NOTES: _____

ACTIONS: _____

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NOTES

Date/Time:	**Order:**
Today 0730	Braden Scale score: Sensory perception 4 Moisture 3 Activity 3 Mobility 2 Nutrition 3 Friction and shear 1 Total 16 (19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, <10 very high risk) Medicated for pain with Acetaminophen 325 mg two tablets in preparation for dressing change. *LL/LPN*
Initials:	**Nurse Signature:**
LL	Lucinda Lawrence, LPN

Josephine Morrow			**Gender:** Female	**Allergies:** Penicillin
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PROVIDER'S ORDERS

Date and time:	Order name and note:	Status:	Timing:	Freq.	Initials:	Due:
Admission Orders 3 days ago	Vital signs weekly and prn	Active	Sched-uled	Weekly	AH	In 4 days
	Activity: Out of bed ad lib; keep legs elevated	Active	Routine		AH	
	Hydrocolloid dressing to right lower leg ulcer; change every 3 days (clean/irrigate with normal saline)	Active	Sched-uled	Every 3 days	AH	
	Diet: Regular with nutritional protein supplement twice daily	Active	Routine		AH	
	Aspirin 81 mg orally	Active	Sched-uled	Daily	AH	0900
	Zinc supplement 1 tablet orally	Active	Sched-uled	Daily	AH	0900
	Multivitamin two tablets orally	Active	Sched-uled	Daily	AH	0900
	Albuterol/ipratropium inhaler two puffs prn for wheezing	Active	prn	prn	AH	prn
	Acetaminophen 325 mg one tab orally prn for pain	Active	prn	Every 6 hrs	AH	prn
	Labs: CBC, BMP, total protein, albumin, and prealbumin	Active	Sched-uled	Weekly	AH	
	Antiembolism stocking (knee-length) on left lower extremity, elastic bandage on right lower extremity	Active	Routine		AH	
	Call orders: HR less than 60/min, greater than 120/min RR less than 10/min, greater than 30/min SpO_2 less than 92% Systolic BP less than 90 mm Hg, greater than 160 mm Hg Diastolic BP less than 50 mm Hg, greater than 95 mm Hg Temperature less than 36 °C (97 °F), greater than 38.5 °C (101.4 °F)	Active			AH	

Initials:	**Provider Signature:**
AH	Alvin Hernandez, MD

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MEDICATION ADMINISTRATION RECORD

Scheduled and Routine Drugs

Medication	Dose	Route	Freq.	Last given
Aspirin	81 mg	Orally	Daily	Yesterday 0900
Zinc supplement	one tablet	Orally	Daily	Yesterday 090
Multivitamin	one tablet	Orally	Daily	Yesterday 0900

PRN

Medication	Dose	Route	Freq.	Last given
Albuterol/ipratropium inhaler	two puffs	Orally	prn for wheezing	0730
Acetaminophen 325 mg	2 tablets	Orally	Every 6 hours prn pain	0730

Continuous infusions

Medication	Dose	Route	Freq.	Last given

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INTAKE & OUTPUT

	Intake					Output				
Time/ date	**Oral**	**Tube feed**	**IV**	**IVPB**	**Other**	**Urine**	**Emisis**	**NG**	**Drains type**	**Other**
23-07										
Shift total:										
07-15										
Shift total:										
15-23										
Shift total:										

This is a worksheet to be used at the bedside to keep track of each intake and output. The totals will then be recorded on the 24 Hour Fluid Balance Sheet

Fluid Measurements

- 1 cc = 1 mL
- 1 ounce = 30 mL
- 8 ounces = 240 mL
- 1 cup = 8 ounces = 240 mL
- 4 cups = 32 ounces = 1 quart or 1 liter = 1000 mL

Sample Measurements

- Coffee cup = 200 mL
- Clear glass = 240 mL
- Milk carton = 240 mL
- Small milk carton = 120 mL
- Juice, gelatin or ice cream cup = 120 mL
- Soup bowl = 160 mL

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VITAL SIGNS

		Date	Adm. 3 days ago							
		Time								
		BP	124/83							
		HR	90							
		RR	21							
		SpO_2	94%							
Temperature	C° 40	F° 104								
	39.5	103								
	39	102								
	38.5	101								
	38	100								
	37.5	99								
	37	98	x							
	36.5	97								
	36	96								
		Nurse Initials								

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LABORATORY

Specimen collected:	Yesterday					
Venous Blood Analysis						
Complete Blood Count:						
Hgb (male 14-17.4 g/dL, female 12-16 g/dL)	12					
HCT (male 42-52%, female 36-48%)	42					
WBC (4.5-10.5 x 10^9)	10.5					
Platelets (150-400*10^9)	235					
Basic Metabolic Panel:						
Na^+ (136-145 mEq/L)	142					
K^+ (3.5-5 mEq/L)	3.9					
Cl^- (100-108 mEq/L)	102					
HCO_3^- (19-25 mEq/L)	24					
BUN (8-20 mg/dL)	16					
Creatinine (male 0.6-1.2 mg/dL, female 0.4-1.0)	1.1					
Glucose (70-110 mg/dL)	85					
Miscellaneous:						
Total Protein (6.0-8.3 g/dL)	5.8*					
Albumin (3.4-5.4 g/dL)	3.2*					
Prealbumin (19-38 mg/dL)	18.1					

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SBAR

Before calling the provider:

1. Assess the patient
2. Have charts and relevant information in front of you

SBAR Report	Patient Information	Notes
Situation	Identify yourself: Patient's name and reason for report: Concerns:	
Background	History includes: Current problems are: Any patient complaints:	
Assessment	Vital signs: Pain level: Lab values: Interventions completed: Give your conclusions:	
Recommendation	What I need from you is: Be specific about a time frame: Suggestions for tests/treatments: Verify orders and when to call back:	

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name: Josephine Morrow		**Evaluator's Name:** Lucinda Lawrence			Today			
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of con-sciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 2 of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4			
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	3			
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3			
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	2			
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV=s for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3			
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almostconstant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		1			
		(19-23 no risk, 15-18 mild risk, 13-14 moderate risk, 10-12 high risk, <10 very high risk)		Total Score:	16			