Examples of Possible Assessment Findings

VS: BP-Temp-Pulse-Resp	*120/60-98.1-60-12*
Mental- Level of Conciousness	*A&O: Non responsive: Responds appropriately for age: New onset Confusion*
Neuro:	*PERRL:+cough/gag/blink: L pupil irregular:no centeral reflexes*
Developmental-Psychosocial	*50 y/o age appropriate: unable to stand. Cheerful lives with wife*
Motor Check: Range of Motion	*complete ROM X4 extremities: non purposeful motion LUE: quad*
Muscular: Sensation-Contractures	*Intact: numbness BLE: toes contracture and bilateral foot drop*
Skin Turgor-Temp-Color	*good turgor, W&D, acyanotic: pale:clammy:peripheral cyanosis*
Integrity or Wounds(check)	*stage II sacral 0.5cmX1.2cm healing with no drainage*
Heart Sounds-Peripheral Pulses	*S1&S2 rgular: palpable BUE and BLE: thready irregular*
Edema-Peripheral-Dependent	*2+ BLE pitting edema: trace dependent edema trunk: none*
Breath Sounds-Respiratory Staus	*Mechanical respirations: spontaneous: even and unlabored: clear A&P*
Character of Resp. Secreations	*Thin white secreations via ETS prn: yellow thick secretions via cough*
Trach: Status-Size-Site	*#6.0 cuffed shiley trach midline with site benign: stoma with clear drainage*
Abd: Distention-Pain-BS	*round, soft, non tender + bowel sounds X 4 quads*
Nutrition	*regular diet ate 75% of breakfast (milk, cereal, banana*
Feeding Tube: Type and Site	*GTUBE #22 french LUQ site benign, 2 mm of granulation tissue inferior surface*
Shift BM Record	*1 large brown formed stool: incontinent*
Urine Color -Clarity-Odor	*#16 french foley cath patent and draining clear yellow urine*
LMP-Discharge	*N/A: Dec. 10-15 regular cycle: no vaginal discharge*
Comfort-Pain	*Denies pain: Level 2 ache in L toe declines PRN meds*
Client Teaching	*Reinforced POT: Re: aseptic ETS-return demonstrated by wife*
	The above shows multiple example of terminology that can be used when documenting your assessment. Please call your RNCC II or the Nursing department at 919-872-7999 for questions.

Documenting Handoff of Patient
(Bottom portion of shift note)

Assumed care of client from: *Billy Bob*

Client left in care of: *Patients Wife*

PRN's Given During Shift? No Yes *(If this is marked yes then the meds should be documented on the PRN sheet of the MARS*

Any standing meds held? No Yes (If Standing meds are held make sure you document why they were held)

All documentation on Assessment, Flowsheet, MSRs, and Report Note? Yes or No, see additional notes.*(If your shift is a regular, normal shift no additional notes are needed as long as the above were done. If you have anything out side of the ordinary care that was done additional documentation is needed.)*

Report Note: *Care was assumed patient was lying in bed in no obvious distress. Patient tolerated all treatments and meds without incident. Patientwas left in care of patients wife sitting in wheelchair watching TV in no distress."OR" Client slept later than usual today, refused bath, denied pain or discomfort, he was quiet today not much conversation.*

Flow Sheet (page 2): This is chart the same as the "old" flow sheet by the hour with empty spots to write in anything that is not listed. Note that your vent checks, settings, and reads are also recorded here.

*****Italic print indicates directions on how area is to be filled out or an actual example.***

***** White Copy gets sent into the office weekly! Yellow copy stays in the home chart .**