High Quality Care Nursing, Inc.

"Bringing High Quality Care to you"

217 Main St. Laurel. MD 20707. Tel: 301-617-9315 Fax: 240-786-5382 Fax: 301-364-9119

NURSES NOTES

Patient Name:	Time In: AM PM	Patient In (If different): AM PM	Time Out: AM PM	Medical Record Number:	Date:

VITAL SIGNS

Time	Temperature ❑ Oral ❑ Axillary ❑ Other	Pulse ❑ Apical ❑ Radial	Respirations	Blood Pressure ❑ Left ❑ Right ❑ Standing ❑ Sitting ❑ Lying	O2 Saturations	Pain Intensity

Pain Assessment:

Wong-Baker FACES Pain Rating Scale©

No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
0	2	4	6	8	10

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Location:__________ Duration: __________
Onset: __________ Current pain regimen: __________
Is pain regimen effective: ❑ Yes ❑ No (If no, describe interventions)
Note pain intensity above with vital signs
Description of pain/comments: __________

NEUROLOGICAL

Seizure: ❑ NA ❑ No ❑ Yes If yes, see seizure log.
❑ Shunt ❑ NA Type __________
Fontanel: ❑ NA ❑ Flat ❑ Soft ❑ Sunken ❑ Bulging
❑ Verbal ❑ Nonverbal
❑ Alert ❑ Lethargic ❑ Sedated ❑ Comatose ❑ Semi-comatose
Oriented: ❑ Time ❑ Place ❑ Person
Appropriate for age: ❑ Yes ❑ No
Tone: ❑ Active ❑ Flaccid ❑ Jittery ❑ Rigid ❑ Tremors
❑ Pupils equal and reactive ❑ Other __________
Comments:__________

CARDIOVASCULAR

Heart Tones: ❑ Regular ❑ Irregular
Color: ❑ Pink ❑ Flushed ❑ Pale ❑ Cyanotic ❑ Other __________
Skin Temp: ❑ Warm ❑ Hot ❑ Cool ❑ Other __________
Edema: ❑ No ❑ Yes Site: __________
❑ Pitting ❑ Non-pitting
Capillary Refill: ❑ Less than 3 seconds ❑ Greater than 3 seconds site: ____ ____
Peripheral Pulses: ❑ Strong ❑ Absent ❑ Other __________
Comments:__________

RESPIRATORY

❑ Regular ❑ Labored ❑ SOB while resting ❑ SOB during exertion ❑ Shallow
❑ Grunting ❑ Tachypneic ❑ Nasal Flaring ❑ Retractions: __________
Sounds: ❑ Clear ❑ Rales ❑ Rhonchi ❑ Diminished ❑ Wheeze
If other than clear, indicate where: __________
Cough: ❑ None ❑ Productive ❑ Non-Productive
Secretions: ❑ NA Amount: ❑ Small ❑ Moderate ❑ Large
Consistency: ❑ Thin ❑ Thick ❑ Tenacious ❑ Frothy
Color: ❑ Clear ❑ White ❑ Yellow ❑ Green ❑ Blood tinged
❑ **Oxygen:** ❑ NA ____L/min via ❑ NC ❑ Mask ❑ Trach ❑ Intermittent ❑ Continual
❑ **Oximeter:** ❑ NA Alarm settings: High __________ Low __________
❑ **Apnea Monitor:** ❑ NA Alarm settings: High __________ Low __________
Tracheostomy: ❑ NA
Type: __________ Size: __________
❑ Uncuffed ❑ Cuffed Date last changed: __________ Date due: __________
Stoma Care: ❑ ½ strength H_2O_2 + H_2O ❑ NS ❑ Warm soapy H_2O ❑ Other __________
Tracheostomy tie changes __________ Inner cannula changes __________ ❑ NA
Site: ❑ Dry ❑ Intact ❑ Redness ❑ Excoriation ❑ Drainage
Intervention: ❑ MD notified ❑ Supervisor notified __________
Ventilator: ❑ NA Hrs. / Day on Ventilator: __________ Type: __________
Physician ordered settings (see Plan of Care): See ventilator flow sheet for current readings
Rate: ______ bpm TV: ______ ml. PEEP: ______ cm.
Pressure control: ______ cm.
Inspiratory time: ______ High Alarm: ______ Low Alarm: ______
Mode: ❑ SIMV ❑ AC ❑ PC ❑ PS ❑ Other __________
❑ Volume mode ❑ Pressure mode
❑ CPAP: ❑ NA Settings __________
❑ BiPAP: ❑ NA Settings __________
Other: __________
Comments:__________

GASTROINTESTINAL

Weight: _____lbs. _____oz. _____kg. Approximate date of weight: __________
Height: _____ft. _____ in. _____ cm.
Approximate date measured __________
Diet: ❑ NPO ❑ Regular ❑ Restricted/Type: __________
Amount:______ Frequency: ______ Route: ______
❑ Feeding tube:
Fluids: ❑ No Restriction ❑ Restriction
Flushes/amount/frequency __________
❑ Feeds self Appetite: ❑ Good ❑ Fair ❑ Poor
Abdomen: ❑ Soft ❑ Flat ❑ Distended ❑ Other
Bowel Sounds: ❑ Present ❑ Hyper ❑ Hypo ❑ Absent ❑ Other__________
Feeding Tube: ❑ NA Date feeding tube last changed __________
❑ Feeding bag changed
❑ NG: size______ FR ❑ J Tube: size______ FR
❑ G Tube: size______ FR ❑ Mickey Button: size______ FR
❑ Other __________
Tube Site Care: ❑ ½ strength H_2O_2+H_2O ❑ NS ❑ Warm Soapy H_2O
GT Site: ❑ Dry ❑ No S/S of Infection ❑ Redness ❑ Drainage
Stools: Last BM: __________ appearance: __________
❑ **Ostomy** ❑ NA (Type, size, appearance): __________
Comments:__________

EARS/ NOSE/ THROAT/ MOUTH/ HEAD

Face: ❑ Symmetrical ❑ Asymmetrical
Ears: ❑ Unremarkable ❑ Drainage ______ ❑ Hearing loss
Eyes: ❑ Sclera white ❑ Other __________
Nose: ❑ Patent ❑ Congested ❑ Discharge ❑ Bleeding
Mouth: ❑ Unremarkable ❑ Sores
❑ Teeth intact ❑ Dentures ❑ Gum problems
Pharyngeal: ❑ Unremarkable ❑ Hoarseness ❑ Sore throat
Comments: __________

GENITO-URINARY/REPRODUCTIVE

Urine Color: ❑ Clear ❑ Yellow ❑ Cloudy ❑ Discharge ❑ Hematuria
❑ Frequency______ ❑ Urgency ❑ Burning
❑ Diaper ❑ Foley cath (last date changed) ______
Catheter size______ (last date changed) ______
❑ Suprapubic (last date changed) ______ ❑ Intermittent catherization
Catheter size______
❑ Continent ❑ Incontinent Last void: ______
Comments: __________

ENDOCRINE ❑ WNL

Blood sugar: ❑ NA ❑ Last reading (date/time) __________
Glucometer: ❑ Self ❑ PCG Calibrate weekly: ❑ Yes ❑ No
Injection sites: ❑ WNL ❑ Reddened ❑ Swelling ❑ Drainage
❑ Patient and/or family/caregiver independent in diabetes management
Comments: __________

MUSCULOSKELETAL

ROM: ❑ Full ❑ Limited ROM ______ ❑ Contractures ______
Muscles: ❑ Normal ❑ Rigidity ❑ Hypotonic ❑ Hypertonic ❑ Weakness
Ambulation: ❑ Independent ❑ With assist ______ ❑ Immobile
❑ Reposition q2 hours ❑ Passive Range of Motion ❑ Active Range of Motion
Assistive equipment (include frequency of use):
❑ Braces ______ ❑ Cane______
❑ Prosthesis ______ ❑ Walker ______
❑ Splints ______ ❑ Wheelchair ______
❑ Crutches ______ ❑ Hoyer Lift______
❑ Other ______ ❑ Specialty Bed ______
❑ Trapeze ______
Comments: __________

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Patient Name: | **Medical Record Number:** | **Date:**

INTEGUMENTARY STATUS

Skin Turgor: ❑ Good ❑ Fair ❑ Poor
Skin Color: ❑ Pink/WNL ❑ Pale ❑ Jaundice ❑ Cyanotic
Skin: ❑ Dry ❑ Diaphoretic ❑ Warm ❑ Cool
❑ Wounds ❑ Incisions ❑ Rashes

Wound site ____________________

Wound: ❑ NA

❑ See wound flow sheet (use for more than one wound)
Size (L x W x D) ___________cm ❑ U- Undermining ❑ T- Tunneling
Stage: I II III IV ❑ Unable to stage ❑ Resolving ❑ Deteriorating

Wound Bed
Color: ❑ Red ❑ Pink ❑ White ❑ Gray ❑ Black ❑ Tan ❑ Other ________
Tissue: ❑ Pale ❑ Sloughing ❑ Necrotic ❑ Eschar ❑ Granular ❑ Weeping
❑ Healthy ❑ Other________________
Drainage: ❑ Bloody ❑ Serosanguineous ❑ Serous ❑ Purulent ❑ Other ________
Amount: ❑ None ❑ Scant ❑ Moderate ❑ Purulent ❑ Other________
Odor: ❑ Foul ❑ Sweet ❑ None ❑ Other ________
Surrounding skin: ❑ Pink ❑ White ❑ Red ❑ Pale ❑ Warm ❑ Cool
❑ Blanched ❑ Shiny ❑ Edematous ❑ Other ________
Comments ____________________

INTRAVENOUS

Access: ❑ NA
Location: ____________ ❑ Peripheral: ____________
Size: ____________ Date inserted: ____________
❑ CVL: Size/ Type ____________
❑ PICC: Date inserted ________ Size ____ FR
Arm circumference ______ cm Length of exposed tubing ______ cm
❑ Port: ❑ Not accessed Accessed date: ____________
❑ Other: ____________
Site condition: ❑ Intact ❑ Without redness or swelling ❑ Other ________
Date dressing last changed ________ Date bag changed ________
Date tubing changed________ Date cap changed ________
Infusion Device: ____________
❑ Labs ❑ NA Type:____________
Site used: ____________ Attempts: ______
Comments: ____________

PHYSICIAN NOTIFIED

❑ NA ❑ Yes Time: ____________
Spoke to: ____________
Orders received: ❑ Yes ❑ No
❑ Supplemental order written and forwarded to supervisor
❑ Supervisor notified (supervisor must be notified for all changes)

EDUCATION

Taught to:____________
Topic(s): ____________
❑ Medications: ____________
❑ Action ❑ Side effects ❑ Contraindications and interactions
Level of understanding: ❑ Good ❑ Fair ❑ Poor ❑ Needs reinforcement
Evaluation method: ❑ Verbal ❑ Return demo
Need for further teaching: ❑ Yes ❑ No
Patient and/or family/caregiver lacks knowledge of:
❑ Equipment ❑ Therapies ❑ Diet ❑ Disease process
❑ Reviewed procedure to follow for medication / treatment adverse reaction: Discontinue and notify MD.

❑ Goals addressed per Plan of Care ❑ Discharge planning reviewed ❑ NA Comments: ____________

Intake (include measurement as applicable)						Output (include measurement as applicable)					Other
Time	Oral	Tube feed type ____	Flush type ____	IV	Other	Time	Urine	Stool	Emesis	Other	
Total						Total					Total

Nursing documentation: ____________________

Did the clinician accompany the patient to a medical appointment? ❑ Yes ❑ No
If yes, please document start and end time care transferred to another nurse or MD. __ __:__ __ to __ __:__ __
Patient left in care of: ____________________

____________________ RN/LPN/LVN ____________________
Nurse's Name & Title **Nurse's Signature**

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CLIENT'S NAME ________________ NURSE'S NAME ________________

Date And Time	

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