

**24 HOUR FLUID RESTRICTION AMOUNT**

**CC**

**DATE**

	P.O.	TUBE FEED- INGS	IV FLUIDS						URINE	STOOL	EMESIS			
0700														
0800														
0800														
0900														
0900														
1000														
1000														
1100														
1100														
1200														
1200														
1300														
1300														
1400														
1400														
1500														
subtotal	<b>8 HOUR TOTAL INTAKE</b>							<b>8 HOUR TOTAL OUTPUT</b>						
1500														
1600														
1600														
1700														
1700														
1800														
1800														
1900														
subtotal	<b>12 HOUR TOTAL INTAKE</b>							<b>12 HOUR TOTAL OUTPUT</b>						
1900														
2000														
2000														
2100														
2100														
2200														
2200														
2300														
subtotal	<b>8 HOUR TOTAL INTAKE</b>							<b>8 HOUR TOTAL OUTPUT</b>						
2300														
2400														
2400														
0100														
0100														
0200														
0200														
0300														
0300														
0400														
0400														
0500														
0500														
0600														
0600														
0700														
subtotal	<b>8/12 HOUR TOTAL INTAKE</b>							<b>8/12 HOUR TOTAL OUTPUT</b>						
subtotal	<b>24 HOUR TOTAL INTAKE</b>							<b>24 HOUR TOTAL OUTPUT</b>						
Print Name	Title	Initials	Print Name	Title	Initials	Print Name	Title	Initials	Print Name	Title	Initials	Print Name	Title	Initials

ADDRESSOGRAPH



**North Broward  
Hospital District**

**24 HOUR NURSING ASSESSMENT REASSESSMENT**

**Invasive Lines and Sites:**  
**Sites Gauge**

**Insertion Date/Initials**

**Comments/Condition:**

1			Date:
2			Date:
3			Date:
4			Date:

**IV SITE CONDITION KEY:**

B = Blood Return C = 4 day site change D = Discontinued E = Edematous I = Infiltrated N = No redness or edema O = Occluded P = Painful R = Reddened

**ASSESSMENT PARAMETERS:** The following parameters will be considered a negative assessment. If the physical assessment is within normal limits, place a "✓" in the box and no further documentation is required. If there are abnormal findings, place an "X" in the box, and document the findings and time on the lines to the right. Transfer to problem list and initiate plan of care on interdisciplinary plan of care.

**PHYSICAL ASSESSMENT**

"Neurological Assessment" Awake, alert, oriented to person, place & time. Behavior appropriate to situation. Pupils equal & reactive to light. Active ROM to all extremities with symmetry of strength. No paresthesia. Verbalization clear and understandable. Swallowing without coughing or choking on liquids and solids.

"Cardiac Assessment" Heart rhythm regular; S<sub>1</sub>, S<sub>2</sub> present, peripheral pulses present bilaterally; if on cardiac monitor normal sinus rhythm.

"Respiratory Assessment" Respirations 10-20/min. at rest. Respirations quiet and regular. Breath sounds vesicular through both lung fields, bronchial over major airways, with no adventitious sounds. Sputum clear, nailbeds & mucous membranes pink.

"Gastrointestinal Assessment" Abdomen soft. Bowel sounds active (5-34/min.). No pain with palpation. Tolerates prescribed diet without nausea & vomiting. Having brown colored BM's with normal pattern & consistency.  
 Date of last BM \_\_\_\_\_

"Genitourinary Assessment" Able to empty bladder without dysuria. Bladder not distended after voiding. Urine clear & yellow to amber.  
 Date of foley insertion \_\_\_\_\_  
 Initial Amount of urine drained \_\_\_\_\_

**"Integumentary Assessment"** Skin and nail color within patient's norm. Skin warm, dry, & intact. Mucous membranes moist. Absence of skin tears, bruising, hematomas, wounds, pressure ulcers, rashes, or other dermatologic lesions.

NOTE: Document wounds on the Acute/Chronic "Wound Assessment" form.

**"Surgical Dressing and/or Incision Assessment"**

Dressing is dry and intact. Incision is well approximated without redness, inflammation or drainage.

Note: Leave blank if patient does not have a dressing or incision

**"Musculoskeletal Assessment"** Absence of joint swelling and tenderness. Normal ROM of all joints. No muscle weakness. Surrounding tissues show no evidence of inflammation.

No restricted mobility.

**"Peripheral Vascular Assessment"** Extremities are pink, warm. Capillary refill brisk. Peripheral pulses palpable. No edema. Sensation intact without numbness or paresthesia. No calf tenderness.

**"Psychosocial Assessment"** Basic emotional support in place. Patient calm, cooperative & motivated to plan of care. Seems to understand & accept treatment.

**"Pain Assessment"** Verbalizes absence of pain, i.e. pain scale is 0, nonverbal patients exhibit no signs or symptoms of pain. i.e.: facial grimaces, tenderness, guarding, moaning.

NOTE: If pain present, write as a problem on the I.P.O.C., including a goal for pain level.

Document the pain level on the M.A.R. after each medication administration.

Time:	Time:	Time:	Time:	Time:	Time:
Location:	Location:	Location:	Location:	Location:	Location:
Quality:	Quality:	Quality:	Quality:	Quality:	Quality:
Level:	Level:	Level:	Level:	Level:	Level:
Radiation:	Radiation:	Radiation:	Radiation:	Radiation:	Radiation:

0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600

Affix initials, corresponding time assessment done. Circle time if there is deviation from previous findings. Write time & abnormal physical assessment findings on the lines to the right.

## FALL RISK ASSESSMENT

<b>Criteria:</b>	Days 7a	Eves	Nights 7p
History of falls (within past 3 months)	15	15	15
Confusion or Decreased Level of Consciousness	5	5	5
Impaired Judgement/Increased Anxiety	5	5	5
Unable to ambulate independently/unsteady gait	15	15	15
Altered elimination (such as incontinence, urgency)	5	5	5
Cardiovascular/Respiratory disease affecting perfusion and oxygenation	5	5	5
Medications affecting BP or level of consciousness	5	5	5
Syncope/dizziness	5	5	5
Equipment (i.e. IV pole, oxygen, Foley, NG tube, chest tube)	5	5	5
<b>FALL RISK SCORE</b>	<b>TOTAL</b>		
<b>Implement Fall Prevention Protocol for a score of 15 or greater</b>			

**For all patients the following shall be implemented:**

- Telephone and call bell within reach
- Bed in low and locked position
- Instruct patient to call for assistance when they need to get out of bed
- Use of non-skid footwear when ambulating
- Eliminate any environmental hazards (spills and clutter)

**Interventions Implemented for patients identified as being at risk for falls:**

- Fall Prevention Protocol
- ★ Document problem on IPOC with interventions and patient education on IPER
- ★ Toileting every 2 hours
- ★ Fall Risk identifier outside door
- ★ Consider bed alarms
- ★ Move patient nearer to nursing station when possible and keep door open
- ★ Use assistive devices when indicated
- ★ Discharge planning (patient education: making their home safe)

**ADDITIONAL ASSESSMENT NOTES:**

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## Braden Scale -Pressure Ulcer Risk Assessment

Risk Factor	Score/Description				Score
<b>Sensory Perception</b> Ability to respond meaningfully to pressure-related discomfort	<b>1. Completely Limited</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, or limited ability to feel pain over most of body surface.	<b>2. Very Limited</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, or has sensory impairment which limits the ability to feel pain over 1/2 of body.	<b>3. Slightly Limited</b> Responds to verbal commands but cannot always communicate discomfort or need to be turned, or has some sensory impairment which limits the ability to feel pain or discomfort in 1 or 2 extremities.	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit the ability to feel or voice pain or discomfort.	
<b>Moisture</b> Degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected each time the patient is moved or turned.	<b>2. Often Moist</b> Skin is often but not always moist. Linen must be changed at least once a shift.	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day.	<b>4. Rarely Moist</b> Skin is usually dry; linen only requires changing at routine intervals.	
<b>Activity</b> Degree of physical activity	<b>1. Bedfast</b> Confined to bed.	<b>2. Chair fast</b> Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or	<b>3. Walks Occasionally</b> Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. Walks Frequently</b> Walks outside the room at least twice a day and inside the room at least once every 2 hours during waking hours.	
<b>Mobility</b> Ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position.	<b>3. Slightly Limited</b> Makes frequent slight changes in body or extremity position independently.	<b>4. No Limitations</b> Makes major and frequent changes in position without assistance.	
<b>Nutrition</b> Usual food intake pattern <sup>1</sup> NPO: Nothing by mouth <sup>2</sup> IV: Intravenously <sup>3</sup> TPN: Total Parenteral	<b>1. Very Poor</b> Never eats a complete meal. Rarely eats more than 1/3 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 <sup>1</sup> and/or maintained on clear liquids or IV <sup>2</sup> for more than 5 days.	<b>2. Probably Inadequate</b> Rarely eats a complete meal and generally eats only about 1/2 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 optimal amount of liquid diet or tube feeding.	<b>3. Adequate</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered, OR is on tube feeding or TPN <sup>3</sup> regimen which probably meets most of nutritional needs.	<b>4. Excellent</b> 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.	
<b>Friction and Shear</b>	<b>1. Problem</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed and chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	<b>2. Potential Problem</b> 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.	<b>3. No Apparent Problem</b> 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 at all times.		
<b>Very High Risk: 9 or below      High Risk: 10 to 12      Moderate Risk: 13 to 14      At Risk: 15 to 18</b> If other major risk factors are present (e.g., > 75 years of age, fever, poor dietary intake of protein, diastolic B/P < 60 and/or hemodynamic instability, history of pressure ulcers or diabetes, spinal cord injury, etc) advance to next level of risk					<b>TOTAL SCORE:</b>

### Nursing Interventions for the Prevention of Skin Breakdown

Assess skin integrity with special attention to bony prominences. If any skin breakdown noted complete The Acute/Chronic Wound Assessment Form.

Risk Factor	
Sensory Perception, Activity and/or Mobility	<input type="checkbox"/> Any Scores $\leq$ 3 Interventions implemented and check as per specific patient needs: <input type="checkbox"/> Turned and Repositioned patient while in bed every 2 hours with (Check One): <input type="checkbox"/> Foam Wedges <input type="checkbox"/> Pillows <input type="checkbox"/> Chair/wheelchair bound (Check One): <input type="checkbox"/> Needs assistance reposition in chair at least every hour   Independent: Teach to shift weight every 15 minutes <input type="checkbox"/> Pressure Reduction devices: <input type="checkbox"/> Chair cushion <input type="checkbox"/> Elbow pads <input type="checkbox"/> Other: _____ <input type="checkbox"/> Heel Boots <input type="checkbox"/> Heels elevated with Pillows <input type="checkbox"/> Other: _____ <input type="checkbox"/> Specialty Mattress/Overlay/Bed: (Specify Type): _____ <input type="checkbox"/> Inspect and protect skin under (Check): <input type="checkbox"/> tubes <input type="checkbox"/> catheters <input type="checkbox"/> nasal cannulas <input type="checkbox"/> splints <input type="checkbox"/> braces <input type="checkbox"/> SCD/anti-embolics
Moisture	<input type="checkbox"/> Score $\leq$ 3 interventions implemented and check as per specific patient needs: <input type="checkbox"/> Cleansed skin with: <input type="checkbox"/> Bathing/incontinence cloth <input type="checkbox"/> No Rinse Cleanser <input type="checkbox"/> Skin Protection: <input type="checkbox"/> Protective Ointment for intact skin <input type="checkbox"/> Protective Cream for denuded skin <input type="checkbox"/> Urine/Fecal Containment: <input type="checkbox"/> Condom Catheter <input type="checkbox"/> Fecal Collector <input type="checkbox"/> Underpads <input type="checkbox"/> Diapers <input type="checkbox"/> Other: _____
Nutrition	<input type="checkbox"/> Score $\leq$ 2 <input type="checkbox"/> Nutritional Consult (Date): _____ <input type="checkbox"/> Reconsult (Date): _____
Friction and Shear:	<input type="checkbox"/> Score $\leq$ 2 <input type="checkbox"/> Lifting devices: <input type="checkbox"/> Lift Sheet <input type="checkbox"/> Trapeze <input type="checkbox"/> Head elevated 30 degrees or less (if not contraindicated) <input type="checkbox"/> Skin Protection: <input type="checkbox"/> Moisturizers <input type="checkbox"/> Transparent Film <input type="checkbox"/> Skin Prep <input type="checkbox"/> Hydrocolloid <input type="checkbox"/> Other: _____

Instructions:

### PATIENT CARE ACTIVITIES

Enter a " " or use code under corresponding time.		7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6
PERSONAL/DIET	Diet Type: _____																								
	% Taken F=Feed A=Assist																								
	Mouth Care																								
	Skin Care																								
	Peri/Foley Care																								
	Toileting																								
	Hygiene: A=Assist C=Complete																								
	Equipment Devices:																								
	Anti-embolitic Stockings																								
	Sequential Compression Device																								
	Infusion Pump																								
	ACTIVITY	Turn or Position c Assistance																							
Bedrest/BRPc Assistance																									
Ambulates Independently/Assistance																									
A=AROM/P=PROM																									
OOB Chair/Repositioned in chair																									
SAFETY	Seizure Precautions																								
	Least Restrictive Safety Interventions																								
	Checked ID/Allergy Bands																								
	Skin Care/Wound Care Protocol																								
	Bed Alarm																								
NURSING CARE ACTIVITIES	Cough and Deep Breath																								
	Incentive Spirometry																								
	Suctioned-Oral-Nasal-Trach-ETT																								
	Trach Care: Size _____																								
	Cardiac Rhythm																								
	Pulse ox/O2 device																								
	Traction:																								
	Pin Care:																								
	Ostomy Care																								
	NG Type:																								
	NG tube Placement Confirmed																								
	NG tube Irrigated																								
	G-Tube Care:																								
	Gastric Residual Amounts																								