hospital SOLDIERS' MEMORIAL ORILLIA

Patient Identification

DOWNTIME NURSING ASSESSMENT AND DOCUMENTATION

Point of Care Glucose Monitoring

Date						
Time						
CBG						
Initial						

Recommended Targets for Glycemic Control:

FPG / Preprandial PG (mmol/L): 4.0-7.0

2-hour Postprandial PG (mmol/L): 5.0-10.0

VITAL SIGNS							
Date/ Time	Blood Pressure	Pulse	Resp Rate	Temp	Oxygen Saturation	Pain Score	Initials

Vital Signs Standard of Care

Admission
Within one hour of admission, then q12h and PRN
Or as ordered by Practitioner

Post-operative patients
q30mins x2; q1h x2; q4h x24h, then q shift + PRN
Or as ordered by Practitioner

ALC patients
Daily
Or as ordered by Practitioner

Palliative patients
As ordered by Practitioner

Date Time Discipline	**Focus**	**Progress Notes / Signature**

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Patient Identification

Adult In-Patient Assessment

Instructions: Document assessment using tick boxes provided. Use * for any change in status and then document in Progress Notes.
Complete Master Signature Sheet. Complete Assessments and ADL section throughout your shift as appropriate.

ASSESSMENT DATE _____ **Time of Assessment** _____	**initials**	**Isolation** ☐ **Type**_____ **Weight**_____**kg** **Height**_____**cm**	**initials**
Neurological: Alert ☐ Oriented person ☐ place ☐ time ☐ Sedated ☐ Drowsy but rousable ☐ Reorients easily ☐ Resists care ☐ Physically ☐ Verbally ☐ Exit seeking ☐ Wandering bracelet on ☐		**Musculoskeletal:** Sensation: Full ☐ Tingling ☐ Numbness ☐ Absent ☐ Movement: Full ☐ Decreased ☐ Absent ☐ Strength: Good ☐ Weakness *note limb ☐_____ Non weight bearing ☐	
Additional Comments		Additional Comments	
Respiratory: Lungs clear & air entry equal bilaterally ☐ Wheezes: RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL ☐ Crackles: RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL ☐ Decrease Air Entry to Base: Left ☐ Right ☐ Shortness of breath ☐ Short of breath on exertion ☐ Incentive Spirometer ☐ Oxygen Saturation _____ Oxygen flow rate and Delivery system O2___ L via _____ Deep breath & cough encouraged ☐ Trach ☐ Suction ☐ Chest tube: Right ☐ Left ☐ Bi-Pap ☐ C-Pap ☐ Optiflow ☐		**Integumentary:** Braden Scale assessment ☐ Risk Score_____ Skin assessment ☐ Skin intact ☐ Skin Breakdown ☐ Location _____ Prevention Protocol implemented ☐ Surface_____ Prevalon boots ☐ Prevent Drsg to Sacrum ☐ Non-surgical Drg dry and intact ☐ Note site_____ Pressure Ulcer Dressing document on Wound Care Tool Surgical Dressing dry and intact ☐ Note site _____ Staples ☐ Sutures ☐ Incision well approximated ☐ Bruising ☐ Redness ☐ Drain ☐ type_____ Document on fluid balance record	
Additional Comments		Additional Comments	
Cardiovascular: Telemetry ☐ Skin warm and dry ☐ Colour: Normal for ethnicity ☐ Flushed ☐ Pale ☐ Jaundiced ☐ Pitting edema ☐ Edema non-pitting ☐ Pedal pulses present: Left ☐ Right ☐ Teds ☐ Neurovascular extremities: Capillary refill less than 3 secs ☐ Colour Normal ☐ Sensation Normal ☐ Movement Normal ☐		**Fall Prevention Strategies** : Falls Risk Assessment ☐ Universal Precautions ☐ Post Fall Reassessment ☐ Mod ☐ or High ☐ Risk Strategies Implemented 5 P Rounding	
		Specimen Collection: Obtained ☐ Type_____	
		Pain: Subcut Infusion pump ☐ Patient controlled analgesia ☐ Location _____ Pain Scale: _____/10 Document response to analgesia in progress notes	
Additional Comments		Additional Comments	
Gastrointestinal: Abd Soft ☐ Distended ☐ Semi-firm ☐ Bowel sounds present: LUQ ☐ RUQ ☐ LLQ ☐ RLQ ☐ Flatus ☐ Nausea ☐ Emesis ☐ Incontinence ☐ BM: ☐ Document on Stool Chart using Bristol # Classification Nasal gastric tube ☐ Nasal Gastric Replacement □ Ostomy ☐ See and document on fluid balance record		**Activities of Daily Living:** **Activity:** Bed rest ☐ Bathroom privileges only ☐ Ambulates independently ☐ Ambulates Assist x1 ☐ Assist x 2 ☐ Up in chair ☐ Transfer: Assist x1 ☐ Assist x 2 ☐ Transfer device required: Lift ☐ Slider board ☐ Slider sheets ☐ Sara steady ☐ Sit to Stand ☐ Reposition in Bed: Self ☐ Assist x 1 ☐ Assist x 2 ☐ Reposition Every Two hours ☐ Daytime sleep greater than 60 minutes ☐ Non Interrupted Nighttime Sleep ☐ Interrupted night sleep ☐	
Additional Comments		Additional Comments	
Urinary/GU: Urine Clear ☐ Yellow ☐ Concentrated ☐ Hematuria ☐ Other _____ Continent ☐ Incontinent ☐ Attends ☐ Peri pad ☐ Commode ☐ Bedpan ☐ Foley catheter ☐ Urinal ☐ Vag Packing X_____ ☐ Continuous bladder irrigation ☐ Strain urine ☐ Peritoneal Dialysis ☐		**Diet/Nutrition:** Nil per OS (NPO) ☐ Ice chips ☐ Clear Fluids ☐ Full Fluids ☐ Diet as Tolerated ☐ Diabetic Diet ☐ Other *note type ☐ _____ Tube feeds (document type and rate/hr)_____ Self ☐ Assist ☐ Total ☐ Amount Taken: Snacks ☐ HS Snack ☐ Breakfast 0 ☐ ¼ ☐ ½ ☐ ¾ ☐ ALL ☐ Lunch 0 ☐ ¼ ☐ ½ ☐ ¾ ☐ ALL ☐ Supper 0 ☐ ¼ ☐ ½ ☐ ¾ ☐ ALL ☐	
Additional Comments			
Parenteral: Peripheral I.V. site infusing ☐ document on fld balance record PRN adapter care as per protocol ☐ Hypodermoclysis ☐ Central venous access device ☐ Dialysis line ☐ TPN ☐		**Hygiene:** Bed bath ☐ Partial bath ☐ Shower ☐ Self care ☐ HS care ☐ Mouth care ☐	
		Mobility Devices: Wheelchair ☐ Walker ☐ Cane ☐ Crutches ☐	
		Mobility Level _____ **Assist x** _____ **Activity Performed -** _____ **x** _____ - _____ _____ **x** _____ - _____ **x** _____	
Additional Comments			

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