ACES
ADVANCING CARE EXCELLENCE FOR SENIORS

Patient Name: Millie Larsen
Room: 616
DOB: 01/23/1926
Age: 84

MRN: 000-555-000
Doctor Name: Dr. Eric Lund
Date Admitted:

PATIENT CHART

Chart for Millie Larsen

Physician's Orders

Allergies: NKA

Date/Time:	
Day 1, 0900	Bedrest, BRP with assist
	Regular, low fat diet
	I & 0
	captopril 25 mg po three times a day
	metoprolol 100 mg every day
	furosemide 40 mg po twice per day
	Lipitor 50 mg once daily
	pilocarpine eye drops 2 drops each eye 4 times a day
	Fosamax 10 mg every day
	Celebrex 200 mg po once a day
	tramodol for arthritis pain prn
	Ciprofloxacin 250 mg every 12 hours
	Acetaminophen 325 mg po prn
	IV fluids D5 .45 NaCl 20 mEq KCL at 60ml/hr
	Dr. Eric Lund

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Nursing Notes

Date/Time:	
0200	Pt incontinent of urine. Skin intact, no redness noted. Thorough peri-care done. Re-oriented to call light. Will continue to check q 2 hours. T. Milano RN, BSN
0900	Pt is slightly confused. Alert and oriented to self and time, unable to verbalize place or event. Dr. Lund made aware. Re-oriented pt. Will continue to monitor. Liz Townsend, RN

Medication Administration Record

Allergies: NKDA

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
Day 2	Captopril	25 mg	po	three times a day	~~0800,~~ T.M. ~~1200~~ T.M.~~,~~ ~~1600~~ T.M.	Day 2
	Metoprolol	100 mg		every day	~~0800~~ JL	Day 2
	Furosemide	40 mg	po	twice per day	~~0800~~ T.M.1 ~~600~~ T.M.	Day 2
	Lipitor	50 mg		once daily	~~0800~~ T.M.	Day 2
	Pilocarpine eye drops	2 drops each eye		four times a day	~~0800,~~ T.M.~~1200~~ T.M.,~~1600~~ T.M.,~~2000~~ L.T.	Day 2
	Fosamax	10 mg		every day	~~0800~~ T.M.	Day 2
	Tramodol	50 mg	Po	for arthritis pain/prn	~~1600~~ T.M.	Day 2
	Ciprofloxacin	250 mg		every 12 hours	~~0800~~ T.M.,~~ 2000~~ L.T.	Day 2
	Acetaminophen	325 mg	po	prn	~~1400~~ T.M.	Day 2
	Celebrex	200 mg	po	once a day	~~0800~~ T.M.	Day 2

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Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
Day 2	IV fluids D5 .45 NaCl 20 mEq KCL	60ml/hr	Day 2, ~~1400~~ T.M.

Intramuscular legend:	Subcutaneous site code:
A=RUOQ ventrogluteal	1=RUQ abdomen
B=LUOQ ventrogluteal	2=LUQ abdomen
C=R Deltoid	3=RLQ abdomen
D=L Deltoid	4=LLQ abdomen
E=R Thigh Lateral	5=RU arm
F=L Thigh Lateral	6=LU arm
	7=R leg
	8=L leg

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
T.M.	Tracy Milano RN, BSN	L.T.	Liz Townsend

Vital Signs Record

Date:	Day 2	Day 2	Day 2	Day 2	Day 2	Day 2
Time:	0800	1200	1600	2000	0000	0400
Temperature:	37.3	37.2	37.2	37.3	37.2	37.1
BP:	148/82	134/76	142/86	146/90	138/80	136/78
Pulse:	78	80	80	76	78	72
O^2 Saturation:	96	94	96	96	96	94
Weight:						
Respirations:	14	12	16	14	14	14
GMR:						
Nurse Initials:	T.M.	T.M.	T.M.	L.T.	L.T.	L.T.

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Intake & Output Bedside Worksheet

0900-2100 **INTAKE** **OUTPUT**

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240 480 240 240		720			500 750 650 250				
Total Intake this shift: 1920					Total Output this shift: 2150				

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2100-0900 **INTAKE** **OUTPUT**

ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240		720			200 400 400				
Total Intake this shift: 960					Total Output this shift: 1000				

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

Fluid Measurements:	Sample Measurements:
1 ml = 1 cc	Coffee cup = 200 cc
1 ounce = 30 cc	Clear glass = 240 cc
8 ounces = 240 cc	Milk carton = 240 cc
1 cup = 8 ounces = 240 cc	Small milk carton = 120 cc
4 cups = 32 ounces = 1 quart or liter= 1000 cc	Juice, gelatin or ice cream cup = 120 cc
	Soup bowl = 160 cc
	Popsicle half = 40 cc

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Nursing Assessment Flowsheet

GENERAL APPEARANCE:
☐ male ☒ female

☒ awake
☐ cheerful
☐ crying
☐ fearful
☐ sleeping
☐ lethargic
☒ calm
☐ agitated
☐ anxious
☐ combative

SKIN: ☐ see wound care sheet ☐ see nursing notes

BRADEN SCALE SCORE: ☐ risk skin breakdown

COLOR:
☒ acyanotic
☐ pale
☐ ruddy
☐ jaundiced
☐ cyanotic

TURGOR:
☒ <3 sec
☐ > 3 sec

TEMP:
☒ warm/dry
☐ hot
☐ cool
☐ cold/clammy
☐ diaphoretic

HAIR:
☒ shiny
☐ dry/flaking
☐ balding
☐ lesions
☐ lice

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE: 14
O_2: RA
SPO_2:94%

☒ regular
☒ even
☐ irregular
☐ labored
☐ uses accessory muscles
☐ cough

BREATH SOUNDS:

LEFT:
☒ clear
☐ crackles
☐ wheezes
☐ decreased
☐ absent

RIGHT:
☒ clear
☐ crackles
☐ wheezes
☐ decreased
☐ absent

THORAX:
☒ even expansion
☐ uneven expansion

SMOKING:
☐ cigarettes pk/day __________
☐ cigars
☐ marijuana
☐ cocaine

NEUROLOGICAL: ☐ see nursing notes

ORIENTATION:
☒ person
☐ place
☐ time
☒ disoriented
☒ confused
☐ impaired memory

RESPONDS TO:
☒ name
☐ non-responsive

GASTROINTESTINAL/NUTRITION: ☐ see nursing notes

APPEARANCE:
☐ flat
☒ round
☐ obese
☒ soft
☐ gravid

BOWEL SOUNDS:
☒ active
☐ hyperactive

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☐ stimuli

SPEECH:
☒ clear
☐ garbled
☐ slurred
☐ aphasic
☐ inappropriate
☐ cannot follow conversation

FACE:
☒ symmetrical
☐ drooping
☐ drooling

EYES:
☒ PERRLA
☐ unequal
☐ drooping lid

SIGHT:
☐ no correction
☒ glasses
☐ contacts
☐ blind

HEARING:
☐ WNL
☒ HOH
☒ hearing aid

HX:
☐ seizures
☐ CVA
☐ brain injury
☐ spinal injury
☐ other

☐ hypoactive
☐ absent

PALPATION:
☒ non-tender
☐ tender (location)_____
☐ mass (location) ______

LAST BM yesterday

☐ incontinent
☐ stoma- ______
☐ constipation
☐ diarrhea
☐ mucous
☐ blood

DIET: normal

☐ impaired swallowing
☐ choking
☐ NG tube
color drainage:___________
☐ feeding tube
☐ tube feeding
type: ___________ rate:_______

MUSCULOSKELETAL: ☐ see nursing notes

GAIT:
☐ steady ☒ unsteady ☐ non-ambulatory

ACTIVITY:
☐ up ad lib
☐ walker
☐ cane
☐ crutches
☐ wheelchair

ASSIST:
☒ x1
☐ x2
☐ lift
☐ bed bound

HAND GRIPS:
AMPUTATION: ☐ left ☐ right
LOCATION:__________

LEFT:
☐ strong
☒ weak
☐ flaccid

RIGHT:
☐ strong
☒ weak
☐ flaccid

GENITOURINARY: ☐ see nursing notes

☒ voids ☐ catheter ☐ stoma

APPEARANCE OF URINE:
☐ clear
☐ light yellow
☒ amber
☐ brown
☒ cloudy
☐ sediment
☐ red/wine
☐ clots

BLADDER:
☒ soft ☐ firm/distended ☒ incontinent

FEMALES: LMP: " in the 70's sometime"

☒ WNL ☐ dysmenorrheal

BIRTH CONTROL:

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☐ contractures
☐ contractures

ROM:

ARMS:
☒ full
☐ weak
☐ flaccid
☐ contractures

LEGS:
☒ full
☐ weak
☐ flaccid
☐ contractures
☐ TED hose

AMPUTATION:
☐ right
☐ left
☐ BKA
☐ AKA
☐ other

SPINE:
☐ kyphosis
☐ scoliosis
☐ osteoporosis

OTHER:
☐ CAST LOCATION:__________
☐ TRACTION:____________

☐ yes
☐ no
☐ BSE monthly
☐ menopause
☐ taking estrogen

SEXUALITY:
☐ sexually active
☐ safe sex

MED HX:
☐ urinary retention
☐ BPH
☐ Frequent UTI

CARDIOVASCULAR: ☐ see nursing notes

HEART SOUNDS:
☒ normal S_1-S_2
☐ abnormal S_3-S_4
☐ murmur

PULSE:

APICAL:
☒ regular
☐ irregular
☐ strong
☐ faint

RADIAL:
☒ regular
☐ irregular
☐ strong
☐ faint
☐ nonpalpable

PEDALIS:
☒ regular
☐ irregular
☐ strong
☐ faint
☐ nonpalpable

EXTREMITY COLOR & TEMP:
☒ warm
☐ cool
☐ cold
☒ acyanotic
☐ cyanotic
☐ discolor

EDEMA:
☒ none
☐ generalized (anasarca)

SITE #1:__________
SITE #2: __________

PAIN ASSESSMENT: ☐ see nursing notes
☐ see MAR

PRECIPITATING: walking, general movement

QUALITY:_ dull, aching

REGION: bilateral knees

SEVERITY (0-10/10): 3

NOW: 3
AT WORST: 6
AT BEST: 1

TIMING:___________________________________

SAFETY: ☐ see nursing notes
☐ fall risk

PRECAUTIONS:
☒ side rails x 2
☒ bed down
☐ restraints
☐ wrist

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pitting
☐ 1+
☐ 2+
☐ 3+
☐ 4+
☐ non-pitting

pitting
☐ 1+
☐ 2+
☐ 3+
☐ 4+
☐ non-pitting

CAPILLARY REFILL:

FINGERS:
☒ brisk
☐ slow

TOES:
☒ brisk
☐ slow

HX:
☐ Pacemaker
☒ HTN
☐ CAD
☐ CHF
☐ PVD
☐ Other: ________

☒ call light
☒ nightlight
☐ vest

DISCHARGE/TEACHING: ☐ see nursing notes

NEEDS:____

TYPE OF LEARNER:
☒ visual
☐ auditory
☐ kinesthetic

EDUCATIONAL LEVEL: High school

FAMILY PRESENT:
☒ yes
☐ no

FLUID BALANCE: ☐ see nursing notes

INTAKE:
☒ PO
☐ IV

SOLUTION: D5 .45 RATE: 60 ml/hr

SITE LOCATION: L FA

☒ clean
☒ patent
☐ redness
☐ swelling
☐ cool
☐ hot
☐ pain
☐ tubing change
☐ dressing change

MUCOUS MEMBRANES:
☒ moist
☒ pink
☐ sticky
☐ coated
☐ dry

TODAY'S WT: 48 kg **YESTERDAY'S WT:**______

NURSE SIGNATURE: *Tracy Milano RN, BSN*

TIME COMPLETED: 0900

REASSESSMENT:

TIME: 1200

☒ no change ☐ see nurses notes Initials *TM*

TIME: 1600

☒ no change ☐ see nurses notes Initials *TM*

TIME: 2000

☒ no change ☐ see nurses notes Initials *SH*

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Risk Assessments & Nursing Care

	Date: Day 1 0900-2100 Braden Scale Score: 20 Morse Fall Risk Score: 70									Date: Braden Scale Score: 20 Morse Fall Risk Score: 70							
Time		08	10	12	14	16	18			20	22	00	02	04	06		
PAIN ASSESSMENT																	
Intensity (1-10/10)		2	1	2	5	5	2			1	1	1	1	1	1		
Pain Type (see legend)		A	A	A	M	M	A			A	A	A	A	A	A		
Intervention (see legend)		3	3	3	3	3	3			3	3	3	3	3	3		
PATIENT POSITION		B	B	C	A	A	B			B	B	R	L	A	B		
PO FLUIDS (ml)		240		480	240	240				240		480	240	240			
IV SITE/RATE CHECKED		Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y		
PATIENT HYGIENE		Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y		
WOUND ASSESSMENT		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
WOUND BED		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
WOUND DRAINAGE		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
WOUND CARE		n/a	n/a	n/a	n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a		
Nurse Initials		TM	TM	TM	TM	TM	TM			K.C.	K.C.	K.C.	K.C.	K.C.	K.C.		

Initial	Nurse Signature	Initial	Nurse Signature
T.M.	Tracy Milano RN, BSN	L.T.	Liz Townsend

LEGEND: *= see nursing notes

PAIN TYPE:
- **A-** aching
- **ST-** stabbing
- **SH-** shooting
- **T-** throbbing
- **B-** burning
- **P-** pressure

PAIN INTERVENTIONS:
- 1- Relaxation/Imagery
- **2 -** Distraction
- **3-** Reposition
- **4-**Medication

POSTIONING:
- **B-** back
- **R-** right
- **L-** left
- **C-** chair
- **A-** ambulatory

PT. HYGIENE:
- **b-** bedbath
- **p-** partial bath
- **g-** grooming
- **f-** foot care
- **a-** assist bath
- **sh-** shower
- **m** mouth care
- **n-** nail care

WOUND ASSESSMENT
- **# 1-4** Pressure Ulcer stage
- **I –** Incision
- **R –** Rash
- **SK –** skin tear
- **E –**Echymosis
- **A –** Abrasion

WOUND BED:
- **D–** Dry & intact
- **S –** Sutures/ staples
- **G –** Granulation tissue
- **P –** Pale
- **Y –** Yellow
- **B-** Black

WOUND DRAINAGE:
- **0 –** none
- **S –** Serous
- **P –** Purlulent
- **S –** Serosanguinous
- **B –** Bright red blood
- **D –** Dark old blood

WOUND CARE:
- **C –** Cleaned with NS
- **G –** Gauze dressing
- **W –** Gauze wrap
- **A –** ABD pad
- **M –** Medication
- **O –** other **

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