PATIENT CHART

Julia Morales

Patient Name: Julia Morales	**MRN:** 123-456-78
Room:	**Doctor Name:** Dr. Ann Davis
DOB: 1951	**Date Admitted:** 9/24
Age: 65	

Physician's Orders

Allergies: NKA

Date/Time:	
9/24	Admit to Oncology Floor
9/24	Diet as tolerated
9/24	Oxygen per nasal cannula at 2 liters per minutes as needed for comfort
9/24	Meds: • Phenergan 25mg by mouth every 4-6 hours for nausea/vomiting • Vitamins and supplements for nutrition • Oxycodone 20mg by mouth every 4 hours as needed for pain • Ibuprofen 200mg by mouth every 4-6 hours as needed for pain
	Dr. Ann Davis

Nursing Notes

Date/Time:	
9/24 1600	Patient is a 65-year-old female with a four-year history of adenocarcinoma of the lung. Discharged home with hospice/home health on 9/22. She has been treated with chemotherapy and radiation. Admitted for shortness of breath and pain management. She will be evaluated for safety, pain management and other needed services. ----------M. Reyes, RN
9/24 1900	Patient complained of pain 9/10. Medicated, repositioned and aided in guided imagery. Partner at bedside. Partner expressed concerns over being able to manage Julia's pain and other needs at home. States "I just can't move fast enough to get her to the bathroom when she is having diarrhea or needs to throw up. I am trying to help, but just do not know what to do. I support Julia's decision, and after everything we have endured in the last four years, I did not know it would be so hard to see her this way at the end." Consider doing a Caregiver Role Strain assessment tomorrow with patient's partner. ----------M. Reyes, RN

9/24 2030	Patient vomited clear greenish yellow emesis at 2015. Medicated and repositioned. ---------- ----------T. Smith, RN
9/24 2200	Patient denies any nausea. States pain is a 3/10. Reposition patient. States her partner went home but will be back in the morning. ----------T. Smith, RN

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
MR	Maria Reyes, RN	TS	Teri Smyth, RN

Medication Administration Record

Allergies: NKA

Scheduled & Routine Drugs

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Dates Given:
9/24	Multivitamin	1 tab	Orally	Daily		

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
MR	Maria Reyes, RN	TS	Teri Smyth, RN

Medication Administration Record

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

Allergies: NKA

PRN Medications

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
9/24	Ibuprofen	200mg	Orally	Every 4-6 hours as needed for pain	Time:	
					Site:	
					Initials:	
9/24	Phenergan	25mg	Orally	Every 4-6 hours as needed for nausea/vomiting	Time:	~~2030~~
					Site:	
					Initials:	TS
9/24	Oxycodone	20mg	Orally	Every 4 hours as needed for pain	Time:	~~1900~~
					Site:	
					Initials:	MR

Insulin Administration

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					GMR:	
					Initials:	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
MR	Maria Reyes, RN	TS	Teri Smyth, RN

Vital Signs Record

Date:					9/24	9/24
Time:	0000	0400	0800	1200	1600	2000
BP					152/94	149/90
Pulse					82	78
O^2 Saturation					90	94
Weight					113	
Respirations					24	22
Temp					98.2 F	98.3 F
Nurse Initials					MR	TS

Intake & Output Bedside Worksheet

INTAKE					OUTPUT				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other
240mL 240mL					100 150	300mL			
Total Intake this shift: 480mL					Total Output this shift: 550mL				

(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

Nursing Assessment Flowsheet

GENERAL APPEARANCE:
☐ male ☒ female

DOB: 1951
AGE: 65
ETHNICITY: Caucasian
OCCUPATION: Retired
RELIGION: Unitarian

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

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

NEUROLOGICAL: ☐ see nursing notes

ORIENTATION:

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

RESPONDS TO:

RESPIRATORY: ☐ see nursing notes

RESPIRATIONS:
RATE: 24
O_2:Room Air
SPO_2: 90%

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

BREATH SOUNDS:

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

THORAX:
☒ even expansion
☐ uneven expansion

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

GASTROINTESTINAL/NUTRITION: ☐ see nursing notes

APPEARANCE:

☒ flat	☐ soft
☐ round	☐ gravid
☐ obese	

BOWEL SOUNDS:

☒ name ☐ non-responsive
☐ stimuli

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

FACE:
☒ symmetrical ☐ drooling
☐ drooping

EYES:
☒ PERRLA
☐ unequal
☐ drooping lid

SIGHT:
☐ no correction
☒ glasses
☐ contacts
☐ blind

HEARING:
☒ WNL ☐ hearing aid
☐ HOH

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

☒ active ☐ hyperactive
☐ hypoactive ☐ absent

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

LAST BM: loose stool 9/24 1200

☐ incontinent ☒ diarrhea
☐ stoma- _____ ☐ mucous
☐ constipation ☐ blood

DIET: Regular, soft

☐ impaired swallowing
☐ choking
☐ NG tube
color drainage:_____
☐ feeding tube
☐ tube feeding
type: _____ rate:_____
☒ Other:
Sores in mouth – loose dentures

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

RIGHT:
☐ strong
☒ weak

GENITOURINARY: ☐ see nursing notes

☒ voids ☐ catheter ☐ stoma

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

BLADDER:
☒ soft ☐ firm/distended ☐ incontinent

FEMALES: LMP: Post-menopause

☐ WNL ☐ dysmenorrheal

BIRTH CONTROL:

☐ flaccid
☐ contractures

☐ flaccid
☐ 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
☒ not sexually active

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

EXTREMITY COLOR & TEMP:
☒ warm
☐ cool
☐ cold

☐ acyanotic
☐ cyanotic
☐ discolor

PAIN ASSESSMENT: ☐ see nursing notes
☒ see MAR

PRECIPITATING: With coughing and activity

QUALITY: Dull

REGION: Right upper chest

SEVERITY (0-10/10):

NOW: 3 AT WORST: 9-10 AT BEST: 3

TIMING: Intermittent and with activity

SAFETY: ☐ see nursing notes
☒ fall risk

PRECAUTIONS:

☒ side rails x 2
☒ bed down
☒ call light
☐ nightlight

☐ restraints
☐ wrist
☐ vest

EDEMA:
☐ none ☐ generalized (anasarca)

SITE #1: Bilateral LE

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

SITE #2: _____

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

CAPILLARY REFILL:

FINGERS:
☐ brisk
☒ slow

TOES:
☐ brisk
☒ slow

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

DISCHARGE/TEACHING: ☐ see nursing notes

NEEDS: Pain management, home oxygen therapy

TYPE OF LEARNER:
☒ visual
☐ auditory
☐ kinesthetic

EDUCATIONAL LEVEL: _____

FAMILY PRESENT:
☒ yes
☐ no

FLUID BALANCE: ☐ see nursing notes

INTAKE:
☒ PO ☐ IV

SOLUTION: _____ RATE:_____ ml/hr

SITE LOCATION: _____

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

NURSE SIGNATURE: M. Reyes

TIME COMPLETED: 1600

REASSESSMENT:

TIME: 1900

☐ no change ☒ see nurses notes ☒ initials: TS

TIME: 2030

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

TODAY'S WT: 113 **YESTERDAY'S WT:** 115 per pt

☐ no change ☒ see nurses notes ☒ initials TS

TIME: 2200

☐ no change ☒ see nurses notes ☐ initials TS

Risk Assessments & Nursing Care

	Date: 9/24 **Braden Scale Score: 17** **Fall Risk Score: 4**								
Time Hourly	**1600**	**1900**	**2200**						
PAIN ASSESSMENT									
Intensity (1-10/10)	**3**	**9**	**4**						
Pain Type (see legend)	**A**	**A**	**A**						
Intervention (see legend)		**1,3,4**	**3**						
PATIENT POSITION	**B**	**L**	**R**						
PO FLUIDS (ml)	**240**	**240**	**0**						
IV SITE/RATE CHECKED	**n/a**	**n/a**	**n/a**						
PATIENT HYGIENE									
WOUND ASSESSMENT	**0**								
WOUND BED									
WOUND DRAINAGE									
WOUND CARE									
Nurse Initials	**MR**	**MR**	**TS**						

Initial	Nurse Signature	Initial	Nurse Signature
MR	Maria Reyes, RN	TS	Teri Smyth, RN

LEGEND: *= see nursing notes

PAIN TYPE:
A- aching **T-** throbbing
ST- stabbing **B-** burning
SH- shooting **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 **a-** assist bath
p- partial bath **sh-** shower
g- grooming **m** mouth care
f- foot care **n-** nail care

WOUND ASSESSMENT	WOUND BED:	WOUND DRAINAGE:	WOUND CARE:
# 1-4 Pressure Ulcer stage	**D–** Dry & intact	**0 –** none	**C –** Cleaned with NS
I – Incision	**S –** Sutures/ staples	**S –** Serous	**G –** Gauze dressing
R – Rash	**G –** Granulation tissue	**P –** Purlulent	**W –** Gauze wrap
SK – skin tear	**P –** Pale	**S –** Serosanguinous	**A –** ABD pad
E –Echymosis	**Y –** Yellow	**B –** Bright red blood	**M –** Medication
A – Abrasion	**B-** Black	**D –** Dark old blood	**O –** other **