### BASELINE NURSING ASSESSMENT

3-21-2011

NEURO	Mentation/LOC	Oriented to: Oriented to: Person Place Time Stuation/Event Alert Sedated Restless Sleepy/arousable Lethangic Unresponsive Responds only to pain Agitated Confused Combative Hallucinating Other Pain Level 0 (none) to 10 (maximum)
SKIN	Skin Integrity	Intact O Ulceri/Purpura/Skin tears/Locations
		None Location: Size: Depth/Stage
	Wound/Abrasion	Orainage: None Other Drsg
	Surgical incision/Site	№ None Location: □Clean □Dry □Intact Drainage: □Cressing
	Other:	DENone Location: DEAr mattress Specially bed Street
	Equipment	
CARDIAC	Edema	SNone +1/+2/+3/+4 □ Location
	Arterial Pulses/CMS	Strong   Faint   Absent CMS:   WNL   Other: Podal Pulses +1
	Skin Temperature	Warm □Cool □Dry □Clarreny □ Moist □Diaphoretic
	Skin Color	MPinkNatural   Flushed   Pale   Jaundiced   Mottled   Cyanotic
	Capillary Refill	■ Normal (1-2 seconds) □ Delayed (>3 seconds)
		■Regular □ Irregular
	Rhythm/Heart Sounds	
RESP	Respirations	■No distress SOB Shallow Labored
	Breath Sounds	Clear Crackles Fine Coarse Wheezes: Insp./Exp. Diminished
	Cough	Absent Productive Non-productive Weak Moderate Strong
	Sputum/Secretions	Color: @leas Consistency:   Thin   Thick   Suctioned:
	Respiratory Rx	Mone S TCDB IPPB Neb/MDI Other
	O2 Therapy	None 02 6 2 Umin FiO2 16per Month Commonder BIPAP/CPAP
	Oximetry	□None □Intermittent ☑ Continuous Probe Location <u>2 Peder</u>
	Chest Tube	■N.A. Waterseal/ om suction Drainage:
GI	Diet	□NPO □Reg □CL □ADA □Other □Aspiration Precautions
	Appetite	Appetite: Good Fair Di Poor Nausea Emesis Refescel
	NG Tube	IEN.A. □NG/NJ € □ GT € □ Clamped □Int Suction □ Cont. Suction
	Feeding Tube	Other D.F. Gravity Bag/Bil change
	Abdomen *	□Soft □Firm □Hard SiDistended □Guarded Girth: cm Sec Nacco
	Bowel Sounds *	□Normal □Hyperactive Si Hypoactive □Absent □Flatus See Mates
	Stool	Mone   Formed   Soft   Liquid Color:
	86001	□Continent □Incontinent □Condom Cath □Foley □Straight Cath
GU	Urine	
	Discharge	Color: Author Character: Closs  Bladder Scan  Character: Closs Character:
	Crischarge	
ACTIVITY	Drains	None         □         Drainage:           □V.A.C.         Setting         mm Hg         □ Cont.         □ Int.
	× 500,000	□VA.C. Dressing change □ □ Canister change
	Traction	ISON/A ☐ Skeletal/Skin Site: # of pounds
		BBath: Complete Partial ☐ Shower ☐ Oral Care ☐ Pericare ☐ Back Care ☐ Hair Wash
	Hygiene	Other: Self Assist Total
		TEDS Trees off x 30 once  SCD off x
		Bedrest □HO8 © degrees Turned x Dangled x
	Activity	□BRP □ Commode □ Chair x □ Amb.x □ Indep. □ With assist
	Fall Risk	□Low□High (For details see Fall Risk Assessment)
		Call Light in reach/pt. able to use Bed low/brakes on # of siderails up:
	Patient Safety Needs	☐ Seizure Precautions ☐ Overbed Frame: ☐ Safety  ✓ complete
		III D Band on III Allergy Band on/ □ N.A. Other:
LINES	Invasive Lines	□None Size/Site/Type Size Inspection Description Flush Site Tbg Care △
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# **Admission Charting For Nurses**

Caroline Bunker Rosdahl, Mary T. Kowalski

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## **Table of Contents Admission Charting For Nurses**

- 1. Understanding the eBook Admission Charting For Nurses
  - The Rise of Digital Reading Admission Charting For Nurses
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Admission Charting For Nurses
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Admission Charting For Nurses
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Admission Charting For Nurses
  - Personalized Recommendations
  - Admission Charting For Nurses User Reviews and Ratings
  - Admission Charting For Nurses and Bestseller Lists
- 5. Accessing Admission Charting For Nurses Free and Paid eBooks
  - Admission Charting For Nurses Public Domain eBooks
  - Admission Charting For Nurses eBook Subscription Services
  - Admission Charting For Nurses Budget-Friendly Options
- 6. Navigating Admission Charting For Nurses eBook Formats

- o ePub, PDF, MOBI, and More
- Admission Charting For Nurses Compatibility with Devices
- Admission Charting For Nurses Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Admission Charting For Nurses
  - Highlighting and Note-Taking Admission Charting For Nurses
  - Interactive Elements Admission Charting For Nurses
- 8. Staying Engaged with Admission Charting For Nurses
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Admission Charting For Nurses
- 9. Balancing eBooks and Physical Books Admission Charting For Nurses
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Admission Charting For Nurses
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Admission Charting For Nurses
  - Setting Reading Goals Admission Charting For Nurses
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Admission Charting For Nurses
  - Fact-Checking eBook Content of Admission Charting For Nurses
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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