GUIDELINE
for
Nursing Care Documentation
Fundamentals and Med Surg I

Instructions: This is a content guide (may not be all inclusive) for writing your nurse's note each lab and clinical day. You should describe the client as carefully and completely as possible. Abnormal findings or needs should be added to the list of your client's problems/needs. Your plan for what you will do during the course of your clinical day/lab day to meet the nursing care needs related to each problem should also be included in the space provided. Each problem/need must be re-evaluated in focused assessments every two hours throughout the day and documented in your nursing care notes. Focused assessments are a re-evaluation of conditions and/or changes in the client's problems or needs as a result of your intervention. Nursing Care Notes should contain facts only, no views or personal opinions.

Patient Information	**Areas of Focus and Possible Findings**
	Admission Date: Admission Diagnosis: p.o.d (post op day): Code Status: DOB: Age: Gender: Food and drug allergies: Speech: (clear, slurred, garbled) Hearing:(hearing aid, hard of hearing) Vision:(glasses, blind) Surgical Hx: Co-Morbidities: Occupation: Recreational Drug Use: Drinking (alcohol): Smoking: Years: Pks/day: Diet ordered: Fluid requirements: (push, restricted, ice chips) Activity ordered : ADL needs: Tx: (RT, PT, OT, Speech, accu check, wound care, etc.) Lab: WBC RBC HGB Hct Platelets Na+ K+ Cl- CO2 Glucose BUN Creatinine PT PTT INR CA++ MG++ Diagnostics: (x-rays, scans) IV site: Solution: Rate: Precautions: (seizure, safety, falls, aspiration) Isolation: (contact, airborne, droplet)
Vital Signs	**Areas of Focus and Possible Findings**
	Temp _____ Pulse _____ Resp _____ BP _____ Pain _____ O2 Sat _____
Neurological	**Areas of Focus and Possible Findings**
Level of consciousness (Must write out descriptors, abbreviations not acceptable)	Alert (awake, aware of self and environment) Lethargic (drowsy, opens eyes looks at you to verbal stimuli, responds to questions, then goes to sleep Obtunded (opens eyes and looks at you to tactile stimuli, responds slowly and is slightly confused) Stupor (arouses from sleep with noxious stimuli, slow verbally or not at all, lapses into unresponsiveness when stimuli stopped Coma (no response with noxious stimuli)
Orientation (No abbreviations accepted)	Assess client orientation (whether client knows: who they are, what time it is, where they are, why they are here)
Pupils (Must write out descriptors abbreviations are not acceptable)	Pupils Equal (look at the eyes and ensure that both pupils are the same size, measured in mm) (if not ask about injuries, surgeries) Round (shape of both pupils should be round, and midpoint) (if not ask about injuries, surgeries) Reactive to light (shine penlight from side of head to pupil, does it constrict quickly and equally? Sluggish? Not at all?, both pupils should react quickly to light) (if not first darken room and re-assess, then ask about injuries and surgeries) Accommodation (tests the adaptation of the eye for near vision) (ask to focus on a distant object (this dilates the eye) and then have them focus vision to a near object; hold a pen/pencil 4 – 5 inches from the client's nose, you should note constriction, and lens adjusts)
Grasp	Assess strength of hand grasp offer client index and middle fingers and ask them to squeeze fingers as hard as they can. Should have strong equal grasps
Follows Commands	Assess ability to follow commands readily when asking client to grasp fingers, did the client follow

	command readily? Hesitantly?
Response to stimuli	Assess if client not awake, and alert. Did client respond to verbal? Tactile? Or Noxious? Stimuli? Where they purposeful (responds like you would expect?) Or purposeless (response was not what you would normally see in clients)
Devices	Assess stabilizing devices. (braces, halos, collars)
Musculoskeletal	**Areas of Focus and Possible Findings**
Movement	Assess ability to move extremities assess hand strength and arm movement, ask client to lift arms and legs off the bed, have client press feet against hands when assessing feet and pulses, is client able to turn self in bed? Assist with turning? Know client activity level and MD orders)
Gait	Assess client gait when ambulating unless on bedrest, assess ability to walk (steady/unsteady gait, need of assistance, number of people needed, weight bearing/non-weight bearing)
Devices	Assess stabilizing or restrictive equipment. if client is independently mobile, place canes, walkers, crutches within reach, assure that they are in good condition; assess physical restraints for security, proper placement, safety, and compliance with restraint guidelines. Note use of TENS unit (Transcutaneous Electrical Nerve Stimulation unit) for pain management.
Integumentary	**Areas of Focus and Possible Findings**
Color	Assess client's skin color face and neck are best place to assess client's skin color. Can be pale, dusky, cyanotic, jaundiced. Can also assess palms, and earlobes for color changes. Bruising and ecchymosis may not be readily visible on dark skinned patients; evidence of cyanosis, pallor, jaundice may be most evident in mucous membranes or sclera.
Skin	Assess the skin temperature place hand on client's bare upper chest, skin is normally dry and warm. Can be cool, moist, cold and clammy, hot and moist
Mucous Membranes	Assess mucous membranes look in the mouth and nose, should be pink and moist, can be pale, red, jaundiced, dusky, cyanotic and dry
Nailbeds	Assess Nailbeds for color and capillary refill (observe nailbed and note color, should be pink, when compressing nailbed note the amount of time for the nail color to return, should be less than 3 seconds) (can be pale, dusky, cyanotic with sluggish refill, note time in seconds that it takes to return to normal)
Skin Turgor	Assess client forearm, pinch skin gently with thumb and index finger skin should return to normal without "tenting"
Skin Integrity	Assess condition of client skin assess skin during the whole assessment as you assess from head-to-toe; note any deviations from normal, note: size, depth, width, location, color, shape, drainage, tenderness, document exactly what you see; describe wounds and/or lesions and any dressings present
Devices	Assess intravenous and intra-cavity catheters, tubes, and drain sites. observe skin condition for redness, drainage, bleeding, crusting, swelling, assess placement and dressing
Cardio/Peripheral Vascular Assessment	**Areas of Focus and Possible Findings**
Apical pulse	Assess apical heart for one full minute note rate, strength and rhythm, and abnormalities-swooshing, clicking, or unusual sounds (should be: lubb-dubb (one beat) and even rhythm, without any extra sounds
Peripheral Pulses	Assess the brachial, radial, posterior tibial, and dorsalis pedis pulses assess both right and left pulses presence, equality and strength (No need to feel carotids-client awake and talking –they have a carotid) if circulation impaired to lower legs, then assess popliteal and/or femoral pulses) (SCALE: 0 = absent; 1+ = thready, 2+ = normal; 3+ = bounding)
Extremities	Assess hands and feet should all be equally pink and equally warm to touch (don't chart that the hands and feet are dry or moist here-that goes in the Integumentary)
Peripheral Edema	Assess extremities for edema press fingers firmly for 5 seconds into skin on top of foot or inner ankle bone, normal is no imprint or indentations present after fingers released (some client have fat ankles, if not sure whether they are edematous or not ask them) . If edema present: pitting? Non-pitting? Location, how far up it extends, can have generalized edema, meaning they are edematous all over) (when sitting client up to assess posterior lung sounds-assess for sacral edema and/or dependent edema) (SCALE: + 0 = no edema; +1 = 0 to ¼ inch pitting (mild); +2 = ¼ - ½ inch pitting (moderate); +3 = ½ - 1 inch pitting (severe); +4 = greater than 1 inch pitting (severe)
Devices	Assess intravenous catheters and ports for integrity. observe area surrounding insertion site for swelling, redness, cool temperature, tenderness; note SCD (sequential compression devices) and TED hose)
Respiratory	**Areas of Focus and Possible Findings**
Oxygenation	Assess the type of oxygen in use and the amount client is receiving normal would be without; Note

	delivery route (nasal cannula, mask, trach, etc) document liter flow, look on O_2 flow meter and document level of middle of ball.
O_2 saturation	Assess O_2 sat monitor and assess peripheral oxygen percent (normal 90 – 100 %)
Respirations	Assess rate and quality of breathing: should be even and unlabored (normal respiratory rate 12 – 20). Note retractions, depth, rhythm
Lung Sounds	Assess the lung sounds anteriorly and posteriorly in all 5 lobes should be clear and equal throughout rhonchi = secretions in the bronchioles, sounds like a squeaky door, rumbling with expiration most prominent and can be heard sometimes on inspiration, can clear with coughing crackles = excess fluid present, sounds like hair strands rubbing together, noted on inspiration most of the time, can be heard on expiration wheezes = air passing through narrowed airways, can be heard on inspiration and expiration, or can be audible – can hear without a stethoscope)
Cough	Assess cough if client has a cough note if productive or non-productive weak, strong, or forceful
Secretions	Assess secretions produced by cough note the amount, color, and consistency
Devices	Assess invasive devices. observe for patency and placement, note color, consistency, amount drainage from chest tubes, incisional drains; observe oxygen delivery system for effective placement and settings; note inspirometer and volume attained with use
Gastrointestinal	**Areas of Focus and Possible Findings**
Swallow	Assess swallow: assess for risk of choking or aspiration; observe for coughing during eating, change in voice tone or quality after swallowing, abnormal movements of mouth, tongue, or lips; listen for slow, weak, or uncoordinated speech; delayed swallowing or pooling of food may indicate difficulty. Post operative patients may have decreased gag reflex.
Abdomen	Assess the abdomen, first with inspection (look at the abdomen, is it round, flat, pendulous, distended) (should be flat or slightly rounded) Assess the bowel sounds with auscultation x 4 quadrants (place the stethoscope on all 4 quadrants and listen to each for one minute and count the sounds) (normoactive = 5 – 30 X /minute) (hypoactive = < 5 sounds/minute) (hyperactive = > 30 X / minute) (absent = must listen for 5 full minutes – can indicate bowel obstruction) (after surgery common for bowel sounds to be back to normal 1 – 2 days) (after abdominal surgery 3 – 5 days) Assess the abdomen, (after auscultation) with palpation (use light palpation in all four quads (press fingers down 1 – 2 cm) to assess that the abdomen is soft and pliable) (deep palpation (4 – 5 cm) to assess for tenderness, masses, bulges)
Bowel Movements	Assess last bowel movement ask client, record date, amount, color, consistency; if no BM in last 2 days assess need for prn meds; ensure that BMs are documented
Intake and Output	Assess fluid intake: measure and record in ml Assess food intake: measure and record in % of meal/snack taken Assess output: measure and record NG, emesis, colostomy output in ml
Devices	Assess invasive devices. note placement and patency of tubes, drains, and ostomy equipment, and note color, consistency, amount of drainage; note use of briefs
Genitourinary	**Areas of Focus and Possible Findings**
Bladder	Assess bladder place hand slightly above the symphysis pubis, should be flat and non-palpable (if able to feel the bladder, this is abnormal), note if distended, level of extension, or displacement
Urine	Assess urinary output measure and record in ml. Ensure adequate output (> 30 mL/hr), note color, clarity, odor, sediment; record number of times voided and changed if wears briefs; note presence and patency of catheter or drains; note use of bedpan, BSC, urinal; note if continent or incontinent
Devices	Assess invasive devices. note placement and patency of catheters drains, tubes, and color, consistency, amount of output; note use of briefs
Psychosocial	**Areas of Focus and Possible Findings**
Coping Mechanisms	Assess coping mechanisms (ask client about means of relieving stress, talking, thinking, driving, writing, exercise, ignoring, etc)
Involvement in decision making	Assess decision making (anger often results if not involved; are decisions made by self, with family or significant other, slowly, not at all)
Expectation for Recovery	Assess expectation for recovery (return to work, physical/mental limitations, disease management, rehabilitation)
Concerns or fears	Assess concerns or fears (loss of job, financial difficulty, being alone, dying, physical changes, etc)
Support System	Assess support system (name of next of kin, significant other)