## ASSESSMENT

### MENTAL STATUS
- Strong / Weak
- Movements
- Pupil
- Gait / Steady
- Sensation
  - Location

### GASTROINTESTINAL
- Bowel Sounds
- Auscultation
- Vomiting
- GI Tube Drainage

### GUARDIANSHIP
- (N)URO FLOW SHEET
  - (N)EUROS

### CARDIOVASCULAR
- Skin Temperature
- Skin Color
- Capillary Refill
- Pulse

### RESPIRATORY
- Respiratory Pattern
- Breath Sounds

### SLEEP / REST
- Sleep / Rest
- Vital Signs
- Pain
- Bed Area

### COMFORT
- Pain Management
- Location

### BEHAVIORAL RESPONSE
- Thought Processes
- Social / Communication

### INTEGRITY / INTACT
- Dressings
- Wounds
- Wound Dressing

### PRESSURE ULCERS / SORES
- Type
- Site
- Description

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**Pressure Ulcers / Sores**

**Type**

I = Partial-thickness skin loss involving epidermis and/or dermis. Superficial and presents clinically as an abrasion, blister or shallow crater.

II = Full-thickness skin loss involving damage or destruction of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

III = Full-thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.

**Initials**

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(Ro. 10/06)
### Treatment Record

#### Respiratory Care

**Suction**
- Coughing and deep breathing
- Incentive Spirometry (cc)

**Hygiene/Safety**
- Bath
- Brushing of teeth
- Antimicrobial (antibiotics)
- Bedside urinal
- Restraint (soft)
- Isolation (respiratory/influenza)

#### IV Line Care

<table>
<thead>
<tr>
<th>Type</th>
<th>Site</th>
<th>/ = Site Check</th>
<th>D = Dressing Change</th>
<th>DC = Remove</th>
<th>T = Tubing Change</th>
<th>I = Insert</th>
<th>H = Heel Lock</th>
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<tbody>
<tr>
<td>1.</td>
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#### Wound Care/Sites

#### Activity

- Assist turn/self

#### Specimen

- Finger stick

#### Whole Blood Glucose

Reference Range: 70-99 mg/dL

#### Labs

### Legends

1. Mental Status
2. Skin Color
3. Cough
4. Bowel Sounds
5. Capillary refill
6. Secretion/Drainage
7. Respiratory Patterns
8. Sensation
9. Temperature
10. Tongue
11. Chest Tube Site
12. Abdomen
13. Thought Process
14. Wounds
15. Traumatic
16. Open
17. Sutured
18. Sepsis
19. Other
20. PACU
21. SGS
<table>
<thead>
<tr>
<th>TIME/INITIAL</th>
<th>NURSING DIAGNOSIS</th>
<th>NURSING PLAN</th>
<th>EXPECTED OUTCOME</th>
<th>DATE/TIME MET</th>
<th>RN INITIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ALTERATION IN RESPIRATORY STATUS DUE TO PAIN, ANESTHESIA OR VOMITING.</td>
<td>1. OBSERVE FOR S.O.S. OF RESPIRATORY DISTRESS. 2. HAVE PATIENT DEEP BREATH/COUGH PRN. 3. CHEST AUSCULTATION. 4. SUCTION PRN.</td>
<td>1. PATIENT CLEAR AIRWAY MAINTAINED. 2. ADEQUATE VENTILATION MAINTAINED.</td>
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<td>2.</td>
<td>ALTERATION IN CARDIOVASCULAR STATUS DUE TO ANESTHESIA, SURGICAL PROCEDURE AND FLUID IMBALANCE.</td>
<td>1. CHECK VITAL SIGNS. 2. ASSESS CARDIAC RHYTHM. 3. OBSERVE SIGNS OF BLEEDING. 4. ASSESS PERIPHERAL PULSES.</td>
<td>1. VITAL SIGNS WITHIN ACCEPTABLE LIMITS. 2. EFFECTIVE CARDIAC RATE/RHYTHM. 3. NO EVIDENCE OF EXCESSIVE BLEEDING. 4. PERIPHERAL PULSES AS EXPECTED.</td>
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<td>3.</td>
<td>ALTERATION IN LEVEL OF CONSCIOUSNESS/PHYSICAL MOBILITY DUE TO ANESTHESIA/SURGERY.</td>
<td>1. ASSESS LEVEL OF CONSCIOUSNESS. 2. ASSESS SENSATION/EPIPHAL DURAL LEVEL.</td>
<td>1. LEVEL OF CONSCIOUSNESS AS EXPECTED. 2. SENSORY LEVEL AT T-10 OR LESS AND LOWER EXTREMITIES MOVING.</td>
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<td>4.</td>
<td>ALTERATION IN FLUID AND ELECTROLYTE IMBALANCE DUE TO ANESTHESIA/SURGICAL PROCEDURE/NAUSEA AND VOMITING.</td>
<td>1. MONITOR INTAKE AND OUTPUT. 2. PROVIDE TREATMENT FOR N/V PRN.</td>
<td>1. MEASURABLE URINE OUTPUT (I.E. FOLEY) &gt; 300CC/HR OR VOID. 2. PATIENT VERAHILIZE RELIEF OR N/V. 3. INFUSING PO FLUIDS.</td>
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<td>5.</td>
<td>ALTERATION IN COMFORT/ANXIETY RELATED TO SURGICAL PROCEDURE.</td>
<td>1. POSITION OF COMFORT. 2. MEDICATE PATIENT FOR PAIN PRN. 3. MEASURE PATIENT. 4. APPLY BAR HUGGER.</td>
<td>1. LEVEL OF PAIN IS DECREASED. 2. VERBAL OR NON-VERBAL EXPRESSION OF REASONABLE COMFORT.</td>
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<td>6.</td>
<td>ALTERATION IN BODY TEMPERATURE DUE TO EXPOSURE/ANESTHESIA AGENTS.</td>
<td>1. CHECK TEMPERATURE. 2. ADMINISTER WARM BLANKETS. 3. APPLY BAR HUGGER.</td>
<td>1. TEMPERATURE OF 95° OR ABOVE.</td>
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<td>7.</td>
<td>KNOWLEDGE DEFICIT RT SURGICAL PROCEDURE AND POST OPERATIVE PERIOD.</td>
<td>1. DISCUSS POSTOPERATIVE ROUTINGS WITH PATIENT AND FAMILY. 2. INSTRUCT TO DEEP BREATHE AND COUGH OR HOURS PRN. 3. INSTRUCT ON USE OF PCA.</td>
<td>1. PATIENT VERBAZILIZE AND/OP PROVES UNDERSTANDING. 2. USE OF PCA DISCUSSED WITH PATIENT. PT. ASKS APPROPRIATE QUESTIONS/DEMONSTRATES USE.</td>
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<td>8.</td>
<td>INJURY RELATED TO ANESTHETIC ALTERATION IN PERCEPTION AND THOUGHT PROCESS.</td>
<td>1. REORIENT PATIENT TO TIME, PERSON AND PLACE. 2. INSTITUTE SAFETY MEASURES.</td>
<td>1. THOUGHT PROCESSES ARE WITHIN PATIENT NORM. 2. NO INJURY WHILE IN PACU.</td>
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<td>9.</td>
<td>IMPAIRMENT OF SKIN INTEGRITY OTHER THAN EXPECTED SURGICAL INCISION.</td>
<td>1. ASSESS SKIN INTEGRITY, NOTE REDNESS, OPEN AREAS. 2. REMOVE WET/WRINKLED LINEN. 3. REPOSITION PRN.</td>
<td>1. SIGN INTEGRITY IS MAINTAINED.</td>
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