

KEY
N/A - Not Applicable

NIC – Not in Chart

UTD – Unable to Determine

∅ - None

KINGSBOROUGH COMMUNITY COLLEGE
DEPARTMENT OF NURSING

NURSING ASSESSMENT

STUDENT _____

CLIENT INITIALS _____

INSTRUCTOR _____

ROOM NO _____

AGENCY/SECTION _____

DATES OF CARE _____

DIRECTIONS: Please fill in each line/space. Nothing should be left blank.

DATA COLLECTION: HISTORY & HEALTH ASSESSMENT

PRESENT ILLNESS - Chief Complaint (Admission date, reason for seeking care, pt. explanation)

HISTORY OF PRESENT ILLNESS - (When started, description of problem, location, character, severity, timing, aggravating or relieving factors, associated factors, client's perception of what the symptom means)

MEDICAL DIAGNOSIS: _____

CONCURRENT HEALTH PROBLEMS: _____

PAST MEDICAL HISTORY:

Childhood Illness _____

Infectious Diseases _____

Immunizations (Childhood, Hep B, Influenza, Pneumococcal, last Tetanus & TB test) _____

Prior Hospitalizations (Reason, Treatment, Length of Stay) _____

History of: Anemia, Asthma, Cancer, Cardiac Disease, CVA (stroke) Diabetes Mellitus, Emphysema, Kidney Disease, Falls, Fractures, Genetic Disease, Hepatitis, Hypertension, Mental Illness, Sexually Transmitted Diseases, Tuberculosis.

PAST SURGICAL HISTORY: (Type, Date, Place, Length of Stay)

TRANSFUSIONS (Dates) _____ **REACTIONS**(Describe) _____

MEDICATIONS PRIOR TO ADMISSION: (Prescribed, Over the Counter, Vitamins, Herbs, dose and frequency)

ALLERGIES:

Medications: _____

Reactions _____

DRUG USE: Tobacco - # packs/day _____ # years used _____ Alcohol Use - type/amount _____ frequency _____
Recreational Drugs - _____ frequency _____ IVDA - frequency _____ sharing needles _____

FAMILY HISTORY: (Illness in family, mother, father, siblings)

SOCIAL HISTORY: Language Spoken _____ Major loss/change in past year _____

Age: _____ Sex: _____ Marital Status: _____ Developmental Level: _____ Role/Position in Family: _____

Family Constellations (#, Ages): _____ Support System: _____

Education: _____ Occupation: _____

Religious beliefs/practices : _____

Cultural/Ethic Background: _____ Pertinent Cultural Practice: _____

Living Arrangements (# rooms, people, adequate heat/hot water, etc.,) _____

Health Insurance: _____ Financial Concerns: _____

NUTRITIONAL HISTORY: Special diet/Supplements _____ Appetite _____

Number of meals/day: _____ Who prepares meals: _____ Food likes/Dislikes: _____

Religious requirements: _____ Eats alone or with others: _____

Dentition/Dentures/Dominant Hand: _____

Recent Weight Gain/Loss: _____ Dysphagia: _____ Food Allergies: _____ Reaction: _____

Bowel Habits (frequency, consistency of stool, use of laxatives): _____

Urinary elimination (frequency, dysuria, complaints): _____

REST/SLEEP/ACTIVITY:

Usual #hrs/night: _____ Naps (time of day/length): _____ Nocturia _____ Developmental stage Variations _____

Use of meds to sleep: _____ Sleep rituals: _____ Hobbies: _____ Exercise: _____

Need for Assistance with ADL's: _____ Bathing: _____ Toileting: _____ Dressing: _____ Feeding: _____

Ambulating _____ Transferring _____ Stair Climbing _____ Shopping _____ Cooking _____ Home Maintenance _____
(S = self, A = assist, T = total care)

DISCHARGE PLANNING:

Lives: Alone _____ With _____ No known residence _____

Intended Destination Post Discharge _____ Home _____ Undetermined _____ Other _____

Previous Utilization of Community Resources:
____ Home care/Hospice ____ Adult day care ____ Church groups ____ Other ____ Meals on Wheels ____ Homemaker/Home health aide
____ Community support group

Post-discharge Transportation: _____ Car _____ Ambulance _____ Bus/Taxi _____ Unable to determine at this time
Anticipated Financial Assistance Post-discharge?: _____ No _____ Yes Anticipated Problems with Self-care Post-discharge?: _____ No _____ Yes
Assistive Devices Needed Post-discharge?: _____ No _____ Yes

Referrals: Discharge coordinator _____ Home Health _____ Social Service _____ V.N.A. _____ Other Comments _____

TEACHING NEEDS: (Client, Family/Readiness to learn/Barriers to Learning) _____

DATA COLLECTION	PHYSICAL			ASSESSMENT	
	DAY 1			DAY 2	
General Appearance					
Systemic Assessment - circle/describe A. Neurological Mental Status: LOC: alert/drowsy/ lethargic/stuporous/comatose/ restless/confused					
Orientation: time/place/person/recent memory					
Thought Process: reality/delusions/ hallucinations/attention span					
Headaches: Location/frequency					
Eyes: glasses/diplopia/pain/discharge/perla Sclera: red/yellow/clear					
Ears: Hearing loss/tinnitus/vertigo/ deformities					
Speech: Clear/slurred/coherent					
Ability to Swallow:					
Gait:					
Parasthesia:					
Weakness:					
Coordination:					
B. Cardiovascular					
B/P: site/position; Body Temperature & route					
Apical Pulse: rate/rhythm/quality					
Respirations: rate/labored/unlabored Pulse oximetry: O ₂ Sat					
Pain: location/frequency/duration/intensity on a scale of 0 - 10/provokes/palleates/quality/ radiates					
fatigue/dizziness/chest pain/numbness/ tingling in extremities					
		Right	Left	Right	Left
Arterial Pulses	Carotid				
0 – absent	Brachial				
1+ - barely palpable	Radial				
2+ - decrease	Femoral				
3+ - full (normal)	Popliteal				
4+ - bounding	Posterior Tibial				
Symmetry	Dorsalis pedis				
					3

DATA COLLECTION	PHYSICAL		ASSESSMENT	
	DAY 1		DAY 2	
B. Cardiovascular (continued) Capillary refill (norm less than 3 seconds) color/temperature/movement/sensation	TOES	FINGERS		
	R	R		
	L	L		
	symmetry	symmetry		
Homan's Sign (pain upon dorsiflexion)	R	L		
Skin color/temp/diaphoresis/edema				
Cardiac Monitoring:				
C. Respiratory Breath Sounds: Describe all auscultated lung sounds/clear/decreased/absent	Anterior: RUL			
Adventitious: rales/rhonci/wheeze	LUL			
Respiratory rate/rhythm/depth/quality/effort of breathing/dyspnea/SOB	RLL			
	LLL			
	Posterior RUL			
	LUL			
	RML			
	RLL			
Cough/Productive (describe sputum) Non-productive (frequency/precipitation factors/relief measures)				
Chest Symmetry: equal/unequal				
Chest tube: location/drainage				
Oxygen Therapy:				
Mode (type)				
Percentage				
Liter flow rate				
Ventilator FIO2 TV RR				
Ventilator FIO2 TV RR				
CMV, SIMV, CPAP				
PEEP				
Pressure Support				

DATA COLLECTION	PHYSICAL		ASSESSMENT	
D. Integumentary	DAY 1		DAY 2	
Skin:				
Color: pale/cyanotic/flushed/mottled/jaundice				
Temperature: warm/cold/moist				
Turgor/texture				
Mucous Membrane: Color/moisture/integrity				
Rashes/petechiae/ecchymosis/ulcerationss cars/scaling/flaking/purpura/pruritis/ integrity				
Wound: location/approximation/odor, discharge				
Decubitus Ulcers: location/type/size/shape/stage				
Dressings: location/ drainage/ odor				
E. Gastrointestinal:				
Height/Weight:				
Diet/Appetite/Tolerance:				
Nausea/Vomiting:				
Lips: color/moisture/lumps				
Gums & Teeth: swelling/bleeding/discoloration/retraction/ inflammation/loose/missing or carious teeth				
Last Bowel Movement/consistency/color				
Continence/diarrhea/constipation				
Bowel Sounds: present/ absent, hyper/hypo active	RUQ	LUQ	RUQ	LUQ
	RLQ	LLQ	RLQ	LLQ
Abdomen: soft/distended/tenderness/colostomy				
Parenteral Fluids:				
IV:				
Solution:				
Location:				
Rate:				
Site appearance:				
			5	

DATA COLLECTION	PHYSICAL		ASSESSMENT	
E. Gastrointestinal:				
Hyperalimentation:				
Solution:				
Location:				
Rate:				
Site appearance:				
Gavage: (NG, PEG):				
Type:				
route:				
amount:				
frequency:				
residual:				
F. Genitourinary				
Continence:				
Voiding: frequency/ color/clarity/ odor/amount/dysuria/urgency				
Bladder distention:				
Vaginal/Penile Drainage:				
Catheter: type/patency/drainage/				
G. Musculoskeletal				
Extremities: deformities/nodules/atrophy/joint stability				
ROJM:	upper	lower	upper	lower
	R	R	R	R
	L	L	R	R
Muscle Tonus/Strength:				
Coordination/Gait/Balance:				
Pain/Tenderness/Edema:				
Supportive Devices:				
Casts/Traction:				
H. Endocrine/Reproductive:				
Fatigue/wt. change/temperature intolerance				
Hair distribution/ulcers/herpes/warts/ Polydipsia/Polyuria/Polyphagia:				
Breast (masses/dimpling/ discharge/ pain)				
			6	

DATA COLLECTION	PHYSICAL	ASSESSMENT
	DAY 1	DAY 2
H. Endocrine/Reproductive: (continued)		
Last Mammogram/results:		
LMP/last pap smear & results:		
Gravida/Para:		
Penis: location of meatus/chancres/discharge/ tenderness/swelling		
Scrotum: lumps/swelling/ulcers/tenderness/ testicles		
Last Prostate exam & results:		

TEXTBOOK PICTURE (Definition, Major S/S, Tx)

DATA COLLECTION: (document results of admission & current result & significance)	Diagnostic & Lab Tests		
Normal: Include normal parameters for assigned clinical agency.	Admission Date	Current Date	Significance: Circle only the appropriate significant finding or enter the reason if not printed.
Complete Blood Count			
WBC			↑Inflammatory and infectious processes, leukemia. ↓Aplastic anemia, viral infections.
RBC			↑ ↓Below NR – indicates anemia, hemorrhage
Hgb			↑COPD, high altitudes, polycythemia. ↓Anemia hemorrhage, overhydration.
Hct			↑Dehydration, high altitudes, polycythemia. ↓Anemia, hemorrhage, overhydration.
MCV			↑Macrocytic anemia ↓Microcytic anemia
MCH			↑Macrocytic anemia ↓Microcytic anemia
MCHC			↑Spherocytosis ↓Hypochromic Anemia
Platelet			↑Acute infections, chronic granulocytic leukemia, chronic pancreatitis, cirrhosis, collagen disorders, polycythemia, postsplenectomy ↓Acute leukemia, DIC, thrombocytopenic pupura.
<u>Differential</u> Band Neutrophils			↑ Acute infections
Esonophils			↑Allergic reactions, esinophilic and chronic granulocitic leukemia, parasitic disorders, Hodgkin's disease. ↓Steroid therapy
Basophils			↑Hyperthyroidism, ulcerative colitis, mycloproliferative diseases ↓Hyperthyroidism, stress
Lymphocytes			↑Chronic infections, lymphocytic leukemia mononucleosis, viral infections ↓Adrenocortical Steroid therapy, whole body irradiation.
Monocytes			↑Chronic inflammatory disorders, malaria, monocytic leukemia, acute infections, Hodgkins disease. ↓Steroid therapy

DATA COLLECTION: (document results of admission & current result & significance)	Diagnostic & Lab Tests		
Normal: Include normal parameters for assigned clinical agency	Admission Date	Current Date	Significance: Circle only the appropriate significant finding or enter the reason if not printed.
Pt Control INR			↑ Warfarin therapy, deficiency of factors I, II, V, VII, and X, vitamin K deficiency, liver disease.
Ptt Control			↑Deficiency of factors, I,II, V, VII, IX and X, XI, <II; hemophilia; liver disease, heparin therapy.
Serum Electrolytes Na			↑Dehydration, impaired renal function, primary aldosteronism, steroid therapy. ↓Addison's disease, diabetic ketoacidosis, diuretic therapy, excessive loss from gastrointestinal tract, excessive perspiration, water intoxication.
K			↑Addison's disease, diabetic ketosis, massive tissue destruction, renal failure. ↓Cushing's syndrome, severe diarrhea, diuretic therapy, gastrointestinal fistula, pyloric obstruction, starvation, vomiting.
Cl			↑Cardiac decompensation, metabolic acidosis, respiratory alkalosis, steroid therapy, uremia . ↓Addison's disease, diarrhea, metabolic alkalosis, respiratory acidosis, vomiting.
BUN			↑Increase in protein catabolism (fever, distress), renal disease, UTI. ↓Malnutrition, sever liver damage.
Creatinine			↑Active rheumatoid arthritis, biliary obstruction, hyperthyroidism, renal disorders, severe muscle disease ↓Diabetes Mellitus.
Glucose			↑Acute stress, cerebral lesions, Cushing's disease, Diabetes M., hyperthyroidism, pancreatic insufficiency. ↓Addison's disease, hepatic disease, hypothyroidism, insulin overdosage, pancreatic tumor, pituitary hypofunction, postgastrectomy dumping syndrome.
CO₂			↑Compensated respiratory acidosis, metabolic alkalosis ↓Compensated respiratory alkalosis, metabolic acidosis
Mg			↑Addison's disease, hypothyroidism, renal failure ↓ Chronic alcoholism hyperparathyroidism, hyperthyroidism, hypoparathyroidism, severe malabsorption.
Ca			↑ Acute osteoporosis, hyperparathyroidism, Vitamin D intoxication, multiple myeloma. ↓ Acute pancreatitis, hypoparathyroidism, liver disease, malabsorption syndrome, renal failure, Vitamin D deficiency.
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DATA COLLECTION: (document results of admission & current result & significance)	Diagnostic & Lab Tests		
Normal: Include normal parameters for assigned clinical agency	Admission Date	Current Date	Significance: Circle only the appropriate significant finding or enter the reason if not printed
Albumin			↑Dehydration ↓ Chronic liver disease, malabsorption, malnutrition, nephrotic syndrome, pregnancy
Total Protein			↑Burns, cirrhosis (globulin fraction) dehydration. ↓Congenital agammaglobulinemia, liver disease, malabsorption
<u>Urinalysis</u>			
Color	Straw		
Specify gravity			↑Albuminuria, dehydration, glycosuria ↓Diabetes insipidus.
Ph			↑Chronic renal failure, compensatory phase of alkalosis, salicylate intoxication, vegetable diet ↓Compensatory phase of acidosis, dehydration, emphysema
Glucose (negative)			↑Diabetes M. low renal threshold for glucose resorption, physiologic stress, pituitary disorders.
Ketones (negative)			↑Marked ketonuria
Blood (negative)			↑Infection in urinary tract/ See RBC
Protein (negative)			↑Congestive heart failure, nephritis, nephrosis, physiologic stress.
Bile (negative)			↑Hepatitis
Casts (absent)			↑Renal alterations
RBC (negative)			↑Damage to glomerulus or tubules, trauma, disease of lower urinary tract.
WBC (negative)			↑Infection in urinary tract

DATA COLLECTION: (document results of admission & current result & significance)	Diagnostic & Lab Tests		
	Admission Date	Current Date	Significance: Circle only the appropriate significant finding or enter the reason if not printed.
EKG			
Chest X-ray			
Arterial Blood Gases			
ph (7.35 – 7.45)			
pCO ₂ (35 - 45)			
pO ₂ (80 - 100)			
HCO ₃ (22 – 26)			
o ₂ sat (90 – 100)			
Other tests/procedures related to client hospitalization (include normal, client results and significance).			

NAME _____

COURSE _____

SEMESTER _____

STUDENT SELF-EVALUATION

Directions: Take time to do a realistic evaluation of your abilities in the areas listed below. Reflect on your overall performance for the course. What can you identify as support/barriers to your performance. Cite specific examples from your clinical experiences.

1. NURSING PROCESS:

A. Assessment –

What was your ability to gather data? Did you assess the client’s cultural, developmental, emotional, physical, psychological, and spiritual needs? Did you use all sources ex. client, family, staff, medical record etc.

B. Analysis/Diagnosis -

Did you identify significant findings and cluster the data to arrive at diagnosis? Did you use your Nursing Diagnosis book to select the diagnostic label? Did you identify contributing/risk factors for your patient? Did you use the PES format?

C. Planning –

Did you prioritize your diagnoses? Were outcomes stated with specific criteria for measurement? Were nursing actions clear, did you include patient medications and teaching needs?

D. Implementation –

Did you carry out the plan, maintain a safe environment, provide patient/family teaching, collaborate with others?

E. Evaluation –

Were the outcomes met, how? Did you state specific outcome criteria? Does the plan need to be continued or changed?

2. THERAPEUTIC INTERVENTIONS

What psychomotor skills did you perform? What do you need improvement with? What skills would you like to perform?

3. COMMUNICATION ABILITIES

Did you use therapeutic techniques? How effective was your verbal/non-verbal communication with the client/family, staff, peers, instructor? How would you describe your participation and contributions to pre and post conference? Was your written documentation organized clear, concise and complete? Did you complete the flow sheet, I & O, Medex etc?

4. MANAGEMENT

Did you manage your time well? Was all care given? Were your priorities correct?

5. CRITICAL THINKING

Did you apply theoretical knowledge? Can you explain and support the thinking behind the actions you chose? Did you consider . . . What if something goes wrong? or What if we try . . . ? Did you recognize your biases? What would you do differently? Did you have self-confidence? Did you demonstrate good clinical judgement?

NURSING ASSESSMENT AND CARE PLAN EVALUATION CRITERIA

Please note: All elements of the nursing process must be completed in order to receive a satisfactory grade of 75.

ASSESSMENT	(20)
Data is logically summarized:	
a) History and Health Assessment	4
b) Physical Assessment	4
c) Physician's Orders	2
d) Textbook Picture	2
e) Pharmacology Data Analysis	4
f) Diagnostic and lab tests	4
DIAGNOSING (DATA ANALYSIS)	(25)
Clusters Data	
Identifies ALL Significant Findings	5
Identifies ALL relevant nursing diagnoses using the PES format	10
	10
PLANNING (Develops Plan for 4 highest priority diagnoses – 3 physiological/1 psychological)	(15)
Prioritizes all identified diagnoses as HI-MED-LOW	
Identifies appropriate client goals/desired outcomes	5
States criteria for evaluation of client goals/outcomes	5
	5
IMPLEMENTATION	(30)
Identifies independent interventions to accomplish the top priorities for care (including teaching when appropriate)	
	7
Identifies interdependent interventions to accomplish the top priorities of care (including medications when appropriate)	
	7
Cites references for interventions	
	2
Explains scientific rationale for each intervention	
	7
Documents nursing activities on appropriate flow sheets and nurses' notes	
	7
EVALUATION	(10)
Evaluates outcomes for 4 top priority diagnoses using stated criteria for evaluation	
	5
Evaluates (self) performance of care	
	1
Correct grammar is used throughout document	
	2
Paper is legible	
	<u>2</u>
Total Points possible	100

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