KEY
N/A - Not Applicable
NIC – Not in Chart
UTD – Unable to Determine
Ø - None

KINGSBOROUGH COMMUNITY COLLEGE
DEPARTMENT OF NURSING
NURSING 18
USE ONLY APPROVED ABBREVIATIONS

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)

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MEDICAL DIAGNOSIS:____

CONCURRENT HEALTH PROBLEMS: ____

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PAST MEDICAL HISTORY:

Infectious Diseases ____

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

Prior Hospitalizations (Reason, Treatment, Length of stay______________________________________

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

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TRANSFUSIONS (Dates)_________________________ **REACTIONS**(Describe) _________________________

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

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ALLERGIES(Include medication/ food/ latex):

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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)**

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

Age: _____ Sex: _____ Marital Status: _______ Family Constellations (#, Ages): _________________________ Support System: _________________________

Education: _________________________________ Occupation: ____

Religious beliefs/practices : ____ Cultural/ ethnic group client identifies with: ____

Pertinent Cultural Practice: ____

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

Financial Concerns: ____

NUTRITIONAL HISTORY (AT HOME): Special diet/Supplements _____________________ Appetite ______________________

Food likes/Dislikes: ____

Religious requirements: ____

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

REST/SLEEP/ACTIVITY:

Usual #hrs/night: ________ Naps (time of day/length): ___________________________ Nocturia________________ ___________________

Use of meds to sleep: ___________ Sleep rituals: ______________________ Exercise: ____

Need for Assistance with ADL's: (S = self, A = assist, T = total car________ Bathing:______Toileting:________Dressing:_______Feeding:________

Ambulating _________ Transferring ________ Stair Climbing __________ Shopping _______ Cooking _______ Home Maintenance _____________

DISCHARGE PLANNING (REHAB PATIENTS ONLY):

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) ____

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DATA COLLECTION: ***DESCRIBE ALL DATA***	**PHYSICAL Assessment**	
General Appearance		
Systemic Assessment - A. Neurological: Mental Status**:** LOC: alert/drowsy lethargic/stuporous/comatose/ restless/confused		
Orientation: time/place/person/recent memory		
Headaches: Location/frequency		
Eyes:glasses/diplopia/pain/discharge/perla Sclera: red/yellow/clear		
Ears:Hearing loss/tinnitus/vertigo/deformities/Hearing Aid		
Speech: Clear/slurred/coherent		
Ability to Swallow:		
Gait:		
Paresthesia:		
Weakness:		
Coordination:		
B. Cardiovascular: B/P: site/position		
Body Temperature & route		
Apical Pulse: rate/rhythm/quality		
Respirations:rate/labored/unlabored;Pulse oximetryO2sat		
Pain: location/frequency/duration/intensity on a scale of 0 - 10/provokes/palliates/quality/ radiates		
fatigue/dizziness/chest pain/numbness/tingling in extremities		
Arterial Pulses	Right	Left
	Carotid	
0 – Absent	Brachial	
1+ - Barely Palpable	Radial	
2+ - Decreased	Femoral	
3+ - Full (normal)	Popliteal	
4+ - Bounding	Posterior Tibial	
Symmetry	Dorsalis Pedis	

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

DATA COLLECTION	PHYSICAL ASSESSMENT	
D. Integumentary		
Color: pale/cyanotic/flushed/mottled/jaundice		
Temperature: warm/cold/moist		
Turgor/texture		
Mucous Membrane: Color/moisture/integrity		
Rashes: petechiae/ecchymosis/ulcerations scars/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:		
Gums/Tongue/Teeth: swelling/bleeding/discoloration/ inflammation/loose or missing teeth		
Last Bowel Movement/consistency/color		
Continence		
Bowel Sounds: present/ absent, hyper/hypo active		
Abdomen: soft/distended/tenderness/colostomy	RUQ	LUQ
	RLQ	LLQ
Parenteral Fluids:		
IV: Solution:		
Location:		
Rate:		
Site appearance:		
Gavage Feedings: (NG, PEG):		
Type:		
route:		
amount:		
frequency:		
residual:		

F. Genitourinary: Continence/ Incontinence:		
Urine output: frequency/ color/clarity/ odor/amount/ dysuria/ urgency		
Bladder distention:		
Vaginal/Penile Drainage:		
Catheter: type/patency/amount/site		
G. Musculoskeletal		
Extremities: deformities/ mobility		
ROJM:	Upper	Lower
Muscle Tonus/Strength:	R	R
Coordination/Gait/Balance	L	L
Pain/Tenderness/Edema		
Supportive Devices		
Casts/Brace/Splint		
H. Endocrine/Reproductive:		
Fatigue/wt.change/temperature intolerance		
Hair distribution/herpes/warts:		
Breast (masses/dimpling/ discharge/ pain/ mastectomy)		
Penis: location of meatus/ chancres/discharge/ tenderness/swelling		
Scrotum: lumps/swelling/ulcers/tenderness/ Testicles		

TEXTBOOK PICTURE (Definition, Major S/S, Treatment- link your patient's prescribed treatments to the textbook picture)

DATA COLLECTION: PHYSICIAN ORDERS

Date:	ORDERS:
Diet:	
Activity:	
Lab/Diagnostic Tests:	
Treatment/Therapies	
Medications:	

PHARMACOLGY DATA ANALYSIS

TRADE/GENERIC NAME	CLASSIFICATION	RXED DOSE	ACTION	SIDE EFFECTS

PHARMACOLGY DATA ANALYSIS

TRADE/GENERIC NAME	CLASSIFICATION	RXED DOSE	ACTION	SIDE EFFECTS

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TRADE/GENERIC NAME	CLASSIFICATION	RXED DOSE	ACTION	SIDE EFFECTS

PHARMACOLGY DATA ANALYSIS

TRADE/GENERIC NAME	CLASSIFICATION	RXED DOSE	ACTION	SIDE EFFECTS

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.**
WBC		↑Inflammatory and infectious processes, leukemia. ↓Aplastic anemia, viral infections.
RBC		↑ ↓Below NR – indicates anemia, hemorrhage
Hgb		↑COPD, high altitudes, polycythemia. ↓Anemia hemmorhage, overhydration.
Hct		↑Dehydration, high altitudes, polycythemia. ↓Anemia, hemmorhage, overhydration.
Platelet		↑Acute infections, chronic granulocytic leukemia, chronic pancreatis, cirrhosis, collagen disorders, polycythemia, postsplenectomy ↓Acute leukemia, DIC, thrombocytopenic pupura.
Pt Control **INR**		↑ Warfarin therapy, deficiency of factors I, II, V, VII, and X, vitamin K deficiency, liver disease.
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, postgastrectrectomy dumping syndrome.

DATA COLLECTION: **(document results of admission & current result & significance)**	**Diagnostic & Lab Tests**	
Ca		↑ Acute osteoporosis, hyperparathyroidism, Vitamin D intoxication, multiple myeloma. ↓ Acute pancreatitis, hypoparathyroidism, liver disease, malabsorption syndrome, renal failure, Vitamin D deficiency.
Albumin		↑Dehydration ↓ Chronic liver disease, malabsorption, malnutrition, nephrotic syndrome, pregnancy
Total Protein		↑Burns, cirrhosis (globulin fraction) dehydration. ↓Congenital agammaglobulinemia, liver disease, malabsorption
Urinalysis 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
Other tests/procedures related to client hospitalization (include normal, client results and significance).		

<u>DATA ANALYSIS:</u> (sources history; physical assessment; dx test/ labs; MD orders	**<u>NURSING DIAGNOSIS</u>**
______ ______ ______ ______ ______ ______	**P**______ **E**______ **S**______ ______ ______
______ ______ ______ ______ ______ ______	**P**______ **E**______ **S**______ ______ ______
______ ______ ______ ______ ______ ______	**P**______ **E**______ **S**______ ______ ______
______ ______ ______ ______ ______ ______	**P**______ **E**______ **S**______ ______ ______

DATA ANALYSIS: (sources history; physical assessment; dx test/ labs; MD orders	**NURSING DIAGNOSIS**
______ ______ ______ ______ ______ ______	P______ E______ S______ ______ ______
______ ______ ______ ______ ______ ______	P______ E______ S______ ______ ______
______ ______ ______ ______ ______ ______	P______ E______ _ S______ ______ ______
______ ______ ______ ______ ______ ______	P______ E______ S______ ______ ______

KINGSBOROUGH COMMUNITY COLLEGE

OF
The City University of New York

Student ____ Date(s) Experience _____________________
Client's Initials____

NURSING CARE PLAN

Nursing Diagnosis	**Expected Outcome & Criteria for Measuring**	**Nursing Actions**	**Rationale**	**Evaluation of Outcome**
Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

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Student ____ Date(s) Experience ____________________
Client's Initials____

NURSING CARE PLAN

Nursing Diagnosis	Expected Outcome & Criteria for Measuring	Nursing Actions	Rationale	Evaluation of Outcome
Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

KINGSBOROUGH COMMUNITY COLLEGE
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Student ______________________________ Date(s) Experience ____________________
Client's Initials______________________________

NURSING CARE PLAN

Nursing Diagnosis	**Expected Outcome & Criteria for Measuring**	**Nursing Actions**	**Rationale**	**Evaluation of Outcome**
Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

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Student ____ Date(s) Experience _____________________
Client's Initials____

NURSING CARE PLAN

Nursing Diagnosis	Expected Outcome & Criteria for Measuring	Nursing Actions	Rationale	Evaluation of Outcome
Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

Student's Nurses Note

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.

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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?

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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?

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D. Implementation –

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

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E. Evaluation –

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

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2. THERAPEUTIC INTERVENTIONS

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

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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?

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4. MANAGEMENT

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

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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?

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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	5
Identifies **ALL** Significant Findings	10
Identifies **ALL** relevant nursing diagnoses using the PES format	10
PLANNING (Develops Plan for 4 highest priority diagnoses – 3 physiological/1 psychological)	**(15)**
Prioritizes all identified diagnoses as HI-MED-LOW	5
Identifies appropriate client goals/desired outcomes	5
States criteria for evaluation of client goals/outcomes	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	2
Total Points possible	**100**

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