Instructions for use of the Nursing Assessment and Care Record (Form 54928)

Medicine Program
Misericordia and Grey Nuns Community Hospitals

APPROVED BY: Director Medicine and Surgery Programs at the Misericordia and Grey Nuns Hospitals

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REFERENCES
GENERAL
The booklet is a 24-hour assessment based record. It includes the following:
- Signature Log
- Fluid Balance, Intake & Output
- Intravenous Flow Sheet
- Braden Scale with suggested Interventions and Nutrition Interventions
- Patient Care Record
- Three, two-page assessment forms
- Activities of Daily Living

Additional assessment tools may need to be added, including items such as Vital Signs record, neurovascular assessment tool, pain flow assessment sheet.

PURPOSE
The purpose of the Nursing Assessment and Care Record Booklet is to:
- Consolidate and communicate patient assessment and care information to facilitate continuity of care.
- Standardize documents between the sites.

GUIDELINES FOR USING THIS DOCUMENT
It is expected when possible that the physical assessment and documentation be completed within the first half of your shift.

- Throughout the document, please be sure to use the symbols outlined in legends provided.

- A patient identification label is placed at the top right hand corner of each page.

- Signature Log. Place your legible printed name, signature and initials in the appropriate boxes.

- Space is provided for the date, time, and initials of assessor(s) on each assessment page. Joint patient assessments require co-signatures by both/all staff completing the assessment.

- Applicable boxes are check marked (√) and blanks are filled in if appropriate. Checkmarks on the ADL section of the document indicate an intervention/action has been performed.

- If assessment of a body system is not required, check off the □ Not Assessed.

- If a category does not apply to your patient (i.e. vaginal flow) check off the □ NA (not applicable) this indicates that this section does not apply to your patient.
Assessment findings that are abnormal or that need further description are asterisked (*). More explanation is required on the Patient Care Record.

On either the Intake and Output or ADL sections of the document, unused columns can be re-labeled to provide enough room to write.

'Complete' versus 'Focused' Assessment

- All assessments will be charted on the Nursing Assessment Record portion of the Medical and Surgical Patient Care Record.

Complete Assessment

**Definition:** Head to toe assessment covering all systems. Every section of the nursing assessment and care record must be completed.

Complete assessment is required on the day and evening shift for all patients.

- Complete assessment will be done twice a day; e.g. 0800 and 2000. Complete assessments are required on admission from the Recovery Room, Emergency Room, another unit, direct admission or from another hospital.

Focused Assessment

**Definition:** Assessment directed to one or more body systems. The extent of focused assessments is largely based on nursing judgment considering factors such as patient acuity, patient stability, and information from shift report. Focused assessment could be done on night shift or when a staff member takes on additional patient assignments during the shift or at shift change.

In these situations, a complete versus focused assessment is at the discretion of the nurse, based on patient acuity. **Communication between shifts is essential to ensure that the admission assessment process is complete.**

A complete or focused assessment may be required depending on staff changes, patient arrival time on units and the priority of the RN or LPN patient assignment.

Example: If you are working an eight-hour shift then switch to a twelve-hour shift keeping the same patients, complete one assessment. If you have a change in assignment then you need to do a focused assessment, at a minimum, on the new patients you will care for.

On night shift either a complete or focused assessment is required depending on the acuity of patients or unit specific policies.

Documentation Frequency

- The frequency of documentation and the amount of detail are dictated by a number of factors including:
- The policies and procedures of the practice setting
- The complexity of the health problem
- Degree to which the client’s condition puts them at risk
- Degree of risk involved in the treatment or care.

According to the Canadian Nurses Protective Society (CNPS), the recording of nursing care provided should be more comprehensive, in-depth and frequent if the client is very ill, has unstable health-care needs and unpredictable outcomes (Alberta RN, 2007, p.12).

**NURSING ASSESSMENT AND RECORD** (form 54928):

**Date**
Document the Date your shift started. i.e. If your night shift started at 23:30 hours on December 30th, and you finish your shift at 07:45 on December 31st, you would write “December 30th to December 31st “as the date in which you received the patient into care. Use 24 hour clock for time. There must be two dates recorded on the chart indicating the span of time over which the information is recorded.

**Intake and Output**
- This record covers a 24 hour period.
- Intake and output is to be documented in the corresponding boxes of time.
- Each shift is responsible for totaling their intake and output, and for clearing the pump(s).
- Sources of intake or output can be noted at the top of the form and the corresponding volume documented at the appropriate time.
- If a patient requires hourly totals they are to be added together at the end of the shift to produce a shift total. At this time the IV pump ‘total volume infused’ would be cleared.
- The numeric value recorded as urinary “bladder scan results” are not included in the output total, as this is not actual output, but a measurement of bladder stretching.
- At the end of the 24 hour time period the total intake from the day, evening and night shift is calculated and documented on the 24 hour intake line.
- At the end of the 24 hour time period the total output from the day, evening and night shift is calculated and documented on the 24 hour output line
- Calculate the patients 24 hour balance by subtracting the output from the intake. Indicate if the 24 hour fluid balance is negative or positive by checking the appropriate box.
- Depending on unit policy and patient need, totals of specific fluid intake or output can be tallied for the shift at the lower end of the column where it indicates ‘Totals’.
- It is not possible to accurately calculate 24 hour fluid balance when the patient is incontinent.
Fluid Therapy Sheet (IV and/or HDC)

- Fluid therapy is to be documented at the beginning of the shift as well as throughout the shift. At the beginning of a shift, document the IV’s and/or HDC that is infusing on your initial round. Throughout the shift, any IV fluid that is hung or IV access change i.e. saline lock is to be documented on the Fluid Therapy Record. Indicate time, type, site location, cannula size, action, amount and type of solution, rate in mL/hour, tubing changes, injection cap changes, reason for removal and initials. When appropriate use the legend provided.
- If more than one solution is infusing into one lumen of the access device, put a bracket ( { ) around the IV solutions that are infusing into the lumen.
- Cannula size. For CVC/PICC document the ports by indicating, “Distal, Medial, or Proximal”.

If your patient does not have any of the access types check off □ NA

Braden Scale for Predicting Pressure Score Risk / Nutrition

- Completed on admission and subsequently once every 24 hours on the day shift.
- The assessment categories and definitions are provided for reference. Check the boxes that apply to your patient and total the score. Initial and date.
- Fill in or check off the appropriate Braden Scale interventions that apply to the patient.
- By checking the “Care Protocol Risk Category”, you are indicating the plan of care for performing pressure relieving interventions. The time when these interventions are completed should be indicated in the “ADL, Braden Interventions” section and narrative documentation as required.

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<tbody>
<tr>
<td>Ability to respond meaningfully to pressure-related discomfort.</td>
<td>Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished LOC or sedation OR limited ability to feel pain over most of body.</td>
<td>Responds only to painful stimuli. Cannot communicate discomfort by moaning or restlessness Or has a sensory impairment which limits the ability to feel pain or discomfort over half of body.</td>
<td>Responds to verbal commands but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</td>
<td>Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.</td>
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<tr>
<td>Degree to which skin is exposed to moisture</td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</td>
<td>Skin is often but not always moist. Linen must be changed at least once a shift.</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
<td>Skin is usually dry; linen only requires changing at routine intervals.</td>
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<tbody>
<tr>
<td>Degree of physical activity</td>
<td>Confined to bed.</td>
<td>Ability to walk severely limited or non-existent. Cannot weight-bear and/or must be assisted into chair or wheelchair.</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</td>
<td>Walks outside the room at least twice a day and inside every two hours during waking hours.</td>
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<tbody>
<tr>
<td>Ability to change and</td>
<td>Does not make even</td>
<td>Makes occasional slight changes in body or</td>
<td>Makes frequent though slight changes in body</td>
<td>Makes major and frequent changes in</td>
</tr>
<tr>
<td>Control Body Position</td>
<td>Slight changes in body or extremity position without assistance.</td>
<td>Extremity position but unable to make frequent or significant changes independently.</td>
<td>Extremity position without assistance.</td>
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**Nutrition Usual Food Intake Pattern**

<table>
<thead>
<tr>
<th>1. Very Poor</th>
<th>Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Probably Inadequate</td>
<td>Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum of liquid diet or tube feedings.</td>
</tr>
<tr>
<td>3. Adequate</td>
<td>Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered OR is on tube feeding or TPN regimen which probably meets most of nutritional needs.</td>
</tr>
<tr>
<td>4. Excellent</td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings or meat and dairy products. Occasionally eats between meals. Does not require supplementation.</td>
</tr>
</tbody>
</table>

**Friction and Shear**

<table>
<thead>
<tr>
<th>1. Problem</th>
<th>Requires mod - max assist in moving. Complete lifting without sliding against sheets is impossible. Frequently slides in bed or chair, requiring repositioning with max assistance. Spasticity, contractures or agitation lead to almost constant friction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Potential Problem</td>
<td>Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</td>
</tr>
<tr>
<td>3. No Apparent Problem</td>
<td>Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.</td>
</tr>
</tbody>
</table>
Nutrition Interventions

- Mark NA: if anticipated LOS less than 3-4 days unless patient is perceived to have high nutrition risk or if nutritional consult specifies

- Circle the appropriate level of feeding assistance needed (self, assisted, total).

- Document the type of diet (from the legend) that the patient consumed at breakfast, lunch and supper. This can change from meal to meal. Example: NPO @ breakfast, regular @ lunch and supper.

- Document the estimated meal intake for breakfast, lunch and supper. This should be documented as a percentage. Please use the following percentage values to indicate the approximate amount of food consumed - 0%, 25%, 50%, 75% or 100%.

- Document if a supplement is given. Supplements may be given on the meal trays if ordered by the dietician @ breakfast, lunch, and supper. Document the estimated supplement intake. This should be documented as a percentage. Please use the following percentage values to indicate the approximate amount of the supplement consumed - 0%, 25%, 50%, 75% or 100%.

- Document if snacks have been consumed in the same manner above. Snacks are given in the AM, PM, and at HS if ordered by the dietician. Please use the following percentage values to indicate the approximate amount of the snack consumed - 0%, 25%, 50%, 75% or 100%.

- Indicate if the patient is on TPN, and whether it has been ordered as a continuous or cycled infusion. The rate will be documented in the IV section.

- Indicate whether the patient is receiving enteral nutrition, followed by the formula used, and the correct rate as ordered.

- Enteral feeding rate changes must be indicated with * (asterisks) and documented in the Patient Care Record.

- Indicate in the time spaces provided the amount of enteral tube feed residuals that you have checked throughout your shift.

- Med Pass – Indicate if your pt has been ordered supplements with medication administration by checking off yes or no. The formula in which we are using to supplement, the amount ordered, and the times in which they are to be given will be documented in the Med Pass Program sheet provided by the dietician and found in your MAR binder.

- Indicate by checking off yes or no if the patient has been ordered by dietary to receive the administration of pectin and/or protein. You must circle either the pectin, protein or both to indicate which have been ordered.
Patient Care Record – Narrative Notes

- Use this area for narrative charting of abnormal findings or any other documentation not described in the documentation tool. Chart per Policy/Procedure #V-20, Patient Chart Documentation.
- At a minimum, staff should document the time a patient was received into care. Staff members are also expected to document the time, general condition, and method of transport when patients leave and return to the unit following procedures, etc.

Patient Assessment Record

- **Central Nervous System** (must always be assessed)
  
  Neurological Assessment
  - Check all appropriate boxes. *Every shift must determine if a patient is responsive.*

  Orientation
  - Check the boxes provided if the patient is oriented to person, place, and time.
  - Checking “Confused”, the observed behavior(s) must be documented in the narrative charting in the Patient Care Record. E.g. *patient confused to time and place - believes he is on a cruise ship.*
  - Checking “Communication Barrier”, the observed behavior(s) must be documented in the narrative charting (i.e. language, blind, deaf, expressive or receptive aphasia) in the Patient Care Record.
  - Checking restless (unable to physically settle self), drowsy (sleepy but rousable), agitated (unable to settle self requiring frequent reassurance or assistance), sedated (sleepy and difficult to rouse), the observed behavior(s) and intervention(s) must be documented in the narrative charting in the patient care record.

- **Cardio Vascular System** (must always be assessed)
  
  When the cardiovascular system is assessed check off the appropriate boxes.
  - If Extremity Neurovascular Assessments are being done, check this box, which alerts readers to the fact this information is not recorded on this form.

- **Pain** (must always be assessed)
  
  - Check the "denies pain" box if the patient denies pain upon questioning.
  - Rate the patient’s pain on a scale of 0-10 when 0=free from pain and 10=the worst pain that they could imagine. Rate the patient’s pain at rest and/or during activity.
  - Write the location of the pain on the line provided beside pain site(s).
  - Check box if patient has *PCA* (patient controlled analgesic), *epidural*, Regional Nerve Block or any other type of analgesic (e.g. subcutaneous infusion). If the box labeled *other* is checked, please identify the device.
being used on the line provided (e.g. Fentanyl patch, HDC).

- If an Adult Inpatient Pain Assessment flow sheet is being used, please check the box provided and complete the Adult Pain Assessment Flow Sheet accordingly.
- Checking **Unable to Assess**, the reason must be documented in the narrative charting in the Patient Care Record.
- If the box “Anesthetic in last 4 hours” is checked, this is an indicator that the patient is at increase risk for falls

- **Infection Control Additional Precautions**
  - These refer to additional isolation precautions.

- **Limb Compression**
  - If the patient does not require compression therapy, check off □ NA. Otherwise check off what applies to the patient.

- **Oral Status**
  - Check □ Not Assessed if the oral status was not assessed. When the oral status is assessed, check the appropriate box. (See policy “Oral Care Protocol for Adult Patients # VII-D-23).

- **Respiratory System (must always be assessed)**
  - Mark appropriate box(s) and use legend when indicated

- **Oxygen**
  - If the patient is receiving oxygen record the flow rate and check the box for the delivery device in use.

- **Assisted Ventilation**
  - CPAP or BiPAP: Check the box if either is in use.
  - Check **Artificial Airway** if applicable, indicate what type, and document in the Patient Care Record.

- **Auscultation**
  - Utilizing the legend provided (note on the graphic of the lung fields) the breath sounds heard in each lobe.
  - Ideally, posterior auscultation should be completed. If not possible, ensure lower lateral lobes are included with an anterior auscultation.

- **Chest Tubes**
  - Check □ NA if the patient does not have chest tube(s).
  - For each chest tube in place use the grid to note the location of chest tube(s), bubbling (air leak meter number), fluctuation of fluid in the tubing: Yes (Y) or No (N) character of drainage, centimeters of negative pressure ordered and set (or note “to gravity” if not suction), and status of dressing.
  - Palpate the tissue surrounding the chest tubes for subcutaneous emphysema and note location.
Gastro Intestinal System
Mark appropriate box(s)
- Check □ Not Assessed or □ NA if not appropriate for the patient.
- Ostomy- document drainage character and consistency
- Circle either ileosotomy or colostomy, or both, to indicate the type of ostomy

Gastric/Feeding Tubes
- For other write in anything you want to add about color and consistency or contents of drainage
- For assessing position of gastric tubes refer to, Perry & Potter: Clinical Nursing Skills & Techniques.

Genito-Urinary System
- Check □ Not Assessed or □ NA if not appropriate for the patient
- Mark appropriate box
  Urine
  - Urine character (if seen- document color, consistency and odor)

Catheter
- For stent(s) identify their location

Nephrostomy Tube
- Stents: note number of stent(s)

Dialysis
- Site condition- note your assessment and document in long hand charting section anything requiring treatment

Vaginal Flow
- Check □ NA if not appropriate for the patient
- Otherwise indicate findings as appropriate

Incisions and Drains
- Check □ Not Assessed or □ NA if not appropriate for the patient
- Mark appropriate box(s)
  Site (for each incision)
  document location of incision
  Drains (for each drain)
  Document type (i.e. Jackson Pratt, hemovac, or Penrose)
  Drainage: document color and consistency of drainage fluid
  Skin condition
  - Mark appropriate □
  - Use diagram and legend to indicate areas of concern
  - Circle area draw a line to the right or left of the diagram and indicate legend
  - For Negative Pressure Therapy (NPWT) document amount & type of suction

NOTE: all intervention should be documented in narrative notes
Musculoskeletal System

Check □ NA if not applicable to the patient
- Refer to Legend
- DESCRIPTION: Identify specific appliance with number
- LOCATION: Describe location e.g.: Left hand
- APPEARANCE: condition of appliance e.g. intact and dry, wet and soft
- PIN SITES: check if indicated, identify location and skin condition around insertion.
- EQUIPMENT Safety CHECK:
  e.g.: Ensuring that all knobs, bolts screws robes etc. are secure and taped if required.

Weight Bearing Status
To be completed when weight bearing status is ordered by the physician or suggested by physiotherapy.
Mark appropriate □ for weight bearing status
- WBAT (weight bearing as tolerated)– as much weight as tolerated by the patient
- PWB (partial weight bearing)– up to 50% of the patient’s body weight
- FeWB (feather weight bearing) – 25% or less of the patient’s body weight
- NWB – (non-weight bearing), no pressure through the affected limb
- The “affected limb” refers to the limb affected by the weight bearing status.

Activities of Daily Living
- Use the symbols outlined in the legends provided.
- Checkmarks on the ADL section of the document indicate an intervention/action has been performed.
- The 24-hour flow chart was designed to capture the nursing care provided within a 24 hour time period. The vertical columns capture the 24 hours in a day. The rows capture the activities of nursing care. DO NOT draw an arrow or a line across the boxes. According to legal, an arrow or line indicates an “assumption” of care was provided between the times.

Example:

Do NOT chart with arrows or lines

<table>
<thead>
<tr>
<th>Time</th>
<th>08</th>
<th>09</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
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<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>B</td>
<td>C</td>
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</table>
Throughout a 24 hour time period many of the nursing care activities will be done numerous times. The person completing the documentation can fill in the boxes for his/her nursing care throughout their shift, as well as see what the previous shift has completed. Those doing care for others may also document the care they did (if allowed within their scope of practice).

The legend at the bottom of the documentation tool details the acceptable abbreviations for use in the 24-hour flow chart. The headings of the legend correspond to the headings on the left hand side of the tool.

To complete the flow chart portion of the documentation tool, find the legend abbreviation and the corresponding heading. Place the abbreviation in the box with the time the task/activity was performed. When any of these actions are performed, follow the row of the activity to the corresponding time column and complete the box.

If there is no corresponding legend for that particular activity or task place a checkmark in the box. A checkmark indicates completion of the assessment/intervention and findings are unremarkable.

If further charting detail is required for the activity or task, place an “*” asterisk in the box and document in the narrative notes.

Initial at the bottom of the page in the initials box to complete the documentation.

A checkmark in the IV site(s) Assessment row means the site is unremarkable. An asterisk would indicate that further information about the IV site condition or function. Covenant Policy # IV-45

- **Hygiene**
  - Hygiene consists of the nursing care done for basic activities of daily living (ADL). This will include bathing; skincare/moisturize; oral/nose care, pericare/cath care; shampoo/ shave. When any of these ADL’s are performed, follow the row of the activity to the corresponding time when the ADL was completed and fill in the box. Each time an ADL is performed it is to be documented on the 24-hour flow chart.

- **Activity**
  - Activity describes a patient’s mobility. This includes bed rest, bathroom privileges, use of a bedside commode, up in chair or ambulating and how many people it takes to assist a patient with their mobility.
  - For “sleeping” – mark “Y” if sleeping and mark “N” if awake, under the hourly time the nurse visualized the patient. For example, on hourly rounds during a night shift.
Respiratory
- Check which respiratory interventions are in use for the patient

Pain Management
- Pain Management is documenting a patient’s pain score, whether an intervention was done, and evaluating the intervention. The administration of analgesic should be documented in the MARS. Other intervention details should be documented in the narrative notes.

Safety
- Safety encompasses restraint use, bed alarms, call bells, side rails, and height of the bed. A patient in restraints must have assessment and documentation. On the flow chart it must be documented if the restraints are on or released. If the restraints are on there must be supportive documentation in the narrative notes to explain the patient’s behavior and the continuing need for the restraint. When the restraints are discontinued it must also be documented.
- Fall Risk ID Card – indicate the increased Fall risk has been identified for the patient writing a “M” for moderate risk or an “H” for high risk for falls in the hourly checkbox corresponding with when the Fall Risk Card is initiated/reassessed/or status is changed. Please note that significant changes in Fall Risk status requiring further description may be indicated by an asterisk (*) at the time of the corresponding hour checkbox on the ADL sheet, with further documentation in the narrative notes as required.
- Frequent Orientation – For patients requiring frequent orientation, use a checkmark (✓) in the hourly checkbox corresponding with when the reorientation of the patient to person, place or time is performed. At the end of the shift, staff would need to add a narrative note describing the ongoing orientation of the patient (E.g.: “Patient successfully reoriented for short periods of time throughout shift to person and place - see ADL flow sheet.) Please note that significant changes in cognitive status requiring further description would be indicated by an asterisk (*) at the time of the corresponding hour checkbox on the ADL sheet, with further documentation in the narrative notes as required.
- Use of vision and hearing aids/equipment, checked/available with any additional sensory supports in place (teeth/dentures).
- Frequency of safety checks will depend on condition/acute of patient. E.g. confused/cognitively impaired patient requires more frequent checks than stable/cognitively intact patient
- Bed alarm – “A” indicates the alarm is on (activated) and “I” indicates the alarm is off (inactivated).
- Fall risk cards updated frequently.
- Patient/family provided with cueing on risk and to seek assistance for mobility.
- Patient provided with frequent orientation to daily activities, date/time of day, etc.
Braden Interventions
- The Braden interventions will be dictated by the Braden score on the previous page and clinical nursing judgment.
- Document the times that the heels were elevated off the bed.
- Document the times that the head of the bed was less than or equal to 30 degrees unless contraindicated. Document when pillows were used to re-position the patient.
- Document the times when off loading heels was performed.
- Document the time that the patient was turned or repositioned using the legend. (S-supine, L-left, R-right, P-prone)
- Document when the patient was toileted to prevent moisture related damage. If the patient is up at lib, disregard this section.

Miscellaneous
- Miscellaneous includes interventions not covered by the other categories. These interventions include compression devices, (i.e. pneumatic stockings, TEDS, tubigrips); dressing changes, and IV site assessment.
- Family visit/call or family conference also falls within this heading.
- Each time one of these interventions is done follow the row to the appropriate time involved and place a checkmark.
- IV site(s) assessment is to be done hourly and documented accordingly.
- Not all boxes will be filled in as some nursing care is not done every hour. The exception to that are restraints, call bell, and IV site(s) assessment which are to be done hourly and documented.
- Family and patient education on unit initiatives or special needs falls here.

- Document the type of bed surface the patient is on (either a standard mattress and frame or a specialty mattress). Chart exact name of bed, e.g. Versa Care, Eclipse. Document if any special seated surfaces are in use to redistribute the pressure (for example Ro-Ho cushions/foams).

REFERENCES