

Basic Assessment of Patient

- 1). VS (T, HR, BP, Resp, O₂ sat) Notify charge RN if abnormal (*see reportable assessment*)
- 2). Feel for peripheral pulses - radial/brachial/dorsalis/pedal
- 3). Symmetry of extremities
- 4). Temperature of extremities, CMS
- 5). Edema (*see edema scale*)
- 6). Lung sounds, anterior and posterior
- 7). Bowel sounds
- 8). Any dressing check for drainage, old and new, placement and aseptic appearance
- 9). Drains, tubes, catheters, check for patency and note quantity q8hrs
- 10). Check skin while doing above. Check bilateral heels and sacrum q8hrs (*see skin care assessment*)
- 11). Check any machine or apparatus attached to patient for maintenance..
- 12). Assess IV site appearance, noting redness, streaking, warmth, edema, pain
- 13). Pain? Constipation? Ask client for any problems or concerns that they have. (*see adult pain scale*)

Pediatric Assessment

*Copy of normal VS for peds

Respirations - get them first

Head circumference

Chest circumference

Weight

I&O - nurse must know because children cannot tell you.

Remember to count diapers and formula+spit-up

Age	Avg pulse	Avg resps.	Systolic BP	Diastolic BP
infant	80-180	20-40	74-100	50-70
toddler	80-140	20-30	80-112	50-80
preschooler	70-115	20-25	82-110	50-78
school age	65-110	17-22	84-120	54-80
adolescent	60-90	15-20	94-140	62-88

CHILD PAIN SCALE

Wong-Baker Faces Pain Rating Scale



Laboratory Values

Electrolytes

Sodium (Na ⁺)	135-145 mEq/L
Potassium (K ⁺)	3.5-5.0 mEq/L
Calcium (Ca ⁺⁺)	4.3-5.3 mEq/L
Magnesium (Mg ⁺⁺)	1.5-1.9 mEq/L
Chloride (Cl)	95-108 mEq/L
Bicarbonate (HCO ₃ ⁻)	22-26 mEq/L
Phosphate (HPO ₄ ²⁻)	1.7-2.6 mEq/L

Arterial Blood Gases

pH	7.37-7.43
acidosis	< 7.37, alkalosis > 7.43
pCO ₂	80-100 mmHg
(partial pressure of CO ₂)	
pO ₂	22-26 mEq/L
(partial pressure of O ₂)	
HCO ₃ ⁻	22-26 mEq/L
(amount of bicarbonate in blood)	

Emergency Assessment

A- Airway and cervical spine

patent
stabilize cervical spine

B- Breathing

maintain the airway
observe respirations
uneven chest movement
labored
cyanosis
gasping
coughing up blood
nasal flaring
wheezing/stridor
chest injury - plug any hole in chest wall immediately!

C- Circulation and Bleeding

palpate pulse
reassess breathing
may have to begin CPR
watch for shock
rate of capillary refill

D- Disability

A, V, P, R Neuro

A-Alert-speaks and moves spontaneously

V-Verbal-answers to verbal stimuli

P-Pain-answers to painful stimuli

U-Unresponsive

Eyes - PERRLA + C

PE-Pupils Equal
(*see pupil size diagram*)

R-Round

RL-React to Light

A-Accommodation

C-Coordinated

E- Expose and Examine

anywhere you might think there's an injury
anywhere the person complains about

Post Partum Assessment

Temp - up to 101° in first 24 hrs OK, but not higher or for longer than 24 hrs.

Pulse - check for both bradycardia (which is not unusual) and tachycardia (which could be a sign of blood loss)

If dizzy, check **BP**

Nipples - dry, cracked, inverted, erect

Breasts - soft, engorged, firm

Involution of fundus - 1cm/day have pt. check q 8hrs

Lochia - color

rubra=red 1st 2 days

serosa=pink-brown next 7days

alba=yellow-white starts day10

Lochia - amount

scant <1" on pad

light <4" on pad

moderate <6" on pad

heavy = pad saturated <1 hour

Bladder - empty 300-400 mL at a time

fundus at midline and firm

DVT-----assess legs, look for Homan's sign

perineum--turn on side

hemorrhoids

if C-section; also check

lungs because of

anesthesia

have pt TCDB

bowel sounds

pain

incision

Laboratory Values (cont)

Hematology

Hct(hematocrit)

Normal Ranges

males 45-52%

females 37-48%

RBC(red blood cells)

males 4.6-6.2 million/mm³

females 4.2-5.9 million/mm³

WBC(leukocytes)

4,300-10,800/mm³

Coagulation

PTT

30-45 sec

INR

2-3 (for therapeutic results)

Bleeding Time

3-7 minutes

Platelets

150,000-300,000/mm³

Blood Chemistry

BUN

8-25mg/100mL

serum creatinine

70-130mL/minute

Urinalysis

specific gravity

1.010-1.025

creatinine clearance

0.6-1.5mg/100mL

Skin Care Cheat Sheet

Assess the Skin

Integrity

(blister, excoriation, ulceration)

Location

(underlying bony prominence?)

Color

(purple, red, black, etc.)

Satellite Lesion

(red dots, usually on periphery; indicates presence of candida)

Evaluate for Causative Factors

Moisture

(incontinence, diaphoresis, drainage)

Friction

(elevated HOB, drawsheet lifts--R/O skin shearing)

Pressure

(bony prominence, pannus skinfolds, drainage tubes)

Initiate Treatment

- Apply dressing to manage exudate and protect from further trauma.
- If dressing doesn't stay in place for at least 24 hours: D/C dressing and use skin barrier products per protocol.
- If satellite lesions are present, with or without excoriation, check with MD for ointment orders..
- Pressure and moisture-related skin damage may require an overlay mattress per protocol.

Reportable Observations

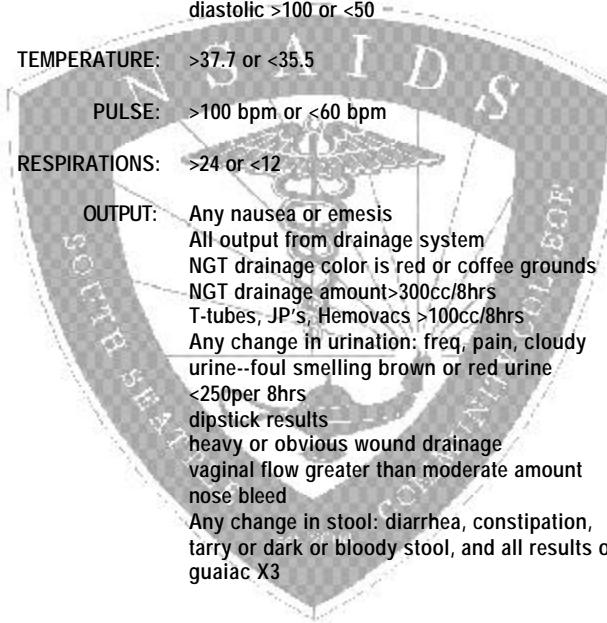
BP: systolic >150 or <100
diastolic >100 or <50

TEMPERATURE: >37.7 or <35.5

PULSE: >100 bpm or <60 bpm

RESPIRATIONS: >24 or <12

OUTPUT: Any nausea or emesis
All output from drainage system
NGT drainage color is red or coffee grounds
NGT drainage amount >300cc/8hrs
T-tubes, JP's, Hemovacs >100cc/8hrs
Any change in urination: freq, pain, cloudy urine--foul smelling brown or red urine <250per 8hrs
dipstick results
heavy or obvious wound drainage
vaginal flow greater than moderate amount
nose bleed
Any change in stool: diarrhea, constipation, tarry or dark or bloody stool, and all results of guaiac X3



Glasgow Coma Scale			Modified Coma Scale For Infants		
Activity	Best Response		Activity	Best Response	
Eye Opening	Spontaneous	4	Eye Opening	Spontaneous	4
	To speech	3		To speech	3
	To pain	2		To pain	2
	None	1		None	1
Verbal	Oriented	5	Verbal	Coos, babbles	5
	Confused	4		Irritable	4
	Inappropriate words	3		Cries to pain	3
	Nonspecific sounds	2		Moans to pain	2
	None	1		None	1
Motor	Follows commands	6	Motor	Normal movement	6
	Localizes pain	5		Withdraws to touch	5
	Withdraws to pain	4		Withdraws to pain	4
	Abnormal flexion	3		Abnormal flexion	3
	Extend	2		Abnormal extension	2
	None	1		None	1

Adult Pain Scale

- 10 **Emergency Situation**
- 9 **Intense:** Regular use of antiinflammatory and/or muscle relaxers. Activity limited to necessary self-care.
- 8 muscle relaxers. Activity limited to necessary self-care.
- 7 care.
- 6 **Moderate:** Probably using regular pain medication, possibly muscle relaxers. Activity very limited, but functional for family and social roles.
- 5 medication, possibly muscle relaxers. Activity very limited, but functional for family and social roles.
- 4 very limited, but functional for family and social roles.
- 3 **Low:** No pain medications. Normal levels of activity
- 2 activity
- 1
- 0 **No Pain**

Report

chem-sticks, bladder ultrasound (PVR), O₂ sat results outside parameters to RN and document.
loose or soiled dressings
problems with swallowing or chewing
poor dietary intake
change in level of consciousness (LOC)
sedation, confusion (new), restless, anxiety
change in mobility: dizziness, witnessed unsteadiness
Risk for falls

Any c/o pain, discomfort or pressure, c/o acid indigestion, pain in extremities, IV site, abdominal distension

Change in skin color/moistness/pallor/cyanosis/diaphoresis

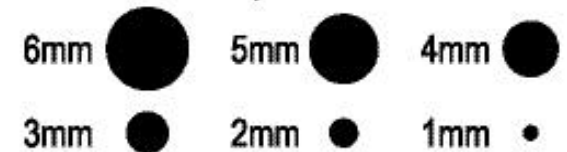
Report pump alarms and low IV/TF bags

Credits:

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Pupil Size:



Reaction: N-normal, S-sluggish, F-fixed

DATE	TIME	PUPIL SIZE		EXTREMITY MOVEMENT/RESPONSE	GLASGOW COMA SCALE			VITAL SIGNS									
		R	L		VERBAL	MOTOR	EYE	RESP	RESP	BP	PULSE	RESP					

Edema Scale (Pitting Edema)

- 0.....none observed
+1.....minimal < 2mm
+2.....depression 2-4mm
+3.....depression 5-8mm
+4.....depression > 8mm