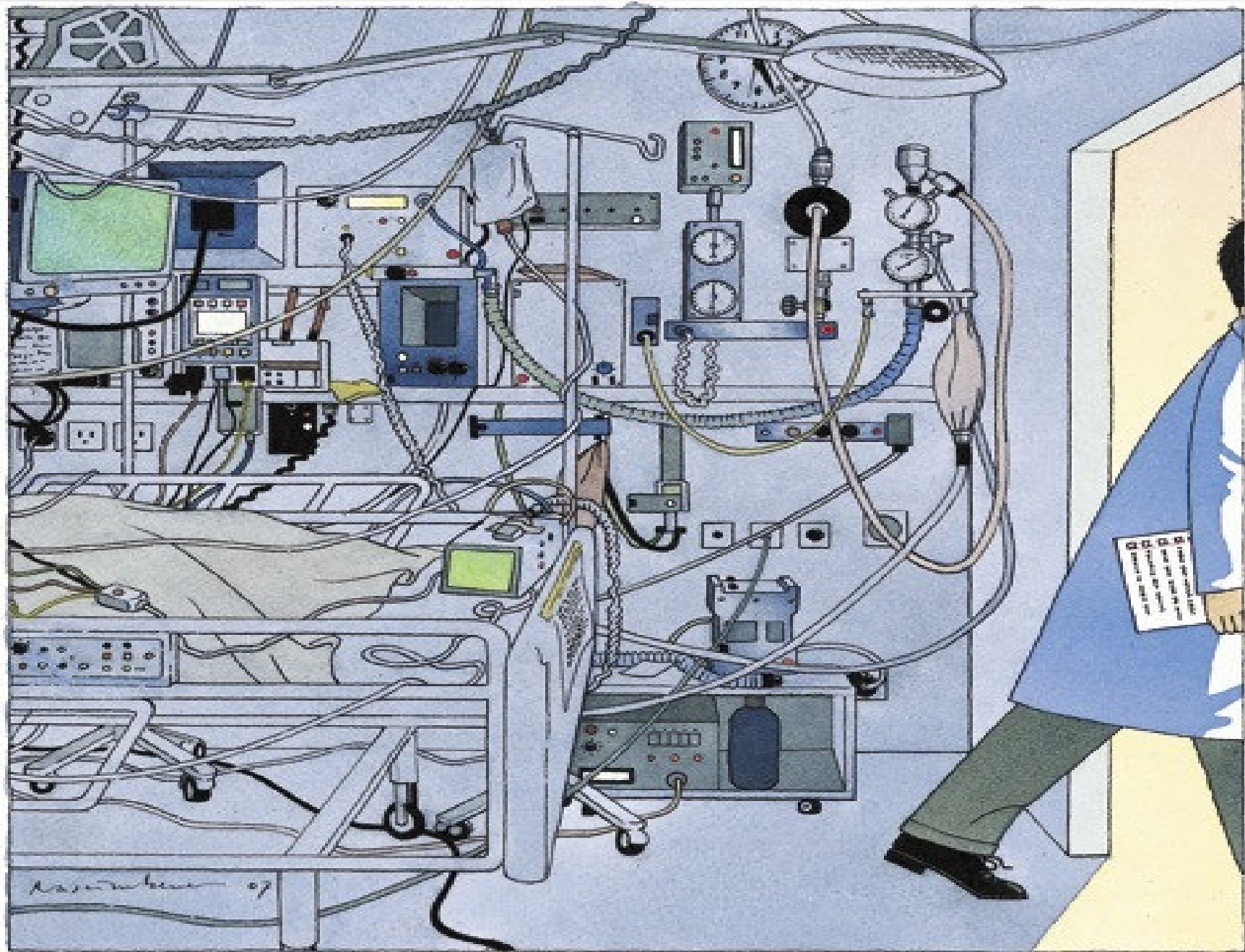


Patient assessment: the experience at AUBMC

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Asamblea 07

What we **believe** patient assessment is for:

- For planning of care
- For continuity of care
- For monitoring efficiency/outcomes of interventions
- For multidisciplinary coordination of care
- For trusting relationship with the patient
- For the nurses' image
- For elevating the professionalism in nursing practice



We make it an **Expectation**

- Part of the job description
- Part of the performance appraisal
- When NM, APN, and CE round
- During multidisciplinary rounds



Employee Name:	Job Title: RN -unit	ID #:
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III. Critical Functions & Accountabilities: Specific results expected to be achieved during the evaluation period (or project)	Expected Standards / Outcomes	Relative Weight	Score	Weighted Score
<p>A. To provide age-specific patient-centered care utilizing the nursing process:</p> <p>A.1. Perform patient assessment:</p> <ul style="list-style-type: none"> a. Collect initial pertinent (physical, psychological, cultural, and educational needs) data using appropriate and age-specific assessment techniques that provide the baseline for the plan of care. b. Involve the patient, significant others, and health care providers in data collection when appropriate. c. Ensure that the data collection process is systematic and ongoing. d. Document relevant data in the medical record according to hospital/departmental standards. 	<p>~ Accurate, thorough, and up-to date age-specific patient assessment according to hospital/department/unit policies and guidelines. (Refer to chart reviews and anecdotes).</p>	<p>10%</p>		<p>Score out of Range</p>

Policy

- Based on JCI and MOH
- Policy on assessment and reassessment
- Specialty-based



American University of Beirut
Faculty of Medicine
& Medical Center



AUBMC_Assessment & Reassessment of
Inpatients_0708_2nd Ed

Title:	Assessment and Reassessment of Inpatients	Index Number:	AOP-MUL-003 <small>(Func. - Categ. - Sr.No.)</small>	
Function:	Assessment of Patients	Category:	Clinical Services	
Scope of application:	Clinical, Nursing, and Other Professional Services	Original Date:	Reviewed On:	Next Review Date:
		05.10.2005	16.07.2008	16.07.2011

1. Policy

- 1.1. All patients at the American University of Beirut Medical Center (AUBMC) receiving inpatient services shall have an initial assessment and appropriate follow-up reassessments based upon their individual needs.
- 1.2. The assessment of inpatients shall be a multi-disciplinary process involving medical, nursing, and other healthcare professionals involved in the patient care process.
- 1.3. The initial assessment findings shall provide information to form an initial diagnosis.
- 1.4. Individualized initial assessments for special populations (very young patients, frail adults, women in labor, etc.) shall be used to determine and prioritize the patient's needs and plan of care.

The main points of the policy:

- **All patients** should be assessed and reassessed
- **Multidisciplinary** process
- **Individualized** for special populations
- The **basic** minimums:
 - Physical status
 - Psychosocial status
 - Nutritional status
 - Functional status
 - Pain
 - Educational needs
 - Fall risk
 - Discharge planning
- Assessment **timeframe** matrixes and **documentation** matrixes



AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER
Inpatient Assessment and Reassessment Documentation Timeframe Matrix

Specialty / Staff Category	Medical	Surgical Gynecology ENT Ophth.	Anesthesia	Pediatrics	Obstetrics L&D	Obstetrics Post Partum	Nursery	Critical Care Units	CCCL
Medical Staff									
Assessment	4 hrs	4 hrs	Pre-operative (within 30 days) Pre-Induction brief reevaluation	4 hrs	4 hrs	4 hrs	4 hrs	4 hrs	4 hrs
Reassessment Acute phase patients	Daily	Daily	Within 48 hrs post operatively	Daily	Daily	Daily	Daily	Daily and as needed	Daily
Reassessment Non-acute phase patients	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days	Once every 7 days
Nursing Staff									
Assessment	8 hrs	8 hrs	<u>PACU</u> First 15 minutes	8 hrs	8 hr	8 hrs	<u>NICU</u> 2 hours <u>Nursery</u> Within 24 hrs	<u>CCU/ICU/CSU/RCU/</u> <u>PICU</u> 2 hrs	8 hrs
Reassessment	Every shift and as needed. Acuity levels I and II are not assessed during the night shift	Every shift and as needed. Acuity levels I and II are not assessed during the night shift.	<u>PACU</u> Every 15 min. for the first 2 hours & every 1 hour thereafter	Every shift and as needed. Acuity levels I and II are not assessed during the night shift	<u>DS</u> NVD: vital signs immediately post delivery and before transfer Post c/section vital signs every 15 min for the first 1 hour & then every 1 hour for 2 hours. Or as ordered.	Every shift and as needed. Acuity levels I and II are not assessed during the night shift	<u>NICU</u> Every shift & as needed / ordered <u>Nursery</u> Once every 24 hrs	<u>CCU /</u> <u>RCU/ICU/CSU/PICU</u> Every shift and as needed / ordered. Acuity levels I and II are not assessed during the night shift	Every shift and as needed. Acuity levels I and II are not assessed during the night shift
Inhalation Therapist									
Assessment	Patients on mechanical ventilation: Immediately								
Reassessment	Patients on mechanical ventilation: Every 8 hrs								
Dietitian									
Assessment	High risk (score ≥ 4): Within 48 hours after initial screening Moderate risk (score 2-3): Within 72 hours after initial screening (during normal working hours) Low risk (score < 2): Upon request								
Reassessment	High risk: at least 3 times / week until goals are achieved, then once / week Moderate risk: at least 2 times / week until goals are achieved, then once / week Low risk: Upon request								
Social Worker									
Assessment	Immediately upon request or the same day when they are informed for discharge of patients Other patients: Within 24 hrs after referral to Social Service								
Reassessment	As needed								
Physical Therapist									
Assessment	Within 24 hrs (for referred patients)								
Reassessment	Acute cases: Daily according to treatment plan Chronic cases: Weekly								
Psychosocial Therapist									
Assessment	During the initial visit to the Children's Cancer Center in Lebanon								
Reassessment	Repeated every 6 months								

AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER

Inpatient Assessment and Reassessment Content Matrix

(All entries in the patient's medical record shall reflect the date and time)

AOP-MUL-003
Appendix 7.2

Specialty / Staff Category	Medical	Surgical	ENT / Opth.	Anesthesia	Pediatrics / Neonatology	Obs, L&D & Gyn.	Critical Care Units	CCCL
Nursing Staff								
Assessment	Nursing Data Base	Nursing Data Base OR Operating Room Nurses Record	Nursing Data Base	PACU Post Anesthesia Nurses Record	Pediatric: Nursing Data Base Nursery Nursing Data Base	L&D Nursing Data Base Obs / Post-partum Nursing Data Base	CCU, RCU, CSU, ICU Nursing Data Base PICU Nursing Data Base	Regular Admissions Nursing Data Base Short Stay Nursing Data Base
Reassessment	Patient Reassessment- Medical Surgical	Patient Reassessment - Medical Surgical	Patient Reassessment - Medical Surgical	Post Anesthesia Nurses Record	Flow Sheet - Pediatric NICU Flow Sheet - Neonatal Intensive Care Unit	DS Flow Sheet / Record	Patient Reassessment CCU Flow Sheet - ICU Flow Sheet - CSU Flow Sheet - RCU Flow Sheet - PICU	Flow Sheet Pediatrics Short Stay Multidisciplinary Notes
Inhalation Therapist								
Assessment (IT1)	Patients on mechanical ventilation: Ventilation mode, patient data (measured parameters), alarms setup, and other settings.							
Reassessment	Patients on mechanical ventilation: Ventilation mode, patient data (measured parameters), alarms setup, and other settings.							
Dietitian								
Assessment	No standard assessment format. Assessment findings are recorded on the progress notes of the patient's medical record.							
Reassessment	No standard reassessment format. Reassessment findings are recorded on the progress notes of the patient's medical record.							
Social Worker								
Assessment (S1)	Emotional, physical & medical data, social & environmental findings, household composition.							
Reassessment	As needed.							
Physical Therapist								
Assessment (PT1)	Assessment findings are recorded on the Physical Therapy Form according to the assessment guidelines. One copy of the Form is maintained in the patient's medical record.							
Reassessment	According to the treatment plan.							
Psychosocial Therapist								
Assessment (PsT1)	Assessment findings are recorded on the Psychomotor Assessment Form and a plan of care is initiated. The Form is kept in the Psychomotor therapist's Office.							
Reassessment	Repeated after 6 months to evaluate psychomotor progress.							
(S1) Department of Social Service Record		(PsT1) Psychomotor Assessment Form		(PT1) In-patient Evaluation Form			(IT1) Mechanical Ventilation Flow Sheet	

Forms

- Database
- Each area has specialty forms for physical assessment
- Pain assessment flow sheet
- PU assessment form
- Falls assessment
- Skin assessment
- Educational needs assessment



***Documentation
& Pt. Assessment
Training***

**American University of Beirut Medical Center
Nursing Services
Patient Assessment / Reassessment - Medical Surgical**

Patient Label

Patient Name: _____ Patient Number: _____

	<input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7 <input type="checkbox"/> Acuity 2 Date: _____ Time: _____	<input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7 <input type="checkbox"/> Acuity 2 Date: _____ Time: _____	<input type="checkbox"/> 7-3 <input type="checkbox"/> 3-11 <input type="checkbox"/> 11-7 <input type="checkbox"/> Acuity 2 Date: _____ Time: _____
<p>Neuromuscular</p> <p>Alert, oriented to person, place, time. PERRLA, speech clear and appropriate, purposeful movement in all extremities, stable gait</p>	<p><input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>LOC</p> <p><input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose</p> <p>Disoriented to</p> <p><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time</p> <p>Pupils</p> <p><input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive</p> <p>Sensory</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Movement</p> <p><input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM</p> <p>Speech</p> <p><input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>LOC</p> <p><input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose</p> <p>Disoriented to</p> <p><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time</p> <p>Pupils</p> <p><input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive</p> <p>Sensory</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Movement</p> <p><input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM</p> <p>Speech</p> <p><input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>LOC</p> <p><input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Obtunded <input type="checkbox"/> Stupor <input type="checkbox"/> Unresponsive/comatose</p> <p>Disoriented to</p> <p><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time</p> <p>Pupils</p> <p><input type="checkbox"/> Non reactive <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Unequal reactive</p> <p>Sensory</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Altered vision <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Altered hearing <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Movement</p> <p><input type="checkbox"/> Unstable gait <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Limited ROM</p> <p>Speech</p> <p><input type="checkbox"/> Slurred <input type="checkbox"/> Aphasia <input type="checkbox"/> Incomprehensible</p>
<p>Behavioral</p> <p>Calm, cooperative, appropriate responsiveness and communication, no illusions/hallucinations</p>	<p><input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Restlessness <input type="checkbox"/> Agitation <input type="checkbox"/> Unclear thinking <input type="checkbox"/> Fear <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Illusions/ Hallucinations <input type="checkbox"/> Delayed responsiveness <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Insomnia</p>
<p>Respiratory</p> <p>Breathing unlabored, breath sounds clear bilaterally, no cough</p>	<p><input type="checkbox"/> Not indicated for assessment* <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>Breathing Pattern</p> <p><input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use</p> <p>Unclear Breath Sounds</p> <p><input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Cough</p> <p><input type="checkbox"/> Productive <input type="checkbox"/> Non productive</p> <p>Sputum</p> <p><input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>Breathing Pattern</p> <p><input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use</p> <p>Unclear Breath Sounds</p> <p><input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Cough</p> <p><input type="checkbox"/> Productive <input type="checkbox"/> Non productive</p> <p>Sputum</p> <p><input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged</p>	<p><input type="checkbox"/> Not indicated for assessment <input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p>Breathing Pattern</p> <p><input type="checkbox"/> Apnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Dyspnea <input type="checkbox"/> Shallow <input type="checkbox"/> Orthopnea <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscle use</p> <p>Unclear Breath Sounds</p> <p><input type="checkbox"/> Wheezes <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Crackles <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Diminished <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Absent <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>Cough</p> <p><input type="checkbox"/> Productive <input type="checkbox"/> Non productive</p> <p>Sputum</p> <p><input type="checkbox"/> Whitish <input type="checkbox"/> Yellowish <input type="checkbox"/> Brownish <input type="checkbox"/> Thick <input type="checkbox"/> Frothy <input type="checkbox"/> Bloody <input type="checkbox"/> Blood tinged</p>

* For initial Assessment all systems need to be assessed



Patient Name: _____

Patient Number: _____

<p>Cardiovascular</p> <p>Regular pulse, normal heart sounds, no edema, capillary refill <3 seconds, no JVD, no ascitis, palpable peripheral pulses (DP and Radial)</p>	<p><input type="checkbox"/> Not indicated for assessment*</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Irregular pulse</p> <p><input type="checkbox"/> Abnormal heart sounds</p> <p>Peripheral pulses non palpable</p> <p>Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p><input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill</p> <p><input type="checkbox"/> Cyanosis</p> <p>Edema</p> <p><input type="checkbox"/> Grade 1 : Quickly disappears</p> <p><input type="checkbox"/> Grade 2 : Remains 10-15 Seconds</p> <p><input type="checkbox"/> Grade 3 : Remains 1-2 Minutes</p> <p><input type="checkbox"/> Grade 4 : Remains 2-5 Minutes</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Irregular pulse</p> <p><input type="checkbox"/> Abnormal heart sounds</p> <p>Peripheral pulses non palpable</p> <p>Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p><input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill</p> <p><input type="checkbox"/> Cyanosis</p> <p>Edema</p> <p><input type="checkbox"/> Grade 1 : Quickly disappears</p> <p><input type="checkbox"/> Grade 2 : Remains 10-15 Seconds</p> <p><input type="checkbox"/> Grade 3 : Remains 1-2 Minutes</p> <p><input type="checkbox"/> Grade 4 : Remains 2-5 Minutes</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Irregular pulse</p> <p><input type="checkbox"/> Abnormal heart sounds</p> <p>Peripheral pulses non palpable</p> <p>Radial <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p>DP <input type="checkbox"/> Rt <input type="checkbox"/> Lt</p> <p><input type="checkbox"/> JVD <input type="checkbox"/> Delayed Capillary Refill</p> <p><input type="checkbox"/> Cyanosis</p> <p>Edema</p> <p><input type="checkbox"/> Grade 1 : Quickly disappears</p> <p><input type="checkbox"/> Grade 2 : Remains 10-15 Seconds</p> <p><input type="checkbox"/> Grade 3 : Remains 1-2 Minutes</p> <p><input type="checkbox"/> Grade 4 : Remains 2-5 Minutes</p>
<p>Gastro - Intestinal</p> <p>Abdomen soft, not distended, not tender, present bowel sounds 5-30/minute, bowel movement as per routine, good appetite, oral mucosa pink</p>	<p><input type="checkbox"/> Not indicated for assessment*</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Oral mucositis</p> <p>Bowel Sounds</p> <p><input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Oral mucositis</p> <p>Bowel Sounds</p> <p><input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Distended <input type="checkbox"/> Tender <input type="checkbox"/> Rigid</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Oral mucositis</p> <p>Bowel Sounds</p> <p><input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive</p>
<p>Genito- Urinary</p> <p>Voiding with no difficulties, clear colored and adequate urine output</p>	<p><input type="checkbox"/> Not indicated for assessment*</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria</p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine</p> <p><input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria</p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine</p> <p><input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Oliguria <input type="checkbox"/> Dysuria <input type="checkbox"/> Anuria</p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/> Dark colored urine</p> <p><input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Retention <input type="checkbox"/> Abnormal discharge</p>
<p>Pain</p> <p>No Pain at exam time</p>	<p>For Initial Assessment</p> <p><input type="checkbox"/> Refer to Nursing Data Base</p> <p>For Reassessment</p> <p><input type="checkbox"/> Criteria Met</p> <p><input type="checkbox"/> Criteria Not Met (Pain Identified)</p>	<p><input type="checkbox"/> Criteria Met</p> <p><input type="checkbox"/> Criteria Not Met (Pain Identified)</p>	<p><input type="checkbox"/> Criteria Met</p> <p><input type="checkbox"/> Criteria Not Met (Pain Identified)</p>
<p>Integumentary</p> <p>Skin is warm, dry, no rash, lesions, or pressure ulcers</p>	<p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundices</p> <p><input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Ecchymosis</p> <p><input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass</p> <p><input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer</p>	<p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundices</p> <p><input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Ecchymosis</p> <p><input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass</p> <p><input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer</p>	<p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Clammy <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundices</p> <p><input type="checkbox"/> Diaphoresis <input type="checkbox"/> Hot <input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Ecchymosis</p> <p><input type="checkbox"/> Hematoma <input type="checkbox"/> Palpable mass</p> <p><input type="checkbox"/> Lesion/laceration <input type="checkbox"/> Pressure ulcer</p>
<p>Surgical Wound/Incision</p> <p>No Wound/ Incision. Wound clean, dry, no discharge noticed. No wound infection or dehiscence.</p>	<p><input type="checkbox"/> Not indicated for assessment*</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Redness <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence</p> <p>Discharge</p> <p><input type="checkbox"/> Bloody <input type="checkbox"/> Purulent</p> <p><input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Bilary</p> <p><input type="checkbox"/> Serous <input type="checkbox"/> Odorous</p> <p>Amount</p> <p><input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Redness <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence</p> <p>Discharge</p> <p><input type="checkbox"/> Bloody <input type="checkbox"/> Purulent</p> <p><input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Bilary</p> <p><input type="checkbox"/> Serous <input type="checkbox"/> Odorous</p> <p>Amount</p> <p><input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive</p>	<p><input type="checkbox"/> Not indicated for assessment</p> <p><input type="checkbox"/> Criteria Met <input type="checkbox"/> Criteria Not Met</p> <p><input type="checkbox"/> Redness <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Tenderness <input type="checkbox"/> Dehiscence</p> <p>Discharge</p> <p><input type="checkbox"/> Bloody <input type="checkbox"/> Purulent</p> <p><input type="checkbox"/> Sero-sanguineous <input type="checkbox"/> Bilary</p> <p><input type="checkbox"/> Serous <input type="checkbox"/> Odorous</p> <p>Amount</p> <p><input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Excessive</p>
	<p>RN Name and Signature</p>	<p>RN Name and Signature</p>	<p>RN Name and Signature</p>

Fall Risk Assessment Tool

Patient Name: _____ Bed Number: _____ Patient Number: _____

Assessment is to be done upon admission, weekly and whenever patient condition changes.

Put patient on fall risk precaution if any item of the following is present:

	Upon admission, as condition changes, and weekly						
Date							
Time							
Fall Risk Items							
1. Age more than 65 years							
2. History of unexplained fall for the past year							
3. Post operation within 8 hrs							
4. Physical Status:							
Dizziness/Unsteady gait							
Operation in lower extremities							
Weakness/Paresis							
Seizure disorder							
Sight impairment							
Hearing impairment							
Orthostatic hypotension							
5. Mental Status							
Confusion/disorientation							
Impaired memory and judgment							
6. Medications							
Drugs that have diuretic effect							
Drugs that suppress the thought process and/or create hypotensive effect: Sedatives, psychotropics, hypnotics, tranquilizers, anti-hypertensives and antidepressants							
Drugs that increase GI motility: Laxatives, cathartics							
Chemotherapeutic and antineoplastic agents							
7. Use of assistive devices:							
<input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches							
<input type="checkbox"/> Cane <input type="checkbox"/> Others (specify): _____							
8. Alcohol Use							
Check the appropriate assessment finding	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk	<input type="checkbox"/> Risk
	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk	<input type="checkbox"/> No Risk
Initials							

RN Name	Initials	RN Name	Initials



الجامعة الأمريكية في بيروت - المركز الطبي
AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER

Patient Identification

Multidisciplinary Patient / Family Education Record

Patient Name:

Patient Number:

PFE-MUL-001
Appendix 6.1

I. Assessment of Educational Needs (Registered Nurse)

Learning Needs:			Barriers to Learning? <input type="checkbox"/> Yes <input type="checkbox"/> No			Preferences:			Upon discharge:
	Date D/M/YY	Initials		Date D/M/YY	Initials		Date D/M/YY	Initials	
<input type="checkbox"/> Disease process			<input type="checkbox"/> Physical			<input type="checkbox"/> Reading			Physician Name:
<input type="checkbox"/> Treatment			<input type="checkbox"/> Cultural			<input type="checkbox"/> Demonstration			
<input type="checkbox"/> Hygiene			<input type="checkbox"/> Religious			<input type="checkbox"/> Hearing			Physician Signature:
<input type="checkbox"/> Exercise			<input type="checkbox"/> Motivation			<input type="checkbox"/> Visual			
<input type="checkbox"/> Diet			<input type="checkbox"/> Reading ability			<input type="checkbox"/> Others(specify)			Date and Time:
<input type="checkbox"/> Medications			<input type="checkbox"/> Language						
<input type="checkbox"/> Equipment			<input type="checkbox"/> Cognitive						
<input type="checkbox"/> Procedure			<input type="checkbox"/> Physical						
<input type="checkbox"/> Others(specify)			<input type="checkbox"/> Others(specify)						

Name and Status	Initials	Name and Status	Initials

Education

- Historically
- 4-hour workshop to all nurses
- Phys assess “stars”
- Train-the-trainer approach



Education

- During orientation (classroom and clinical)
- When a need arises (e.g. pressure ulcer assessment)
- School of nursing also incorporates assessment in curriculum



Accessibility of **supplies**

- Some available in the room (BP cuff, Stetho in critical care units)
- Others (penlight, tongue blade) available on the unit



Incorporation in the overall plan

- Based on assessment findings, nursing diagnoses are chosen
- Progress note describes the abnormal findings, interventions, and outcomes



Thank you

