**NURSING HEALTH AND SAFETY ASSESSMENT**

**Section I: Identifying Information**

1. **Name**:

Age:       DOB: (mm/dd/yyyy)       Male [ ]  Female [ ]

1. **Address**:

City       State       Zip Code

1. **Name of Evaluator**:

Date of Report: (mm/dd/yyyy):

1. **Purpose of Evaluation**: [ ]  Annual [ ]  Change in Status [ ]  Initial
2. **Living Situation**: [ ]  ICF [ ]  Waiver
3. **Race**: [ ]  African American [ ]  Asian [ ]  Hispanic [ ]  White
 [ ] Native American [ ]  Other (specify)

7. **Current Medical Information**:

|  |  |
| --- | --- |
| Current Diagnoses | Date Diagnosed(mm/dd/yyyy) |
|       |       |
|       |       |
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|       |       |

8. **Communication**: [ ]  Verbal [ ]  Sign [ ]  Assistive Technology
 [ ]  Nonverbal (Comments:     )

|  |
| --- |
| 9. **Activities of Daily Living**  Self Care Ability: (Please score each area with the following scale)0=Independent; 1=Assistive Device; 2=Assistance from Others; 3=Assistance from device; 4=Totally Dependent |
| Eating/Drinking:  |       | Transferring:  |       |
| Bathing/al Hygiene:  |       | Ambulation:  |       |
| Dressing:  |       | Bed Mobility:  |       |
| Toileting:  |       |  |       |
| Comment:       |

10. **Adaptive equipment**: [ ]  None
 [ ]  (If yes, *list all*)

11. **Medical equipment**: (*include glucose monitoring, enteral feeding, respiratory supplies, medical alert device, etc.*) [ ]  None
Indicate type and frequency of use:

12. **History of Falls**: [ ]  No [ ]  Yes (specify frequency & follow-up)

Risk Assessment for Falls Completed: Yes [ ]  No [ ]

**Section II: Brief Health History**

13. **Hospitalizations, ER visits, and Illnesses during the past year**: (Dates and Reasons)

**Significant Family History**

* Information obtained from health record [ ]  Yes Date:       [ ]  No
* Information obtained from family member: [ ]  Yes Date:       [ ]  No
* If Yes, give name:
* Relationship to person

14. **Family History of** **Cardiac Problems/Hypertension**

15. **Family History of** **Diabetes**

16. **Family History of** **Seizure**

17. **Family History of** **Cancer**

18. **Family History of** **Known Genetic Disorders**

19. **Other Family History**

**Section III: Health Data**

|  |
| --- |
| 20. **Allergies**:  [ ]  Food [ ]  Environmental [ ]  Medication Reaction [ ]  No known allergy If any reaction, identify antigen & clinical reaction:        EpiPen: Yes [ ]  No [ ]  |

21. **Person’s Health Concerns**
*Person’s Perspective:*

*Family Member’s perspective (give name/relationship):*

|  |
| --- |
| 22. **Seizure Disorder**: Type       Frequency       Not Applicable      Summary of seizure data:       |

23**. Current Medications**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DateStarted | Medication | Dosage | Times | Route | Reason |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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|       |       |       |       |       |       |

24. **Describe best approach for administering medication including: whether tablet should be crushed, given with liquids or food, or liquid form of medication should be used**. (Include person’s usual response to taking medications)

|  |
| --- |
| 25. **Medication regimen** (indicate one): [ ]  no changes over the past quarter [ ]  changes over the past quarterDescribe changes:       |

|  |
| --- |
| 26. **Medication concerns:**       |

|  |
| --- |
| 27. Is a self-administration program utilized for any of the above listed medications? [ ]  Yes [ ]  No If Yes, summarize the data sheet:       |

28. **Date of most recent self-administration assessment**: (mm/dd/yyyy):
29**. Sexuality**

|  |
| --- |
| Is the person sexually active (including masturbation)? [ ]  Yes [ ] NoDoes the person have multiple sex partners? [ ]  Yes [ ]  NoComments:       |
| List any Sexually Transmitted Diseases (STDs)/method of contraception currently used:       |
| Need for sex education programs: [ ]  Yes [ ]  No Education Referral:        Date of Referral (mm/dd/yyyy)       |

|  |
| --- |
| 30. **History of abuse:** [ ]  Yes [ ]  No If yes, mark at that apply: [ ]  Physical [ ]  Economical [ ] Sexual [ ]  Emotional & VerbalComments:       |

**Section IV: Review of Health Systems**

31. **Vital Signs:**

 B/P:       (Sitting, Lying & Standing) T:       P:       R:       SPO2% (if applicable):

Date of last annual medical review with primary care practitioner:      /     /

**Physical Exam findings**

**32. SKIN** [ ]  clear, healthy skin [ ]  clear, healthy scalp [ ]  no problems or deviations assessed

[ ]  lesions [ ]  rashes [ ] bruises [ ]  wound [ ]  drainage [ ]  itching [ ]  skin color variation [ ]  cyanosis [ ]  pallor

[ ]  jaundice [ ]  erythema [ ]  dry, rough texture [ ]  scaling/xerosis [ ]  poor turgor [ ] edema

[ ]  unusual hair distribution

[ ]  hair loss [ ] reduced hair on extremities [ ]  hirsutism

[ ]  hair characteristics [ ] normal [ ]  oily [ ]  dry [ ]  coarse [ ]  infestation/lice/bed bugs

[ ] Braden Scale: Date

Results

[ ] Severe Risk: (Total score 9) [ ]  High Risk: (Total score 10-12)

[ ]  Moderate Risk: (Total score 13-14) [ ]  Mild Risk: (Total score 15-18)

|  |
| --- |
| Comments:       |

**STOMA** [ ]  Not Applicable

[ ]  clean, dry [ ] redness [ ]  discolored [ ] drainage [ ]  swelling [ ] prolapse

|  |
| --- |
| Comments:       |

**FINGERNAILS & TOENAILS**

[ ]  color, shape, cleanliness good [ ]  no problems or deviations assessed

[ ]  irregularities in surface:

[ ] inflammation around nails:

[ ]  fungal problem:

|  |
| --- |
| Comments:       |

**33. HEAD & NECK** [ ]  No problems or deviations assessed

Head motion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (describe)

[ ]  asymmetric head position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(describe)

[ ]  shrugs shoulders [ ]  unable to support head midline & erect

[ ]  periorbital edema [ ]  lymph node enlargement [ ]  thyroid enlargement [ ]  tracheal displacement

|  |
| --- |
| Comments:       |

**Physical Exam findings**

**34. NOSE & SINUSES** [ ]  No problems or deviations assessed

[ ]  nasal drainage [ ]  inflamed [ ]  tender

[ ]  nasal mucosa irregularities

[ ]  right nostril swelling [ ]  left nostril swelling

|  |
| --- |
| Comments:       |

**35. MOUTH & PHARYNX** [ ] No problems or deviations assessed

Inspect the following: [ ] inner oral mucosa [ ] buccal mucosa [ ]  floor of mouth [ ]  tongue [ ]  hard palate [ ]  soft palate

[ ]  altered oral mucous membrane:       (describe)

[ ]  inflammation:       (describe)

[ ]  hoarseness [ ]  bruxism (grinds teeth) [ ]  loose teeth [ ]  missing teeth [ ]  decay [ ]  halitosis [ ]  excessive salivation [ ]  lips dry, cracked [ ]  lip fissures [ ]  lip bleeding [ ]  gums inflamed [ ]  gums bleed [ ]  gum retraction

[ ]  thick tongue [ ]  tongue dry, cracked [ ]  tongue fissures [ ]  tongue bleeds

Deviations:       (describe)

[ ]  lesions, vesicles:       (describe)

[ ]  gag reflex absent [ ]  gag reflex hyperactive [ ]  poor denture fit or not using [ ]  chewing problem

|  |
| --- |
| Comments:       |

**36. EYES**

Inspected the external eye structures: [ ]  eyebrows [ ]  orbital area [ ]  eyelids [ ]  lacrimal ducts [ ]  conjunctiva

[ ]  sclera [ ]  cornea

Abnormalities:       (specify/describe)

Visual fields/peripheral vision present: [ ]  right [ ]  left

Eye tracking present: [ ]  up [ ]  down [ ]  right [ ]  left

Blink reflex: Right: [ ]  present [ ]  absent Left: [ ]  present [ ]  absent

Pupil & iris direct light response: Right: [ ]  present [ ] absent Left: [ ]  present [ ]  absent

Pupil & iris consensual light response: Right: [ ]  present [ ]  absent Left: [ ]  present [ ]  absent

[ ]  Signs of diminished vision (explain):

|  |
| --- |
| Comments:       |

**Physical Exam findings**

**37. EARS**

Inspect the following external ear structures: [ ]  auricle [ ]  lobule [ ]  tragus [ ]  mastoid

External ear structure abnormalities: [ ]  swelling [ ]  nodules [ ]  tenderness [ ]  discharge [ ]  no abnormalities

Other abnormalities

[ ]  Signs of Diminished Hearing: explain:

|  |
| --- |
| Comments (coordination of Care, i.e.: ENT consults, etc.):       |

**38. HEART & VASCULAR** [ ] No problems or deviations assessed

Auscultated heart sounds: [ ]  S-1 at 5th intercostal space on left [ ]  S-2 at 2nd intercostal space left or right side apical pulse:       (rate & rhythm)

Jugular venous distention: [ ]  present [ ]  absent

Capillary refill: [ ]  > 1 second [ ]  < 2 seconds

[ ]  PMI palpable – 5th intercostal space medial to left midclavicular line [ ]  PMI [ ]  not palpable

[ ]  edema:       (describe)

Palpate bilaterally the following pulses: [ ]  radial [ ]  ulnar [ ]  brachial [ ]  femoral [ ]  popliteal [ ]  dosalis pedis [ ]  posterior tibial

List any pulse deviations:

|  |
| --- |
| Comments:       |

**39. THORAX & LUNGS** [ ]  No problems or deviations assessed

Is the person a smoker? [ ]  Yes or [ ]  No, if yes, how many cigarettes does the person smoke per day?

|  |
| --- |
| Describe smoking patterns:       |

Inspect: [ ]  posterior thorax [ ]  lateral thorax [ ]  anterior thorax

List thorax deviations

Auscultated breath sounds: [ ] vesicular sounds at periphery intercostal space lateral to sternum

[ ]  bronchovesicular sounds between scapulae or 1st – 2nd [ ]  bronchial sounds over trachea

Diminished sounds:       (describe)

[ ]  wheezes [ ]  crackles [ ]  rhonchi (Location(s)

[ ]  productive cough [ ]  non-productive cough

List breath sound deviations:

Respiratory distress: [ ]  nasal flaring [ ]  use of accessory muscles [ ]  SOB [ ]  intercostal retraction

|  |
| --- |
| Comments:       |

**Physical Exam findings**

**40. ABDOMEN** [ ]  No problems or deviations assessed

Bowel Sounds: [ ]  auscultate all 4 quadrants [ ]  hypoactive [ ]  hyperactive [ ]  tympanic

[ ]  absent       (location)

Abdomen: [ ]  flat [ ]  distended [ ]  soft [ ]  firm [ ]  rounded [ ]  obese [ ]  asymmetry [ ]  pain [ ]  rebound tenderness [ ]  gastrostomy [ ]  jejunostomy [ ]  ostomy

[ ]  mass:       (location/describe)

Skin:       (texture)       (color)

|  |
| --- |
| Comments:       |

**41. NUTRITIONAL/METABOLIC PATTERN(S)**

Height:       Weight:       [ ]  Recommended Ideal Body Weight (IBW)       [ ]  less than IBW [ ]  more than IBW [ ]  BMI      [ ]  Type of Diet       Is there a mealtime protocol? [ ]  yes or [ ]  No

|  |
| --- |
| Comments:       |

**42. GENITOURINARY & GYNECOLOGIC** [ ]  No problems or deviations

Menses: [ ]  LMP      [ ]  pattern of painful menses [ ]  irregularity [ ]  heavy flow [ ]  assistance needed for menstrual hygiene [ ]  self-care during menses [ ]  Premenopausal [ ]  menopausal

|  |
| --- |
| Comments:       |

**GYN Exam w/PAP: Date:**       **Results:**

*(As recommended by GYN/PCP)*

**Mammogram/Sonogram: Date:**       **Results:**

*(As recommended by GYN/PCP)*

**Prostate Exam: Date:**       **Results:**

*(As recommended by PCP)*

**Breast Self-Exam: Date:**       **Results:**

*(Most recent date performed)*

**Testicular Self-Exam: Date**      **Results:**

*(Most current date performed)*

Was educational material or information provided? [ ]  Yes, if yes explain in comments [ ]  No

|  |
| --- |
| Comments:       |

THIS SECTION OF THE PHYSICAL EXAM IS REQUIRED FOR PEOPLE WHO ARE UNABLE TO SELF-EXAM

**GENITOURINARY & GYNECOLOGIC**

External genitalia (female): [ ]  No problems or deviations

 [ ]  excoriations [ ]  rash [ ]  lesions [ ]  vesicles [ ]  inflammation [ ]  bright red color [ ]  bulging [ ]  discharge [ ]  inguinal hernia [ ]  odor [ ]  itchy

|  |
| --- |
| Comments:       |

Breast Exam (male & female): [ ]  No problems or deviations

Deviations assessed in: [ ]  size [ ]  symmetry [ ]  contour [ ]  shape [ ]  skin color [ ]  texture [ ]  venous pattern

 Nipple deviations: [ ]  retraction [ ]  discharge [ ]  bleeding [ ]  nodules [ ]  edema [ ]  ulcerations [ ]  gynecomastia

|  |
| --- |
| Comments:       |

External genitalia (male): [ ]  No problems or deviations

[ ]  testicular mass [ ]  tight scrotal skin [ ]  enlarged scrotum [ ]  displaced meatus [ ]  lesions/sores [ ]  rash [ ]  bright red color [ ]  odor [ ]  discharge [ ]  inflammation [ ]  inguinal hernia [ ]  itchy

|  |
| --- |
| Comments:       |

**43. MUSCULOSKELETAL** [ ]  No problems or deviations assessed

[ ]  gait abnormalities:

[ ]  posture abnormalities:

[ ]  Impaired Weight Bearing:

[ ]  asymmetry:

[ ]  misalignment:

[ ]  decreased ROM:

[ ]  joint swelling [ ]  stiffness [ ]  tenderness [ ]  Warm to touch

[ ]  contractures

[ ]  increased muscle tone (hypertonicity):

[ ]  decreased muscle tone (hypotonicity):

[ ]  gross motor skills impaired

[ ]  fine motor skills impaired

|  |
| --- |
| Comments:       |

**Physical Exam findings**

**Neurologic System**

**44. MENTAL & EMOTIONAL STATUS**

[ ]  alert (person/place/self) [ ]  non-verbal [ ]  impaired level of consciousness

[ ]  able to communicate [ ]  limited verbalization [ ]  vocalized sounds only

[ ]  intellectual impairment [ ]  memory impairment [ ]  abstract reasoning impaired

[ ]  impaired association ability [ ]  impaired judgment [ ]  sleeps well at night [ ]  difficulty falling asleep

[ ]  difficulty staying asleep [ ]  difficulty with early awakening

[ ]  naps during day due to: [ ]  age [ ]  health status [ ]  medications

[ ]  sleep aids used:

[ ]  sleep safety devices used: [ ]  bedrails [ ]  pillow(s) [ ]  mat beside bed

[ ]  other:

|  |
| --- |
| Comments:       |

[ ]  Dementia screening (required for people with Down syndrome 40 years and over and others with cognitive changes

[ ]  Not indicated [ ]  Completed Date

|  |
| --- |
| Comments:       |

**45. SENSORY FUNCTION**

Touch [ ]  intact [ ] impaired:       (describe)

Pain [ ]  intact [ ]  impaired:       (describe)

**46. BEHAVIOR** [ ]  No maladaptive behaviors

Maladaptive Behaviors: [ ]  ritualistic [ ]  stereotypical [ ]  PICA behavior [ ]  mood swings [ ]  self-injurious [ ]  aggression towards others [ ]  illicit drug use [ ]  elopement [ ]  suicidal ideations [ ]  other behaviors (describe):

[ ]  Receives:       (medication) for behavior(s)

[ ]  A behavior program is in place [ ]  An exception to behavior medication reduction is in place

|  |
| --- |
| Comments:       |

 **47.** **Glasgow Depression Screen: Date**

[ ]  No discrepancies noted [ ]  Referred for assessment Date

Instructions: **To be used for measuring pain in people who have dementia and/or unable to self-report**

**Abbey Pain Scale**

For measurement of pain in people with dementia who cannot verbalize**.**

**How to use scale:** While observing the resident, score questions 1 to 6

**Name of resident: ………………………………………………………………………...**

**Name and designation of completing the scale: ………………………….**

**Date: ….………………………………………Time: ………………………………………**

**Latest pain relief given was…………………………..…………..….….at ………..hrs.**

**Q1. Vocalization**

|  |
| --- |
|       |

**eg. whimpering, groaning, crying**

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q1**

**Q2. Facial expression**

|  |
| --- |
|       |

**eg: looking tense, frowning grimacing, looking frightened**

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q2**

**Q3. Change in body language**

**eg: fidgeting, rocking, guarding part of body, withdrawn**

|  |
| --- |
|       |

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q3**

**Q4. Behavioral Change**

|  |
| --- |
|       |

**eg: increased confusion, refusing to eat, alteration in usual patterns**

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q4**

**Q5. Physiological change**

**eg: temperature, pulse or blood pressure outside normal limits,**

|  |
| --- |
|       |

**perspiring, flushing or pallor**

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q5**

**Q6. Physical changes**

|  |
| --- |
|       |

**eg: skin tears, pressure areas, arthritis, contractures, previous injuries.**

*Absent 0 Mild 1 Moderate 2 Severe 3* **Q6**

|  |
| --- |
|       |

**Add scores for 1 – 6 and record here Total Pain Score**

|  |  |  |  |
| --- | --- | --- | --- |
| 0-2No Pain[ ]  | 3-7Mild[ ]  | 8-13Moderate[ ]  | 14+Severe[ ]  |

**Now click the box that matches the**

**Total Pain Score**

**Finally, click the box which matches**

|  |
| --- |
| Acute and Chronic[ ]  |

|  |
| --- |
| Acute[ ]  |

|  |
| --- |
| Chronic[ ]  |

**the type of pain**

**Dementia Care Australia Pty Ltd**

**Website: www.dementiacareaustralia.com**

**Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.**

**Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002**

(This document may be reproduced with this acknowledgment retained)

|  |
| --- |
| Comments:       |

****

Instructions: If the person denies pain, please record no pain below. If pain is verbalized, rate the pain and provide a full description below (location, frequency, radiates, throbbing, triggers, etc.). A pain management plan will need to be designed to further address pain relief interventions.

|  |
| --- |
| Comments:       |

www.wongbakerFACES.org

|  |
| --- |
| **Additional Information and Date (i.e., lab work, revisions to nursing assessment, etc.):**      |

For information regarding specific areas of concern and expected outcomes, see the attached Health Management Care Plan. Also, note that there may be other assessments as appropriate to the nursing care of the person attached to the Nursing Assessment, i.e. Braden scale, fall risk assessment dementia screening assessment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 (Print) RN’s Name & Title Signature and Date of Completion