**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**:

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| --- | --- |
| Current Diagnoses | Date Diagnosed  (mm/dd/yyyy) |
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8. **Communication**:  Verbal  Sign  Assistive Technology  
  Nonverbal (Comments:     )

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| 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):*

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

23**. Current Medications**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Started | 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)

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| 25. **Medication regimen** (indicate one):  no changes over the past quarter   changes over the past quarter  Describe changes: |

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| --- |
| 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 No  Does the person have multiple sex partners?  Yes  No  Comments: |
| 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 & Verbal Comments: |

**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

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| --- |
| 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

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| 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

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| --- |
| 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**

|  |
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*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**

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

|  |  |  |  |
| --- | --- | --- | --- |
| 0-2  No Pain | 3-7  Mild | 8-13  Moderate | 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**

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| --- |
| Comments: |

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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

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| --- |
| **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.

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