BOARDER PATIENT MEDICAL RN-LPN ADULT SHIFT ASSESSMENT	
Date:	**Time of Assessment:**
Height:	Weight:
Patient Indicators:	Allergies:
SHIFT	
Shift:	☐0700-1530 ☐1500-2330 ☐2300-0730 ☐0700-1930 ☐1900-0730 ☐0300-1530 ☐1500-0330 ☐Others (Specify)
LEVEL OF CARE	
What is the LEVEL OF Care of this patient? (ie. ICU LEVEL, TELEMETRY LEVEL)	_____
LANGUAGE	
Is the preferred language used during the shift in explaining patient's healthcare needs?	☐Not Applicable ☐Yes ☐No
NEUROLOGICAL	
Level of Consciousness	☐Person ☐Time ☐Place ☐Sedated ☐Awake ☐Stuporous ☐Unresponsive ☐Confused ☐Incoherent ☐Lethargic ☐Others (Specify)
Range of Motion:	☐Full ☐Limited ☐Left Sided Weakness ☐Right Sided Weakness ☐Others (Specify)
Gait	☐Steady ☐Unsteady ☐Bedfast
Grip	☐Equal ☐Bilateral ☐Weakness Upper Right ☐Weakness Upper Left ☐None ☐Unable to assess (Specify)
PSYCHOSOCIAL	
Appearance	☐Relaxed ☐Restless ☐Apprehensive ☐Sedated ☐Comatose ☐Obtunded ☐Others (Specify)
Behavior	☐Cooperative ☐Slumped Posture ☐Rigid, Tense Posture ☐Anxiety, Fear, Apprehension ☐Depression, Sadness ☐Anger, Hostility ☐Threatening ☐Decreased Variability of Expression ☐Bizarre Behavior ☐Unresponsive ☐Sedated ☐Others (Specify)
Communication	☐Verbal ☐Signs/Gestures ☐Written ☐Language Barrier ☐Non-Responsive ☐Sedated ☐Others (Specify)
CARDIOVASCULAR	
Telemetry Rhythm	☐Not on Cardiac Monitor ☐NSR ☐Sinus Bradycardia ☐Sinus Tachycardia ☐w/PVCs ☐Sinus Arrythmia ☐Atrial Fibrillation (A-FIB) ☐Atrial Flutter ☐Junctional Rhythm ☐Atrial Tachycardia ☐1st Degree AV Block ☐2nd Degree AV Block ☐3rd Degree AV Block ☐Bundle Branch Block ☐Pacemaker ☐Wandering Pacemaker ☐Ventricular Tachycardia (V-Tach) ☐Ventricular Fibrillation (V-FIB) ☐Others (Specify)
Skin Appearance and Color	☐Normal ☐Hot ☐Flushed ☐Diaphoretic ☐Jaundiced ☐Cool ☐Clammy ☐Pale ☐Cyanotic ☐Mottled ☐Ruddy ☐Poor Turgor ☐Ashen ☐Others (Specify)
Mucous Membranes & Nail beds	☐Pink ☐Cyanotic ☐Pale ☐Others (Specify)

PATIENT ID LABEL

Jugular Veins	☐Flat ☐Distended
Capillary Refill: N= <3secs A+>3sec	☐RUE Normal ☐LUE Normal ☐RLE Normal ☐LLE Normal ☐RUE Abnormal ☐LUE Abnormal ☐RLE Abnormal ☐LLE Abnormal
Pulses	☐+4 Bounding ☐+3 Strong, Palpable ☐+2 Weak, Palpable ☐+1 Intermittent ☐Absent ☐Doppler ☐Others (Specify)
PERIPHERAL VASCULAR	
Edema	☐No Edema ☐No Indentation ☐1+ Indent Gone Quick ☐2+ Indent 10-15 Seconds ☐3+ Indent 1-2 Minutes ☐4+ Indent>7 Minutes ☐Others (Specify)
Rash	
Decubitus	
Bruises/Abrasions	
Incision	☐Not Applicable ☐Healing ☐Intact ☐No Redness ☐Red, Puffy, Warm ☐Well Approximated ☐Obviously Infected
Describe Dressing Condition	☐Not Applicable ☐Clean and Dry ☐Intact ☐w/Drainage (Specify)
Location of Dressing (s)	
IV SITE	
Indications for IV Devices	☐None/Not Indicated ☐IV Fluid Administration ☐IV Medication Administration-ie: antibiotics, vasopressors ☐IV Electrolyte Administration ☐Parenteral Nutrition ☐Blood or Blood Product Transfusion ☐Pressure Monitoring ☐ Other (Specify)
Catheter Types	☐Not Applicable ☐Peripheral Venous Catheter ☐Pulmonary Artery Catheter ☐Peripheral Arterial Catheter ☐Peripherally Inserted Central Venous Catheter ☐Totally Implantable (ie: Portacath) ☐CVC Triple Lumen Permanent ☐Tunneled CVC (e.g. Broviac, Hickman, Permacath) ☐Non-Tunneled CVC (e.g. Mahurkar, Quinton) ☐Midline Catheters ☐Umbilical Vein Catheter (for Nursery use) ☐Umbilical Arterial Catheter (for Nursery use) ☐Umbilical Catheters
Has Patient Education Detail been completed on prevention of intravascular device related infections?	☐Not Applicable ☐Yes ☐No
If No, Please complete the Patient Education Detail.	
IV or saline lock site check	☐Not Applicable ☐Intact & Patent ☐Redness ☐Swelling ☐Tenderness ☐Infiltrated ☐IV Burn ☐Leaking ☐ Others (Specify)

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IV or saline lock insertion site	☐Right Hand ☐Left Hand ☐Right Wrist ☐Left Wrist ☐Right Arm ☐Left Arm ☐Left Antecubital ☐Right Antecubital ☐Axillary ☐Right Foot ☐Left Foot ☐Right Leg ☐Left Leg ☐UV ☐UA ☐Scalp ☐Right Internal Jugular ☐Left Internal Jugular ☐Right Femoral ☐Left Femoral ☐Right Subclavian ☐Left Subclavian ☐Not Applicable ☐ Others (Specify)
IV Fluid Types	
RESPIRATORY	
Breath Sounds	☐Clear-Bilateral ☐Equal ☐Crackles Right ☐Crackles Left ☐Crackles Bilateral ☐Wheezes Bilateral ☐Wheezes Left ☐Wheezes Right ☐Rhonchi Bilateral ☐Rhonchi Left ☐Rhonchi Right ☐Diminished Left ☐Diminished Right ☐Absent Right ☐Absent Left
Bilateral Lung Expansion	☐Equal ☐Unequal ☐Spontaneous
Respiratory Pattern	☐Regular/Even ☐Irregular ☐Dyspneic w/Exertion ☐Dyspneic ☐Bradypnea ☐Tachypnea ☐Labored Inspiration ☐Apnea ☐ Others (Specify)
Cough	☐No ☐Yes, Non-Productive ☐Yes, Productive
Respiratory Secretions	☐None ☐Suction Required ☐Frothy ☐Thin ☐Thick ☐Copious ☐Green ☐Yellow ☐Bloody ☐Pinkish ☐ Others (Specify)
O2 Use/Delivery System	☐None-Room Air ☐Nasal Cannula ☐Simple Mask ☐Venti-Mask ☐Non-Rebreather ☐Bi-Pap ☐C-Pap ☐Ventilator ☐ Others (Specify)
O2 Delivery Device Settings	
Chest Tube Locations	
GENITO-URINARY	
Voiding	☐Continent ☐Urinal ☐Bed Pan ☐Bedside Commode ☐Incontinent ☐Stress Incontinence ☐Foley ☐TEX Catheter ☐Dialysis ☐Nephrostomy Tube ☐Suprapubic Catheter ☐ Others (Specify)
Has Patient Education Details been completed on prevention of catheter-associated urinary tract infections?	☐Yes ☐No ☐Not Applicable
If NO, please create an entry In the Patient Education Detail showing that teaching has been provided regarding Foley care.	
How many days has the current foley catheter been in place?	

PATIENT ID LABEL

Urine Appearance	☐Clear ☐Hazy ☐Cloudy ☐Sediment ☐Blood Clots ☐Not Applicable
Urine Color	☐Light Yellow ☐Dark Yellow ☐Amber ☐Pink ☐Red ☐Milky ☐Tea-Colored ☐ Others (Specify) ☐Not Applicable
Foley Catheter Size	
24 Hour Urine Collection?	
INDWELLING URINARY CATHETERS	
Indication/s for Indwelling Urinary Catheters:	☐Not Applicable ☐Acute Urinary Retention or Bladder Outlet Obstruction ☐Strict I&O for Critically Ill Patients, Physician Order ☐Perioperative Use for Selected Surgical Procedures ☐Anticipated Prolonged Duration of Surgery ☐Large Volume Infusions or Diuretics during Surgery ☐Need for Intraoperative monitoring of urinary output ☐Need for accurate post-op monitoring of urinary output ☐Strict I&O monitoring due to medication. ☐Assist Healing-Open Sacral/Perineal Wounds in Incontinent Pt ☐Potentially Unstable Thoracic or Lumbar Spine ☐Multiple Traumatic Injuries-Pelvic Fractures ☐Comfort for End of Life Care ☐Others (Specify)
GASTROINTESTINAL	
Bowel Sounds	☐Normal ☐Absent ☐Hyperactive ☐Hypoactive ☐ Others (Specify)
Abdomen	☐Soft ☐Firm ☐Flat ☐Round ☐Distended ☐Obese ☐Hard ☐Tender ☐Non-Tender ☐ Others (Specify)
Bowel movement	☐Irregular Bowel Habits ☐Incontinent ☐Daily Bowel Movement ☐BM Every Other Day ☐Laxative Use ☐No Bowel Movement
Stool	☐ Not Applicable ☐Incontinent ☐Liquid ☐Soft ☐Frequent ☐Formed ☐Ostomy ☐ Blood in Stool
Gastrointestinal Tube Location	☐None ☐Oral ☐Right Nare ☐Left Nare ☐Percutaneous (Specify) ☐ Others (Specify)
Last Bowel Movement	
BM Color	
GYN	
Pad Count	
Drainage/Discharge	
ACTIVITY	
Activity Level	☐Bed rest ☐Up with One Assist ☐Up with Two or More ☐Up in Chair ☐Ambulate with Assistance ☐UP AD LIB ☐Bed rest C BRP ☐Bedside Commode ☐Dangle ☐Sedated ☐ Others (Specify)

PATIENT ID LABEL

Activity Tolerance	☐Good ☐Poor ☐Fair ☐Sedated ☐Others (Specify)
Turn q2 hours	☐Not Applicable ☐Yes ☐No
Fracture	
TRANSMISSION BASED PRECAUTIONS	
Is this a newly initiated precaution for this patient during this hospitalization?	☐Not Applicable ☐Yes ☐No
Is the patient on any of the following Transmission based Precautions?	☐None ☐Contact Precautions ☐Special Contact Precautions ☐Droplet Precautions ☐Airborne Infection Isolation
If one of more are chosen above please complete Patient Education Details form.	
PAIN ASSESSMENT	
Presence of Pain	☐Yes (Specify in Notes) ☐No
Location of Pain	
Pain Level (Select)	☐0-No Pain ☐1 ☐2-Mild Pain ☐3 ☐4-Moderate Pain ☐5 ☐6 ☐7 ☐8-Severe Pain ☐9 ☐10-Worst Pain ***NOTE: At any time the patient report pain, all documentation (comprehensive assessment, interventions, and reassessment) shall be done in the Pain Assessment Flow sheet.***
Pain Assessment Tool Used: The use of an identified Pain Tool MUST be consistent throughout the patient's admission. It shall only change when the patient's condition has changed.	☐Verbal Analog Scale ☐Faces ☐Multilingual Pain Assessment Tool ☐FLACC (Pediatrics) ☐NIPS (Nursery) ☐Cries (Nursery) ☐ Critical Care Pain Assessment Tool
HYGIENE	
Type of Bath/Shower taken	☐Not Applicable ☐Refused ☐Deferred ☐Sponge ☐Shower ☐Tub ☐Bed Bath ☐Therapeutic Bath/Shower
Oral Care Completed	☐Not Applicable ☐Self ☐Assisted ☐Completed by Staff ☐Denture Care Self
Peri Care	☐Not Applicable ☐Yes ☐No
NUTRITION	
Diet Type	
Feeding	☐Self ☐Assistance ☐Total Feed ☐Not Applicable ☐Others (Specify)
Tube Feeding: Rate/Type	
TF Residual	
Tube Placement Q4 hours	☐Not Applicable ☐Yes ☐No

PATIENT ID LABEL

BRADEN SCALE BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK	
Ability to respond to meaningfully to pressure-related discomfort	☐COMPLETELY LIMITED: Unresponsive to painful stimuli. =*1* ☐VERY LIMITED: Responds only to painful stimuli-moan/restless =*2* ☐SLIGHTLY LIMITED: Responsive but can't communicate discomfort =*3* ☐NO IMPAIRMENT: Responsive, No sensory deficit =*4*
Degree to which skin is exposed to moisture	☐CONSTANTLY MOIST: Skin is moist most of the time(sweat/urine) =*1* ☐VERY MOIST: Often, but not always moist =*2* ☐OCCASIONALLY MOIST: Requires extra linen change once a day =*3* ☐RARELY MOIST: Skin is usually dry. Routine linen changes =*4*
Degree of Physical Activity	☐BEDFAST: Confined to bed =*1* ☐CHAIRFAST: Walking severely limited or non-existent. =*2* ☐WALKS OCCASIONALLY: Only short distances. Mostly sitting =*3* ☐WALKS FREQUENTLY: Walks outside or inside of room frequently =*4*
Ability to change and control body position	☐COMPLETELY IMMOBILE: No body/extremity position changes alone=*1* ☐VERY LIMITED: Slight, but insignificant changes in position.=*2* ☐SLIGHTLY LIMITED: Independent changes in body/extra positions =*3* ☐NO LIMITATION: Major, frequent changes without assistance =*4*
Usual food intake pattern	☐VERY POOR: Unable to, or rarely eats more than 1/3 of meal =*1* ☐PROBABLY INADEQUATE: Eats about 1/2 of meals =*2* ☐ADEQUATE: Eats over 1/2 of meals, on tube feedings, or TPN =*3* ☐EXCELLENT: Eats most of every meal; No supplements required =*4*
Friction & Shear	☐PROBLEM: Requires mod-to-max assistance and inability to lift =*1* ☐POTENTIAL PROBLEM: Require minimum assist but skin still shears =*2* ☐NO APPARENT PROBLEM: Moves independently in bed & chair =*3*
Total Score: _____ ***Please calculate total score.***	
Is the Score less than 12?	☐Yes ☐No

RESTRAINTS USE	
Is the Patient on Physical Restraints?	☐Yes ☐No ☐Not Applicable
If YES, complete the Restraint Use Justification Assessment and the Behavioral and Activity Assessment.	

MORSE FALL SCALE ASSESSMENT TOOL ADULT	
History of Falls: (Options: Yes=25; No=0)	☐Yes = *25* ☐No = *0*
Secondary Diagnosis: (Two or more medical Diagnoses (Options: Yes=15; No=0)	☐Yes = *15* ☐No = *0*
Ambulatory Aid: (Options: Furniture=30; Crutches/Walker/Cane=15; None/Bedrest/Wheelchair/Nurse= 0)	☐Furniture = *0* ☐Crutches/Walker/Cane = *15* ☐None/Bedrest/Wheelchair = *0*
IV/Saline Lock: (Options: Yes=20; No= 0)	☐Yes = *20* ☐No = *0*
Gait Transferring: (Options: Impaired= 20; Weak=10; Normal/Bedrest/Immobile=0)	☐Impaired = *20* ☐Weak = *10* ☐Normal/Bedrest/Immobile = *0*
Mental Status: (Options: Forgets Limitations=15; Oriented to own ability=0)	☐Forgets Limitations = *15* ☐Oriented to own ability = *0*

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TOTAL SCORE: _____

(If score is greater than 45, complete the Fall Prevention Program Environmental Checklist)

Level of Risk Scores:

If score is 0-24 = Low Risk for Fall and Standard Fall Precautions should be implemented.

If score is 25-44 = Moderate Risk for Fall and Standard Fall Precautions PLUS additional preventative measures should be implemented.

If score is greater than 45 = High Risk for Fall and Standard Fall Precautions PLUS additional high risk preventative measures should be implemented.

****Implement appropriate fall prevention strategies based on patient's risk level.****

FURTHER INSTRUCTIONS

Is this the first reported High Fall Risk for the patient?	☐Not Applicable ☐Yes ☐No
Does the patient need a Fall Risk Care Plan?	☐Yes ☐No

Please *INITIATE* The *Fall Risk Care Plan.*

Was Fall Risk Precaution Taught?	☐Not Applicable ☐Yes ☐No

If No, Please complete the Patient Education Detail.

FALL MEDICATIONS

Is this patient on any of these high alert medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.

Benzodiazpines	**Antipsychotics**	**Anticonvulsants**	**Tricyclic Antidepressants**	**Sedatives**
☐Not Applicable ☐chlordiazepoxide ☐diazepam ☐ clonazepam ☐alprazolam ☐ lorazepam	☐Not Applicable ☐haloperidol ☐chlorpromazine ☐ quetiapine ☐ risperidone	☐Not Applicable ☐phenytoin ☐carbamazepine ☐gabapentine (if not renal dosed)	☐Not Applicable ☐amitriptyline ☐nortriptyline ☐doxepin	☐Not Applicable ☐phenobarbital ☐zolpidem

Is the patient on 1 or more of these HIGH ALERT medications above?	☐ Not Applicable ☐ Yes ☐ No

If yes, document strategies to Recommend to physician to reduce medication related falls by Choosing one of these boxes:

☐Not Applicable
☐lowering the dose
☐tapering off the medication
☐ discontinuing the agent
☐ reducing overall fall-risk-inducing drug (FRID) load

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Is this patient on any of these CAUTION Medications? If yes please click box next to medication (s). If not, click box next to Not Applicable.

Opioids	Antihistamines	Muscle Relaxants
☐ Not Applicable ☐ fentanyl ☐ meperidine ☐ morphine ☐ hydromorphone ☐ oxycodone ☐ hydrocodone ☐ butorphanol ☐ codeine ☐ tramadol	☐ Not Applicable ☐ diphenhydramine ☐ hydroxyzine ☐ promethazine ☐ benztropine	☐ Not Applicable ☐ cyclobenzaprine ☐ baclofen ☐ methocarbamol
SSRI Antidepressants	**Cardiovascular Agents**	**Other**
☐ Not Applicable ☐ paroxetine ☐ fluoxetine ☐ sertraline	☐ Not Applicable ☐ clonidine ☐ doxazosin ☐ digoxin	☐ Not Applicable ☐ meotclopramide ☐ trazodone ☐ large volume magnesium infusion for L&D

Is the patient on 2 or more of these CAUTION medications above?	☐ Not Applicable ☐ Yes ☐ No
If yes, Document strategies to Recommend to physician to Reduce medication related falls by clicking on boxes	☐ Not Applicable ☐ lowering the dose ☐ tapering off the medication ☐ discontinuing the agent ☐ reducing overall fall-risk-inducing drug (FRID) load

PROBLEM LIST

Please complete problems list:	

CLINICAL ALARMS

Is the patient using any of the following high risk clinical Alarms (VentilatorIs the patient using any of the following high risk clinical alarms (Ventilator, CPAP/BIPAP, Fetal Monitor, Infant Warmer, Patient Monitoring System, OB Trace Vue, Infant Ventilator, Oscillator Ventilator, Infusomat Infusion Pump, Nurse Call Light System, Bedside Monitor(Telemetry/Vital Signs), Perfusor Infusion Pump, Kidney Machine, Vital Signs Monitor)?	☐ Yes ☐ No ☐ Not Applicable
Are the alarms set and audible?	☐ Yes ☐ No ☐ Not Applicable
Was education provided on the high risk clinical alarm?	☐ Yes ☐ No ☐ Not Applicable

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If education was provided, please indicate for which High Risk Clinical Alarms	☐Not Applicable ☐Ventilator ☐CPAP/BIPAP ☐Fetal Monitor ☐Infant Warmer ☐Patient Monitoring System ☐OB Trace Vue ☐Infant Ventilator ☐Oscillator Ventilator ☐Infusomat Infusion Pump ☐Nurse Call Light System ☐Bedside Monitor (Telemetry/Vital Signs) ☐Perfusor Infusion Pump ☐Kidney Machine ☐Vital Signs Monitor
EQUIPMENT	
Equipment in Use	☐None ☐ER Cardiac Monitor ☐Lifepak Monitor ☐Feeding Pump ☐Infusion Pump ☐K-Pad ☐Trapeze & Frame ☐Traction ☐PCU Bed ☐Bariatric Bed ☐Air Mattress ☐Telemetry Monitor ☐PCU Monitor ☐Tri-flow ☐Suction ☐Incentive Spirometer ☐Cooling Blanket ☐Sequential Compression Device ☐Intermittent Compression Boot ☐TED Hose ☐PCA Pump ☐Pulse OX ☐Oxygen ☐Bedside Commode ☐Walker ☐Crutches ☐Cryo Cuff ☐BIPAP ☐CPAP ☐Ventilator ☐Wheelchair ☐ICU Central Monitor ☐ICU Bed ☐Others (Specify)
ABUSE	
Are there any signs of abuse or neglect? (If YES, please document in NOTES).	☐Yes ☐No ☐Unknown
SUICIDE ASSESSMENT	
Suicide Risk Level **Any changes in the patient's level must have detailed assessment documentation in the Progress Notes.** **LEVEL 1 (MINIMAL SUICIDE PRECAUTIONS)** **LEVEL 2 (STRICT SUICIDE PRECAUTIONS)**	☐Not Applicable ☐LEVEL 1:: Has active thoughts, no plan, assessed as having significant risk for suicidal attempt or self-harm ☐LEVEL 2: Has active thoughts, with plans, has presented with an existing Suicide attempt or attempted self-harm.
HOME MEDICATIONS	
Have home medications been reconciled this admission?	☐Yes ☐No ☐Not Applicable ***If not, please explain why:***

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CHARGES	
Daily Air Mattress Charge:	☐Not Applicable ☐Yes ☐No
Daily Alternating Leg Pressure Pump Charge:	☐Not Applicable ☐Yes ☐No
Daily Traction/Trapeze Equipment Use Charge:	☐Not Applicable ☐Yes ☐No
Daily Isolation Cart Charge:	☐Not Applicable ☐Yes ☐No
Daily Bilirubin Therapy Use Charge:	☐Not Applicable ☐Yes ☐No
NAME & SIGNATURE	
Licensed Practical Nurse's Name, Title, & Signature	
Registered Nurse's Name, Title, & Signature	

ASSESSMENT NURSING NOTES:

PATIENT ID LABEL