BOARDER PATIENT PEDS RN LPN SHIFT ASSESSMENT	
Date of assessment:	Shift: ☐ 7-3 ☐ 3-11 ☐ 11-7
Is the preferred language used during this shift in explaining patient's health care needs?	☐ Not applicable ☐ Yes ☐ No
ACTIVITY	
Activity level	☐ Awake ☐ Alert ☐ Asleep ☐ Crying ☐ Playful ☐ Up ad lib ☐ Bedrest ☐ Ambulate ☐ Ambulate w/ assist ☐ Up in wheelchair ☐ Bedrest with BRP ☐ Drowsy ☐ Irritable ☐ Lethargic ☐ Obtunded ☐ Appropriate for age
MD activity	☐ None ☐ Phoned ☐ Visited
Activity tolerance	☐ Good ☐ Poor ☐ Fair
Used equipment	☐ Wheelchair ☐ Crutches ☐ Walker ☐ Not applicable
NEURO-PSYCHIATRIC	
Neurological problem	☐ Seizure ☐ Vertigo ☐ Tremors ☐ Incoordination ☐ Weakness ☐ Apparent anxiety ☐ Depression ☐ Euphoria ☐ Flat affect ☐ Delusions ☐ Hallucinations ☐ Bizarre expressions ☐ "Word salad" ☐ Syncope ☐ Not applicable
HEAD/EYES/EARS/NECK	
Fontanel	☐ Not applicable ☐ Open ☐ Closed ☐ Flat ☐ Bulging ☐ Soft ☐ Tense ☐ Sunken
Eyes	☐ Clear ☐ Drainage (Describe and note side) ☐ Jaundice (Sclera) ☐ Redness (Note side) ☐ Puffy lid (Note side) ☐ PERRLA
Ears	☐ Drainage ☐ Ringing ☐ Pain ☐ Not applicable
Neck	☐ Supple ☐ Rigid
RESPIRATORY ASSESSMENT	
Breath sounds	☐ Rhonchi ☐ Equal ☐ Unequal ☐ Clear ☐ Coarse ☐ Crackles ☐ Wheezing ☐ Diminished
Respiratory character	☐ Easy ☐ Nasal flaring ☐ Grunting ☐ Retractions ☐ Apnea ☐ Tachypnea ☐ Shallow ☐ Stridor ☐ Loose cough ☐ Dry cough ☐ Tight cough
Oxygen support	☐ Not applicable ☐ Nasal cannula ☐ Simple mask ☐ NRB mask ☐ Oxyhood ☐ Blowby ☐ Venturi ☐ Ventilator
Amount of oxygen:	Oxygen saturation:
RESPIRATORY TREATMENT	
Inhalation therapy:	
CPT, specify location if applicable:	
Positioning:	
Used equipment:	☐ Not applicable ☐ Apnea monitor ☐ Bedside pulse oximeter ☐ Wall suction ☐ Bulb syringe ☐ Portable suction
Secretion description:	
CARDIAC ASSESSMENT	
Pulse	☐ Regular ☐ Irregular ☐ Murmur ☐ Gallop ☐ Bounding ☐ Loud ☐ Weak ☐ Dilatation of neck vein

Patient ID Label

Skin color	☐ Pink ☐ Pale ☐ Cyanotic ☐ Ashen ☐ Jaundice ☐ Flushed
Used equipment	☐ Cardiac monitor ☐ Arterial line monitor ☐ Not applicable
GASTROINTESTINAL ASSESSMENT	
Abdomen	☐ Soft ☐ Firm ☐ Distended ☐ Flat ☐ Scaphoid ☐ Slightly full ☐ Full
Bowel sounds	☐ Present ☐ Hypoactive ☐ Hyperactive ☐ Absent
Abdominal girth:	GI tubes/dressing and location:
Diet	☐ Regular ☐ Breastfed ☐ Formula (note type) ☐ Babyfood ☐ NPO ☐ Clear liquids ☐ Full liquids ☐ BRAT ☐ Soft ☐ Mechanical ☐ Pureed
Feeding route	☐ Not applicable ☐ PO ☐ IV ☐ Nipple ☐ OGT ☐ NGT ☐ GTT
If tube-fed	☐ Not applicable ☐ Intermittent ☐ Continuous ☐ Kangaroo Pump ☐ Gravity
Note rate/amount if tube-fed:	
Umbilical cord:	☐ Attached, no drainage ☐ Attached, with drainage ☐ Cord dry ☐ Cord off
GENITO-URINARY ASSESSMENT	
Stool frequency:	Stool description:
Voiding:	☐ Continent ☐ Incontinent ☐ Diaper ☐ Urinal ☐ Bedpan ☐ Bedside commode ☐ Foley cath (note size) ☐ Dialysis
Urine color and appearance:	☐ Clear ☐ Cloudy ☐ Straw ☐ Amber ☐ Orange ☐ Red ☐ Foul smelling ☐ Sediment ☐ Concentrated
Has the Patient Education Details been completed on prevention of catheter associated urinary tract infections?	☐ Yes ☐ No ☐ Not applicable
If No, please complete Patient Education Details showing that teaching has been provided regarding Foley care.	
Indication(s) for indwelling urinary catheters:	☐ Not applicable ☐ Acute urinary retention or bladder outlet obstruction ☐ Strict I&O for critically ill patient, 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 urine output ☐ Strict intake and output monitoring due to medication ☐ Assist healing – open sacral/perineal wounds in incontinent patient ☐ Potentially unstable thoracic or lumbar spine ☐ Multiple traumatic injuries, pelvic fractures ☐ Comfort for end of life care ☐ Others (specify)
MUSCULOSKELETAL ASSESSMENT	
Presence of:	☐ Fracture ☐ Deformities ☐ Swelling ☐ Pain ☐ Dressing ☐ N/A
Condition:	☐ Full ROM ☐ Quick cap refill (<3 secs) ☐ Positive sensation ☐ No ROM ☐ Limited ROM ☐ Poor cap refill (>3 secs) ☐ No sensation ☐ Numb ☐ Tingling ☐ Presence of pain (note location
Detailed description, if applicable:	

SKIN ASSESSMENT	
Skin:	☐ Warm ☐ Cool ☐ Mottled ☐ Dry ☐ Rashes ☐ Sores ☐ Abrasion ☐ Laceration ☐ Petechiae ☐ Bruise ☐ Good turgor ☐ Poor turgor ☐ Burns ☐ Bleeding ☐ Circumoral cyanosis ☐ Cyanotic nailbeds ☐ Clubbing of nails
Detailed description if applicable:	
Equipment used:	☐ Not applicable ☐ Warm lamp ☐ Bili light ☐ Bili blanket
INTRAVENOUS SITE ASSESSMENT	
Indications of IV Devices:	☐ None/Not indicated ☐ IV Fluid administration ☐ IV Medication Administration i.e. antibiotics, vasopressors ☐ IV Electrolyte Administration ☐ Parenteral Nutrition ☐ Blood or blood product transfusion ☐ Pressure monitoring ☐ Other (Specify)
IV type:	☐ Not applicable ☐ Peripheral Venous Catheter ☐ Pulmonary Artery Catheter ☐ Peripheral Arterial Catheter ☐ Peripherally Inserted Central Venous Catheter ☐ Totally Implantable (i.e. 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
IV site location:	☐ Upper extremity, right ☐ Upper extremity, left ☐ Lower extremity, right ☐ Lower extremity, left ☐ Dorsum of foot, right ☐ Dorsum of foot, left ☐ Scalp ☐ Internal jugular, right ☐ Internal jugular, left ☐ Femoral, right ☐ Femoral, left ☐ Umbilical ☐ Not applicable
IV site condition:	☐ Intact and patent ☐ Redness ☐ Swelling ☐ Tenderness ☐ Infiltrated ☐ IV burn ☐ Leaking ☐ Not applicable ☐ Other (Specify)
IV delivery method:	☐ Not applicable ☐ Gravity ☐ Infusion pump ☐ Syringe pump
IV Solution A: (Specify name and IV rate)	
IV Solution B: (Specify name and IV rate)	
Has Patient Education Details been completed on prevention of intravascular related infections?	☐ Yes ☐ No ☐ Not applicable
If No, please complete Patient Education Details showing that teaching has been provided regarding IV site care.	
TRANSMISSION BASED PRECAUTIONS	
Is the patient on any of the following transmission based precautions?	☐ None ☐ Contact precautions ☐ Special contact precautions ☐ Droplet precautions ☐ Airborne infection isolation
Is this a newly initiated precaution for this patient during this hospitalization?	☐ Yes ☐ No ☐ Not applicable
If one of more are chosen above please complete Patient Education Details form.	

SAFETY ASSESSMENT	
Safety precautions:	☐ Bed siderails up X1 ☐ Bed siderails up X2 ☐ Bed siderails up X3 ☐ Bed siderails up X4 ☐ Bed in low position ☐ Crib rails up X1 ☐ Crib rails up X2 ☐ Fall safety protocol ☐ Call light in reach ☐ Wrist restraints ☐ Ankle restraints ☐ Safety vest ☐ Watcher present at bedside ☐ ID bracelet on patient and parent/support person
Seizure precautions:	☐ Yes ☐ No ☐ Not applicable
Aspiration precautions:	☐ Yes ☐ No ☐ Not applicable
Sleeps on:	☐ Bed ☐ Crib ☐ Open warmer ☐ Isolette ☐ Bassinet ☐ Other, specify
RESTRAINT USE	
Is the patient on physical restraints?	☐ Yes ☐ No ☐ Not applicable
Note: Remember to complete the Behavior Activity Assessment as per policy every 2 hours for medical surgical reasons and every 15 minutes for behavioral management reasons.	
The use of restraints has a limited time frame (restraint episode). If restraints are clinically justified to be continued, a Restraint Use Justification Assessment needs to be completed (for each episode) and accompanied by an MD order for restraints. The MD needs to perform an in-person evaluation before a restraint use order is renewed. Restraint duration for medical-surgical reason is 24 hours. Restraint duration for behavior management is 4 hours (for ages 17 and older), 2 hours (for ages 9-17), and every hour (for ages <9 years old).	

HUMPTY DUMPTY FALLS RISK ASSESSMENT TOOL	
AGE: (CRITERIA: Less than 3 years old = 4; 3 to less than 7 years old = 3; 7 to less than 13 years old = 2; 13 years old and above = 1)	☐ Less than 3 years old (Score 4) ☐ 3 to less than 7 years old (Score 3) ☐ 7 to less than 13 years old (Score 2) ☐ 13 years old and above (Score 1) ☐ Not applicable
GENDER: (CRITERIA: Male = 2; Female = 1)	☐ Male (Score 2) ☐ Female (Score 1)
DIAGNOSIS: (CRITERIA: Neurological Diagnosis = 4; Alterations in Oxygenation Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc. = 3; Psych/Behavioral Disorders = 2; Other Diagnosis = 1)	☐ Neurological Diagnosis (Score 4) ☐ Alterations in Oxygenation Respiratory Diagnosis (Score 3) ☐ Psych/Behavioral Disorders (Score 2) ☐ Other Diagnosis (Score 1) ☐ Not applicable
COGNITIVE IMPAIRMENTS: (CRITERIA: Not aware of limitations = 3; Forgets limitations = 2; Oriented to own ability = 1)	☐ Not aware of limitations (Score 3) ☐ Forgets limitations (Score 2) ☐ Oriented to own ability (Score 1) ☐ Not applicable
ENVIRONMENTAL FACTORS (CRITERIA: History of falls or infant/toddler placed in bed = 4; Patient uses assistive devices or infant/toddler in crib or furniture/lighting(Tripled Room) = 3; Patient placed in bed = 2; Outpatient area = 1)	☐ History of falls or infant/toddler placed in bed (Score 4) ☐ Patient uses assistive devices or infant/toddler crib (Score 3) ☐ Patient placed in bed (Score 2) ☐ Outpatient area (Score 1) ☐ Not applicable

Patient ID Label

RESPONSE TO SURGERY/SEDATION/ANESTHESIA: (CRITERIA: Within 24 hours = 3; Within 48 hours = 2; More than 48 hours/None =1)	☐ Within 24 hours (Score 3) ☐ Within 48 hours (Score 2) ☐ More than 48 hours/None (Score 1) ☐ Not applicable
MEDICATIONS USAGE: (CRITERIA: Multiple usage of sedatives (excluding ICU patients sedated or paralyzed)Hypnotics/Barbiturates/ Phenothiazines/Antidepressants/Laxatives/ Diuretics/Narcotics = 3; One of the medications listed above = 2; Other medications/None = 1)	☐ Multiple usage of medications (Score 3) ☐ One of the medications listed above (Score 2) ☐ Other medications/None (Score 1) ☐ Not applicable

FURTHER INSTRUCTIONS	
Total score:	
*If score is 12 or above (HIGH RISK), complete the FALL PREVENTION PROGRAM – ENVIRONMENTAL CHECKLIST.	☐ Not applicable ☐ Yes ☐ No
*FALL RISK RATING: 7-11 LOW RISK	12 or above HIGH RISK
Is this patient at moderate risk for fall?	☐ Yes ☐ No
Does the patient need a fall risk care plan?	☐ Not applicable ☐ Yes ☐ No
If yes, please add a Fall Risk Care Plan in patient's chart.	
Was Fall Risk Precaution taught?	☐ Not applicable ☐ Yes ☐ No
If no, please complete Patient Education Detail.	

PAIN ASSESSMENT				
Presence of pain:	☐ Yes ☐ No	Level of pain:	☐ 0 - No pain ☐ 1 ☐ 2 - Mild pain ☐ 3 ☐ 4Moderate ☐ 5	☐ 6 ☐ 7 ☐ 8 - Severe pain ☐ 9 ☐ 10 - Worst pain
Location of pain:				
Pain assessment tool used: The use of an identified tool MUST be consistent throughout the patient's admission. It should 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			
At any time the patient reports pain, all documentation (comprehensive assessment, interventions, and reassessment) must be done in the Pain Assessment Flow Sheet. REMINDER: TRANSPORTATION ARRANGEMENTS AT DISCHARGE.				

ABUSE	
Are there any signs of abuse or neglect? (If yes, please specify)	☐ Yes ☐ No ☐ Unknown

SUICIDE ASSESSMENT	
Suicide risk level: **LEVEL 1 (MINIMAL SUICIDE PRECAUTIONS)** **LEVEL2 (STRICT SUICIDE PRECAUTIONS)**	☐ None – No current thoughts, no plans, no risk factors ☐ 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 suicidal attempt or attempted self-harm.
Patient family reminded of transportation arrangements at time of discharge.	☐ Yes ☐ No ☐ Not applicable

HOME MEDICATIONS	
Have home medications been reconciled for this admission?	☐ Yes ☐ No ☐ Not applicable
If not, please explain why:	
Is the patient a teenage mother?	☐ Yes ☐ No

CLINICAL ALARMS	
Is 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
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

CHARGES	
Please select appropriate response for charging purposes. DO NOT forget to process charges.	
Daily Air Mattress Charge	☐ Yes ☐ No ☐ Not applicable
Daily Alternating Leg Pressure Pump Charge	☐ Yes ☐ No ☐ Not applicable
Daily Traction/Trapeze Equipment Use Charge	☐ Yes ☐ No ☐ Not applicable
Daily Isolation Cart Charge	☐ Yes ☐ No ☐ Not applicable
Daily Bilirubin Therapy Use Charge	☐ Yes ☐ No ☐ Not applicable

NAME AND SIGNATURE	
Licensed Practical Nurse's Name and Signature:	
Registered Nurse's Name and Signature:	

BOARDER PATIENT PEDS RN LPN
SHIFT ASSESSMENT

Patient ID Label