OB SYSTEMS ASSESSMENT
RN assessments occur every 12 hours or more frequently determined by patient acuity.

Date: ____________ Time: ____________ Type of Assessment: ☐ Standard ☐ New Admission ☐ Post Operative ☐ Transfer
Check boxes that apply. Circle items that apply. Add comments prn.

NEUROLOGICAL:
☐ Alert ☐ Drowsy ☐ Lethargic ☐ Comatose
Oriented:
☐ Person ☐ Place ☐ Date ☐ Date Disoriented:
☐ Occ ☐ Freq ☐ Constantly
Behavior / Affect:
☐ Appropriate ☐ Flat ☐ Agitated ☐ Anxious
Swallow:
☐ Intact ☐ Impaired
Movement & Sensation:
☐ Intact all 4 extremities ☐ Impaired (describe)
Comments:

PAIN ASSESSMENT:
Current Pain Management: ☐ N/A ☐ PRN Analgesia ☐ Scheduled Analgesia ☐ PCA ☐ Epidural ☐ Non-pharmacologic
Pain Scale Used: ☐ Verbal Descriptive Scale ☐ Numeric Rating Scale ☐ Visual Analogue Scale ☐ ModFlacc
Is the patient currently having pain? ☐ Yes ☐ No, pain not an issue ☐ No, pain management effective
Location/radiation of pain:
Duration: ☐ Chronic ☐ Acute ☐ Constant ☐ Intermittent ☐ Other
Character:
☐ Stabbing ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Other
Comments:

RESPIRATORY:
Spontaneous respirations:
☐ Regular ☐ Irregular ☐ Unlabored ☐ Labored ☐ Symmetrical ☐ Asymmetrical
Oxygen Required:
☐ Yes ☐ No ☐ Intermittently IS use ☐ Yes ☐ No Volume ☐ Other
Oxygen Delivery:
☐ Nasal Cannula ☐ Face Tent ☐ Venti Mask ☐ Non-rebreather
Breath Sounds:
☐ Right ☐ Clear ☐ Bases Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes
☐ Left ☐ Clear ☐ Bases Decreased ☐ Rales ☐ Rhonchi ☐ Wheezes
Comments:

CARDIOVASCULAR:
☐ Nonmonitored: ☐ Regular ☐ Irregular
☐ Pulses present & palp x4 ☐ Pulses abnormal ☐ SCD’s ☐ Foot Pump ☐ TED’s
Edema:
☐ No ☐ Yes ☐ Extremities ☐ General
Comments:

MUSCULOSKELETAL / MOBILITY:
Gait:
☐ Steady ☐ Unsteady ☐ Unable to ambulate ☐ Bed Rest
Transfers:
☐ Independent ☐ Standby Assist ☐ Mod assist ☐ Max Assist
Diligent Equipment in Use:
☐ Yes ☐ No Type:
☐ Stedy ☐ Encore ☐ Tempo ☐ Maxi Slides ☐ Transfer Tube ☐ Tenor
Comments:

GASTROINTESTINAL:
Abdomen:
☐ Soft ☐ Firm ☐ NonDistended ☐ Distended
Bowel Sounds:
☐ Active ☐ Hypoactive ☐ None
Nutrition:
☐ PO Diet ☐ NPO ☐ Tube Feeding ☐ TPN
Stool:
Last BM:
Comments:

OBSTETRICAL:
☐ Fundus WNL ☐ Lochia WNL
☐ Fetal/Uterine Assessment on Labor Record
☐ Fetal movement ☐ Breast WNL
Episiotomy:
☐ Clean & Intact ☐ Swelling & Bruising
Comments:

To reorder, log onto http://www.virginia.edu/uvaprint
GENITOURINARY: □ BSC □ Bed pan □ I & O Cath □ Foley Reason for Foley: 
Urine: □ Yellow □ Amber □ Bloody □ Clear □ Cloudy
Comments:

INTEGUMENTARY: □ Warm □ Cool □ Normal □ Dry □ Moist Skin Color: □ Normal □ Pale □ Jaundiced □ Cyanotic □ Reddened
Use the diagram below to indicate the presence of invasive lines / wounds / drains / dressings / rashes / medication patches, etc. Indicate location by placing a number on the diagram and then list items by number.

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<th>Right ANTERIOR</th>
<th>Left POSTERIOR</th>
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Central venous access: Dressing □ In date □ Changed (Monday, Wednesday, Friday cap and dressing change)
PICC line: Dressing □ In date □ Changed (Monday, Thursday cap and dressing change) PIV(s): □ In date □ Changed every 72 hours □

Braden Risk Assessment Scale: Admission □ Monday □ Wednesday □ Friday 
Circle the number in each category; total at bottom

SCORE: __________ ≤ 15-18 = Skin Breakdown Risk □ Egg Crate
Specialty Bed: □ Kin Air Overlay □ Kin Air □ BariKare □ BariMax □ Still Required? □ Yes □ No

Comments:

PSYCHOSOCIAL: Concerns expressed regarding sexuality, culture, religious beliefs or ethnicity: □ Yes □ No
Patient express coping: □ Yes □ No □ Support Needs Identified: □ Emotional Support □ Family Support □ Other
□ Suicide precautions in place
Suicide Assessment: “You have been placed on suicide precautions. Do you feel like hurting yourself now?” □ Yes □ No
Suicide interventions: □ 1:1 observation maintained □ Constant observation maintained
Comments:

SAFETY: Check all that apply: □ Bed alarm in use □ ID Band □ Bed low position □ Call bell within reach □ Restraints

Schmid Fall Risk Assessment Tool — Circle group number
MOBILITY  □ 0. Ambulates without gait disturbance □ 1. Ambulates or transfers with assist devices or assistance/unsteady gait □ 2. Ambulates with unsteady gait and no assistance □ 3. Unable to ambulate or transfer
MENTATION  □ 0. Alert, oriented x 3 □ 1. Confusion at all times □ 2. Comatose/unresponsive
MEDICATION  □ 1. Anticonvulsants, tranquilizers, psychotropics, hypnotics □ 2. No anticonvulsants, tranquilizers, psychotropics, hypnotics
ELIMINATION □ 0. Independent in elimination □ 1. Needs assistance with toileting □ 2. Incontinent
PRIOR FALL □ 0. No prior history □ 1. Unknown
HISTORY □ 1. Yes, before admission (home or previous admission) □ 2. Yes, during this admission

Total Score: __________ □ 3 or greater = FALL RISK

Comments:

Fall Risk Reduction Intervention
Fall Precaution Procedure: □ Start □ Continue □ Discontinue □ Communicate patient fall risk to charge nurse □ Activate bed alarm system □ Observe Q2 hours and document on the CDFS — “Fall Check” □ Offer elimination and hydration Q 2 hours and document □ Do not leave unattended in bathroom / on BSC. □ Educate/reeducate patient to call for assistance to get out of bed. □ Ensure no clutter around bed and path to bathroom □ Recommend P.T. consult to MD □ Recommend O.T. consult to MD □ Request pharmacist to assess medications □ Increase observation to Q 30 minutes and document on CDFS — “Fall Check” □ Move patient closer to nurses’ station

RN completing systems assessment signature: ___________________________ Date / Time: ___________________________