UNIVERSITY OF VIRGINIA HEALTH SYSTEM

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PLACE LABEL HERE.

FEBRUARY 2008
FORM NO. 050381

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

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 Disoriented: ☐Occ ☐Freq ☐Constantly
Behavior / Affect: ☐Appropriate ☐Flat ☐Agitated ☐Anxious Able to communicate needs: ☐Yes ☐No
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: _____ Pain rating: _____ Pt's pain goal: _____
Duration: ☐Chronic ☐Acute ☐Constant ☐Intermittent ☐Other
Character: ☐Stabbing ☐Burning ☐Sharp ☐Dull ☐Ache ☐Other
Comments:

*For pain reassessment see CDFS

RESPIRATORY: Spontaneous respirations: ☐Regular ☐Irregular ☐Unlabored ☐Labored ☐Symmetrical ☐Asymmetrical
Oxygen Required: ☐Yes ☐No ☐Intermittently IS use ☐Yes ☐No Volume _____ Other pulmonary toilet activities: _____
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 Type of Assistive Device:
Transfers: ☐Independent ☐Standby Assist ☐Mod assist ☐Max Assist Bed mobility: ☐Independent ☐Mod assist ☐Max assist
Diligent Equipment in Use: ☐Yes ☐No Type: ☐Stedy ☐Encore ☐Tempo ☐Maxi Slides ☐Transfer Tube ☐Tenor
Comments:

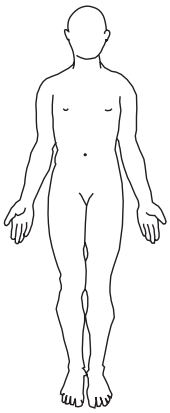
GASTROINTESTINAL:
Abdomen: ☐Soft ☐Firm ☐NonDistended ☐Distended
Bowel Sounds: ☐Active ☐Hypoactive ☐None Flatus: ☐Yes ☐No
Nutrition: ☐PO Diet ☐NPO ☐Tube Feeding ☐TPN
Stool: Last BM: _____
Comments:

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

GENITOURINARY: ☐BSC ☐Bed pan ☐I & O Cath ☐Foley Reason for Foley:
Urine: ☐Yellow ☐Amber ☐Bloody ☐Clear ☐Cloudy
Comments:

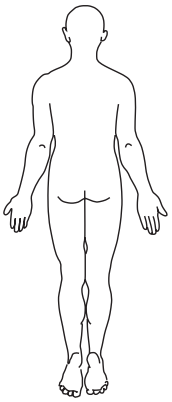
INTEGUMENTARY: ☐Warm ☐Cool ☐Normal ☐Dry ☐Moist Skin Color: ☐Normal ☐Pale ☐Jaundiced ☐Cyanotic ☐Reddened
Use the diagram below to indicate the presence of invasive lines / wounds / drains / dressings / rashes / medication patches, etc.
Indicate location by placing a number on the diagram and then list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

Right ANTERIOR Left



#1. _____
#2. _____
#3. _____
#4. _____
#5. _____
#6. _____
#7. _____
#8. _____
#9. _____
#10. _____

Left POSTERIOR Right



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*

SENSORY PERCEPTION	**4**. No Impairment	**3**. Slightly Limited	**2.** Very Limited	**1**. Completely Limited
MOISTURE	**4**. Rarely Moist	**3**. Occasionally Moist	**2**. Very Moist	**1.** Constantly Moist
ACTIVITY	**4**. Walks Frequently	**3**. Walks Occasionally	**2**. Chairfast	**1.** Bedfast
MOBILITY	**4.** No Limitations	**3**. Slightly Limited	**2**. Very Limited	**1.** Completely Immobile
NUTRITION	**4**. Excellent	**3**. Adequate	**2**. Probably Inadequate	**1.** Very Poor
FRICTION AND SHEAR		**3.** No Apparent Problem	**2.** Potential Problem	**1.** Problem

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.
1 Ambulates with unsteady gait and no assistance
0 Unable to ambulate or transfer
MENTATION **0** Alert, oriented x 3 **1** Periodic confusion
1 Confusion at all times **0** Comatose/unresponsive
MEDICATION **1** Anticonvulsants, tranquilizers, psychotropics, hypnotics
0 No anticonvulsants, tranquilizers, psychotropics, hypnotics
ELIMINATION **0** Independent in elimination
1 Independent with frequency or diarrhea
1 Needs assistance with toileting
1 Incontinent
PRIOR FALL HISTORY **0** No prior history **1** Unknown
1 Yes, before admission (home or previous admission)
2 Yes, during this admission Date _____

*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.
☐ Frequently orient patient to call bell(s)
☐ 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: _____