[redacted] Community Hospital
[redacted], California [redacted]

PATIENT CARE RECORD 12 HR MEDICAL / SURGICAL

DATE: 8-14-03

PATIENT INFORMATION

Duck, Frank A.
MR# K0024632
DOB: 02-27-87
Dr. Prado, M.

ACUITY LEVEL KEY		ACUITY TOTALS	D	N
POINTS	LEVEL	SUBTOTAL SECTION "A"		18
26-37	1	SUBTOTAL SECTION "B"		50
38-55	2	SUBTOTAL SECTION "C"		14
56-70	3	TOTAL POINTS		82
71-83	4	ACUITY LEVEL		4
84-95	5			
96-120	6			
121+	7			

INDICATE DIET TYPE AND % TAKEN (<50% = ▲)	B/AM	L/PM	D/HS
DIET:			
Mechanical soft			
NOURISHMENT:			

	SECTION A *Cued items need supportive documentation	D	N
NUTRITION	DIET CHECK / SELF FEED / SETUP TRAY	2	2
	▲ NPO	2	2
	* ROUTINE INTAKE &/OR OUTPUT	2	2
	* ASSIST WITH MEAL / BREAST FED	2	2
	* CONTROLLED SIPS/CHIPS/FORCE/LIMIT	5	5
	* COMPLEX INTAKE AND OUTPUT/CALORIE COUNT	5	5
	* ASSIST FEED/ASSIST BREAST FEED	5	5
	▲ * TUBE FEED/TOTAL FEED	8	8
	* TEACHING NUTRITION	8	8
	* COMPLEX TOTAL FEED	8	8
HYGIENE	ENVIRONMENTAL CHECK/STANDARD PRECAUTIONS	1	1
	SELF BATH	1	1
	AM / HS / COMFORT CARE	2	2
	TUB / SHOWER WITH OCCASIONAL CHECKS	2	2
	PARTIAL BATH/COMPLETE BATH c PT. ASSIST/CLOTHING	2	2
	▲ COMPLETE BATH/WHEELCHAIR SHOWER/CLOTHING	4	4
	* COMPLEX BATH/SHOWER	5	5
	* TEACHING HYGIENE	5	5
	▲ * MULTIPLE BATHS	5	5
MOBILITY	PATIENT ROUNDS	2	2
	UP AD LIB/CHAIR/BRP	2	2
	* AMBULATE/BRP/COMMODE/CHAIR WITH MIN ASSIST.	2	2
	* AMBULATE/BRP/COMMODE/CHAIR WITH MOD ASSIST.	5	5
	* REPOSITION NON BEDREST PATIENT	5	5
	* BED REST c BRP/COMMODE	5	5
	* BED REST/INFANT NOT YET INDEPENDENT	5	5
	▲ * RESTRICTIVE BED REST	8	8
	* COMPLEX MOBILITY	8	8
	* TEACHING MOBILITY	8	8
	▲ * THERAPEUTIC REPOSITIONING	8	8
	▲ * PHYSICAL RESTRAINTS	10	10
	SUBTOTAL SECTION A =		18

	SECTION B *Cued items need supportive documentation	D	N
MEDICATIONS	MAR CHECK	5	5
	* MEDICATIONS WITHOUT IV'S	8	8
	* IV WITH OR WITHOUT MEDS	15	15
	* MULTIPLE MEDS	15	15
	* IV LOCK WITH OR WITHOUT MEDS	15	15
	* TEACHING MEDICATIONS	15	15
	* MULTIPLE PIGGY BACKS/PUSHES	20	20
	* MONITORED MEDICATION ADMINISTRATIONS/DRIP(S)	20	20
	* BLOOD/BLOOD COMPONENTS	20	20
	* FREQ. ADMIN./INTERVENTION	25	25
	* COMPLEX MEDICATIONS	30	30
BEHAVIOR	RESPONSIVE TO CARE/EMOTIONAL SUPPORT	5	5
	* ORIENTATION TO UNIT	10	10
	* NEUROLOGICAL IMPAIRMENT	10	10
	* INEFFECTIVE COPING/EMOTIONAL DISTRESS	10	10
	* MULTIPLE REQUESTS/CONTINUOUS CRYING	10	10
	* DEPRESSION/GRIEVING	10	10
	* LETHARGIC/SEMICOMATOSE	10	10
	▲ * UNRESPONSIVE/COMATOSE	10	10
	* OVERSTIMULATED/OVERACTIVE	10	10
	▲ * CONFUSED/DISORIENTED	10	10
	* DELUSIONS/HALLUCINATIONS	15	15
	* DELIBERATELY WITHHOLDING INFORMATION	15	15
	* ATTENTION SEEKING BEHAVIOR	15	15
	* DISRUPTIVE	15	15
	* THREATENING PHYSICAL HARM	15	15
STATE	* REVIEW PLAN OF CARE WITH PATIENT	4	4
	* REVIEW DISCHARGE PLAN WITH PATIENT	4	4
	RESPONSIBLE FOR ADL's/ASSISTANCE WITH ADL's	4	4
	* DEPENDENT FOR ADL's	7	7
	* SHORT TERM TEACHING	7	7
	* SOCIAL RESTRICTIONS	7	7
	* DISCHARGE PLANNING	7	7
	* PRE-OP/PRE-SPECIAL PROCEDURE/PRE-DELIVERY PREPARATION	11	11
	* POST-OP/POST-SPECIAL PROCEDURE/POST-DELIVERY NEWBORN	11	11
	* COMPLEX ADMISSION/TRANSFER IN	11	11
	* PLANNING CARE WITH THE PATIENT	11	11
	* COMPLEX DISCHARGE PLANNING/TEACHING	11	11
	* ACUTE PHYSIOLOGICAL INSTABILITY	15	15
	* COMMUNICATION BARRIER SEVERE SENSORY IMPAIRMENT	15	15
	* EXTENSIVE DIRECT NURSING CARE > 3H/SHIFT	20	20
	* EXTENSIVE DIRECT NURSING CARE ≥ 5-7H/SHIFT	30	30
	* EXTENSIVE DIRECT NURSING CARE ≥ 7H/SHIFT	40	40
	SUBTOTAL SECTION B =		50

TREATMENT/PROCEDURE	D	N	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
PHYSICAL ASSESSMENT (7/14)		14																											RS			
VITALS (7)		7																											RS			
DAILY WT. (7)		7																											RS			
O2 therapy		7																											RS			
SUBTOTAL SECTION C = (INCLUDE PG. 4)		14																														

6 "7's" = 14 5 "14's" = 20 6-9 "14's" = 30 10-12 "14's" = 45 3 "20's" = 30 2 "30's" = 45

SIGNATURES/INITIALS

RS-RS Grauy RN

>2 ▲ = Skin Risk >2 Shaded Area = Fall Risk

[redacted] Community Hospital
[redacted] California

PATIENT CARE RECORD 12 HR MEDICAL / SURGICAL

PATIENT INFORMATION

Duck, Frank A.

DATE	7AM - 7PM TIME	INITIALS	7PM - 7AM TIME	INITIALS
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☐ WNL ☐ DEFERRED ☑ EXCEPTION ☐ CONCUR	
ALERT ORIENTED X 4 (age appropriate)	Comments:		Comments:	
MAE's EQUALLY			(L) periorbital area smaller, unable to	
SENSATION PRESENT			assess PERRLA on (L), ↓ Rom to (R)	
			wng. Answers questions appropriately	
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☐ WNL ☐ DEFERRED ☑ EXCEPTION ☐ CONCUR	
RESPIRATIONS REGULAR,	Comments:		Comments:	
UNLABORED BREATHING			LS ↓ to (R) side, tachypnea, c/o	
SOUNDS CLEAR BILATERALLY			slight SOB ≈ exertion, O2 mask	
			@ 8L in place, O2 sats 94-1.	
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☐ WNL ☐ DEFERRED ☑ EXCEPTION ☐ CONCUR	
APICAL PULSE REGULAR	Comments:		Comments:	
PERIPHERAL PULSES PRESENT			HR tachycardic	
NO EDEMA BILATERALLY				
PROMPT CAPILLARY REFILL				
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☑ WNL ☐ DEFERRED ☐ EXCEPTION ☐ CONCUR	
ABDOMEN SOFT, NON-TENDER	Comments:		Comments:	
NON-DISTENDED, + BOWEL				
SOUNDS 4 QUADS				
	DATE OF LAST BM:		DATE OF LAST BM:	
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☑ WNL ☐ DEFERRED ☐ EXCEPTION	
VOIDING SPONTANEOUSLY	Comments:		Comments:	
URINE CLEAR, NO BLADDER			Hasn't yet voided since arrival	
DISTENTION, CONTINENT				
(age appropriate)	☐ FOLEY / SUPRAPUBIC / CONDOM / DIAPER		☐ FOLEY / SUPRAPUBIC / CONDOM / DIAPER	
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☐ WNL ☐ DEFERRED ☑ EXCEPTION	
WARM, DRY, INTACT	Comments:		Comments:	
MOIST MUCOUS MEMBRANES			small hematoma formation to superior	
ELASTIC TURGOR			portion of beak, (L) eye ≈ edema +	
NORMAL COLOR			bluish discoloration. (R) wng fx ≈	
			asg in place	
NORMAL	☐ WNL ☐ DEFERRED ☐ EXCEPTION		☑ WNL ☐ DEFERRED ☐ EXCEPTION	
CLINICAL STATE,	Comments:		Comments:	
CALM & COOPERATIVE			Guardian @ bedside	
SUPPORTIVE FAMILY / SIGNIFICANT				
OTHER				

	NURSES NOTES
0340	Pt admitted to 2021 ext from ER, arrived ≈ gurney in stable condition. Admission hx and assessment completed. Placed on 8L of O2 via facial mask — RS
0425	No Δ in assessment. Dr. Prado in to assess pt. No new orders received — RS
0550	Lab results in. H+H stable. WBC elevated @ 18.9. Dr. Prado notified + pt to be started on IV antibiotic - Rocephin — RS

[redacted] Community Hospital
[redacted] California [redacted]

PATIENT INFORMATION

Duck, Frank A.

PATIENT CARE RECORD 12 HR MEDICAL / SURGICAL

DATE: 8-14-03

											SITE EVALUATION
0346	#22	Rshoulder	WNL		✓		✓			RS	WNL = NO REDNESS, TENDERNESS OR INFILTRATION R = REDNESS T = TENDERNESS I = INFILTRATION * = SEE NURSES NOTE

		INITIALS
ASSIST/TOTAL FEED	REASON	REASON
COMPLEX FEED	☐ RESISTIVE ☐ DIFFICULTY CHEWING OR SWALLOWING ☐ OTHER	☐ RESISTIVE ☐ DIFFICULTY CHEWING OR SWALLOWING ☐ OTHER
COMPLEX BATH/SHOWER	REASON	REASON
MULTIPLE BATHS	☐ PARTIAL X ☐ COMPLETE X ☐ DIAPER/ATTENDS Δ X REASON	☐ PARTIAL X ☐ COMPLETE X ☐ DIAPER/ATTENDS Δ X REASON
AMBULATION/BRP COMMODE/CHAIR BEDREST	FREQUENCY X DISTANCE TOLERANCE RESTRICTIONS	FREQUENCY X 0-7 DISTANCE bed TOLERANCE poor RESTRICTIONS pain, SOB
PRECAUTIONS SIDE RAILS:	☐ CALL LIGHT WITHIN REACH ☐ INITIATE ☐ MAINTAIN ☐ N/A ☐ UP x ☐ PT./FAMILY REFUSED ☑ RECENT FALL WITHIN 8HR	☐ CALL LIGHT WITHIN REACH ☐ INITIATE ☑ MAINTAIN ☐ N/A ☑ UP x 2 ☐ PT./FAMILY REFUSED ☐ RECENT FALL WITHIN 8HR

Sedation Score: 1 - Wide awake 2 - Drowsy 3 - Dosing Intermittently 4 - Mostly sleeping 5 - Waken when aroused

0346	@ sx of distress	noted						

[redacted] Community Hospital
California [redacted]

PATIENT INFORMATION

PATIENT CARE RECORD 12 HR MEDICAL / SURGICAL

DAY

INTAKE							OUTPUT						
PARENTERAL				ORAL / TUBE				URINE					
TIME	TYPE FLUID/ADDITIVE	AMT STARTED	AMT INFUSED	TIME	TYPE	AMT (cc)	TIME	VOID	CATH	GASTRIC NG	STOOL	RESIDUAL	
	TOTAL				TOTAL		TOTALS						
8° INTAKE TOTAL							8° OUTPUT TOTAL						

NIGHT

INTAKE							OUTPUT						
PARENTERAL				ORAL / TUBE				URINE					
TIME	TYPE FLUID/ADDITIVE	AMT STARTED	AMT INFUSED	TIME	TYPE	AMT (cc)	TIME	VOID	CATH	GASTRIC NG	STOOL	RESIDUAL	
0345	NS 50cc/*												
	TOTAL				TOTAL		TOTALS						
8° INTAKE TOTAL							8° OUTPUT TOTAL						

ITEM	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RESTRAINT: "ON"																								
RELEASE / ADL (q2H MINIMUM)																								
ROUNDS (A,R,S)																								
IV CHECK Q1 (- or +)																								
REPOSITIONING (R,L,S,P)																								

[redacted] Community Hospital
[redacted] California

ADULT NURSING ADMISSION HISTORY

P2947 (04/01)

PATIENT INFORMATION
Duck, Frank A.
MR# K00024632
DOB: 02-27-87
MD: Prado, M.

DATE ADMITTED	TIME ADMITTED	HISTORY COMPLETED	ADMITTED PER	ACCOMPANIED BY:
8/14/08	0340	✓	☐ Ambulatory ☐ Wheelchair ☑ Stretcher	ER RN, guardian

ADMITTED FROM
☐ Direct ☑ ER ☐ Ext. Care Facility ☐ Other:

UNABLE TO OBTAIN INFORMATION AT THIS TIME DUE TO:
☐ No Family ☐ No Translator ☐ Other:

SOURCE OF INFORMATION:
☐ Patient ☑ Other: next of kin

Height: 10" Weight: 2.2 kg
☐ Stated ☑ Scale # bed
Patient Understanding of Hospitalization: pt unconscious currently

Reason for Admission MVA: R/o closed head injury, ① mng fx, ② periorbital contusion

Has Advance Directive for Health Care? ☐ Yes ☑ No
If Yes, Copy on Chart ☐ Yes ☐ No Instructed to Bring ☐ Yes ☐ No

ALLERGIES, SIDE EFFECT
Reaction Type

Medications (specify): NKA
☐ Anesthesia NKA
☐ Blood Products Ø
Iodine ☐ Ø Tape ☐ Ø
Food Ø

Hx Flu Shot ☐ Ø Tetanus ☐ never
Pneumovax ☐ Ø PPD ☐ Ø

HOME MEDICATIONS

Medicine	Dose/Freq	Why Taken	Last Taken
Ø meds			

DISPOSITION: ☐ Sent Home ☐ To Pharm ☐ Did not Bring

HISTORY OF:

Yes	No		
☐	☑	Heart Disease	AICD ☐ Pacemaker ☐
☐	☑	Lung Disease	
☐	☑	Diabetes	
☐	☑	Seizures	
☐	☑	High BP	
☐	☑	Cancer	
☐	☑	Jaundice	
☐	☑	Stroke	
☐	☑	Kidney	
☐	☑	Elimination Problems	LBM - unk
☐	☑	Others:	
☐	☐		

PAIN /DISCOMFORT

Location(s):	Q	P	I
1. Ø sx of pain noted			
2. @ this time			
3.			

Nonpharm. Interventions used:

COMMENTS:

Pain scale instructions received: ☐ Yes ☑ No
Acceptable pain level _____ / 10
Understanding verbalized: ☐ Yes ☑ No

PAIN ASSESSMENT
KEY

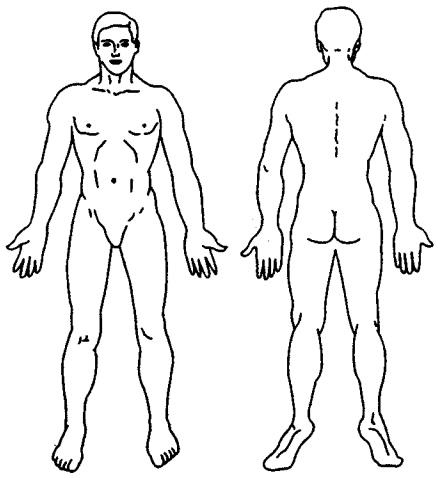
(Q) Quality
A = Dull
B = Sharp
C = Crushing
D = Throbbing
E = Tingling
F = Burning
G = Ache
H = Numbing
I = Other

(P) Pattern
C = Continuous
I = Intermittent

(I) Intensity
Rate on a scale of 0 to 10
0 = no pain
10 = worst pain imaginable

SKIN HISTORY REVIEW

Mark drawing with appropriate letter
A - Amputation
AB - Abrasion
B - Burn
E - Ecchymosis
D - Deformity
DC - Decubitus
DI - Discoloration
L - Laceration
R - Rash
S - Scar
SW - Swelling
O - Ostomy Site
U - Ulcer



PAST HOSPITALIZATION - SURGERIES / DATES

None

Past Transfusions Yes ☐ No ☑
If Yes: Last Product Received _____
Approximate Date _____

Blood Products Accepted Yes ☑ No ☐
If Yes: Consent Signed Yes ☐ No ☑
If No: Blood Refused Form Signed Yes ☐ No ☐

Autologous Blood Available ☐

[redacted] Community Hospital
[redacted], California [redacted]

PATIENT INFORMATION

ADULT NURSING ADMISSION HISTORY

P2947 (04/01)

LIMITATIONS

Yes	No		
☑	☐	Vision	(L) periorbital swelling; (R) eye cataract
☐	☑	Hearing	
☑	☐	Mobility	↓ ROM to (R) wrist
☐	☑	Speech	
☐	☑	Orientation	
☐	☑	Other	
☐	☑	Swallowing / Chewing	
☐	☑	Bed Bound / Wheelchair Bound	
☐	☑	Stairs	
☐	☑	Prosthesis	

ACTIVITIES OF DAILY LIVING

Sleep / Rest Patterns

☑ No Difficulty; ☐ Yes, Describe _____

Limitations in Routine Physical Activity Patterns

☐ No ☑ Yes, Describe (R) wrist fx

BELONGINGS

		DATE / RM #	DATE / RM #	STAFF Initials	Given to Family/SO Date/Time Signature of person receiving
Dentures ☐ Yes ☑ No	Upper				
	Partial				
	Lower				
Glasses / Contacts					
Hearing Aid ☐ Yes ☑ No					
Jewelry none					
Cane / Walker / WheelChair					
Prosthesis					
Clothing none					

FOOD HABITS

Special Diet ☐ Yes ☑ No ☐ Assisted Feeding Device

Type _____

NUTRITIONAL SCREEN

Hx. of Diabetes	☐	Constipation/Diarrhea	☐
Hx. of Cancer	☐	Recent Wt. Loss > 5 lbs.	☐
Hx. of Renal Failure	☐	Decubitus Ulcer	☐
Nausea/Vomiting	☐	Tube Feeds	☐
Poor Appetite	☐	TPN	☐
Lactating Mother	☐	✓ = Required Dietaty Consult	

PRIOR LEVEL OF CARE

☐ SOCIAL SERVICES
☐ HOME HEALTH
☐ DIABETIC CENTER – ☐ OWNS GLUCOSE METER
☐ HOSPICE
☐ PUBLIC HEALTH
☐ NEBULIZER
☐ CPAP MACHINE
☐ O2
☐ FEEDING PUMP or BOLUS FEEDS ☐ PEG ☐ J-TUBE
☐ MEALS ON WHEELS
☐ DIALYSIS FREQUENCY _____
☐ INDWELLING CATHETER

IV DEVICE	SITE
☐ PICC	
☐ Portacath	
☐ Hickman	
☐ AV Fistula	
☐ Field IV	

* must be Δ'ed within 24°

SOCIAL HISTORY

You Drink Alcohol? ☐ Yes ☑ No More than 3 drinks per day ☐ Yes ☐ No
You Use Recreational Drugs? ☐ Yes ☑ No
Describe Below (what, how, often, how much) _____
Domestic violence verbalized ☐ Yes ☑ No
Assessment: ☑ Negative ☐ Positive (Police Notified) _____
Social Service referral: Date: _____ Time: _____ Person: _____
Present Intake of (frequency, quantity)
☐ Smoker # of Packs per Day _____ # of Years _____
Pt. lives with: ☐ Alone ☐ Spouse ☐ Parents ☐ Children ☐ Other Relatives
Other: The Bald One
Support System / Caregiver Available: Bald One - allaboutfrank.com
Type of residence: ☐ Apartment ☑ Private Home ☐ Mobile Home ☐ Nursing home / SNF
☐ Residential care / board & care Name _____
☐ **Can return to same residence?** ☑ Yes ☐ No

Culture _____
Religion none
Basic Education High School
Primary Language Spoken English
Interpreter _____ Phone# _____

SIGNATURE [signature] INITIALS PS DATE 8/14/03 TIME 0345

[redacted] Community Hospital
[redacted] California [redacted]

Graphic Record

P2936 (09/01)

Patient Identification

Duck, Frank A.
MR# K0002463Z
DOB# 02-27-87

DATE		8-14-03																											
F	C	02	06	10	14	18	22	02	06	10	14	18	22	02	06	10	14	18	22	02	06	10	14	18	22	02	06	10	14	18	22
105.8	41.0																														
TEMPERATURE																															
104.0	40.0																														
(A) AXILLARY																															
102.2	39.0																														
(R) RECTAL																															
100.4	38.0																														
(T) TYMPANIC																															
NORMAL																															
98.6	37.0																														
96.8	36.0																														
		• Axillary																													
	35.0																														
PULSE	140																														
	120	118																													
(I = IRREGULAR)	100																														
A = APICAL	80																														
	60																														
	40																														
RESPIRATION		30																													
BLOOD PRESSURE	SBP	91																													
	DBP	46																													
	10																														
PAIN (0-10 SCALE) PAIN GOAL ON ADMIT _____	9																														
	7																														
	5																														
	3																														
	1																														
	0																														
TIME																															
FiO_2		04																													
OXIMETRY		[redacted]																													
Intake: 24° Total		0z																													
Output: 24° Total																															
BLOOD SUGARS																															
# of Bowel Movements																															
WEIGHT/HT.		2.2kg 10"																													

BRADEN SCALE–For Predicting Pressure Sore Risk

SEVERE RISK: Total Score ≤ 9 **HIGH RISK:** Total score 10 - 12
MODERATE RISK: Total score 13 - 14 **MILD RISK:** Total score 15 - 18

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS ➡ 8/14/03			
					1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. COMPLETELY LIMITED–** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, **OR** limited ability to feel pain over most of body surface.	**2. VERY LIMITED–** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. SLIGHTLY LIMITED–** Responds to verbal commands but cannot always communicate discomfort or need to be turned, **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. NO IMPAIRMENT–** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	3			
MOISTURE Degree to which skin is exposed to moisture	**1. CONSTANTLY MOIST–** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. OFTEN MOIST–** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. OCCASIONALLY MOIST–** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. RARELY MOIST–** Skin is usually dry; linen only requires changing at routine intervals.	4			
ACTIVITY Degree of physical activity	**1. BEDFAST–** Confined to bed.	**2. CHAIRFAST–** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY–** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. WALKS FREQUENTLY–** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	3			
MOBILITY Ability to change and control body position	**1. COMPLETELY IMMOBILE–** Does not make even slight changes in body or extremity position without assistance.	**2. VERY LIMITED–** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. SLIGHTLY LIMITED–** Makes frequent though slight changes in body or extremity position independently.	**4. NO LIMITATIONS–** Makes major and frequent changes in position without assistance.	3			
NUTRITION Usual food intake pattern [1] NPO: Nothing by mouth. [2] IV: Intravenously. [3] TPN: Total parenteral nutrition.	**1. VERY POOR–** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, **OR** is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE–** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. ADEQUATE–** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, **OR** is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. EXCELLENT–** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
FRICTION AND SHEAR	**1. PROBLEM–** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM–** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM–** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		2			
TOTAL SCORE	Total score of 12 or less represents HIGH RISK				19			

ASSESS #	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS #	DATE	EVALUATOR SIGNATURE/TITLE
1	8/14/03	RStraughn RN	3	/ /	
2	/ /		4	/ /	

NAME–Last First Middle	Attending Physician	Record No.	Room/Bed
Duck Frank A.	M. Prado	K0024632	2026 A

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BRADEN SCALE