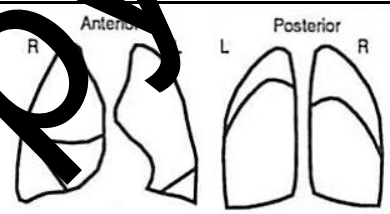
SYSTEMS ASSESSMENTS

DAY

NORMAL FINDINGS	ABNORMAL SIGNS
CNS ☐ Orientation to time, place, person ☐ Alert ☐ Calm ☐ **See Neurological Vital Signs Record**	☐ Lethargic ☐ Confused ☐ Disoriented ☐ Drowsy ☐ Restless ☐ Agitated ☐ Withdrawn ☐ Dizziness ☐ Unsteadiness ☐ Pupils unequal ☐ Speech slurred
CVS ☐ Heart Rate regular	☐ Heart murmur ☐ Arrhythmia ☐ Tachycardia ☐ Bradycardia ☐ Cyanosis ☐ Palpitations ☐ Calf cramping ☐ Delayed Capillary refill >2 sec. Edema: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Location _____ ☐ Generalized
Resp ☐ Chest sounds clear ☐ Regular	☐ SOB ☐ SOBOE ☐ Cough ☐ Sputum ☐ Slow ☐ Rapid ☐ Irregular ☐ Laboured ☐ Shallow ☐ Stridor ☐ Chest Tube ☐ Trach ☐ O_2 _____ L/min Via:_____ **Breath Sounds** A: Absent W: Wheezing D: D[illegible] C: [illegible]ackles B: [illegible]ronchial BV: [illegible]ronchial Vesic[illegible] 
GI ☐ Bowel sounds normal x 4 quadrants ☐ Soft ☐ **See Bowel Care Record**	☐ Nausea ☐ Vomiting ☐ NPO ☐ NG ☐ Diarrhea ☐ Constipation ☐ [illegible]atulence ☐ [illegible]eeding tube ☐ Hypoactive ☐ Hyperactive ☐ A[illegible]ent ☐ [illegible]ostomy ☐ Firm ☐ Distended ☐ Ten[illegible] ☐ Stool incontinence
GUR ☐ Voids without difficulty ☐ Clear and amber	☐ Burning ☐ Frequen[illegible] ☐ Hesitancy ☐ Hematuria ☐ Retention ☐ Foul Odo[illegible] ☐ Urostomy ☐ Urine incontinence ☐ Catheter in situ Colour _____Character_____ ☐ Anuric
Integ ☐ Intact, even-toned, warm ☐ Good turgor	☐ Pallor ☐ F[illegible]shed ☐ Cyanosis ☐ Impaired skin integrity ☐ Diaphoretic ☐ D[illegible] ☐ Rash ☐ Pressure injury risk tool completed ☐ Erythema ☐ Bru[illegible] ☐ Jaundice ☐ Dres[illegible]sion/Wo[illegible]d dry and intact _____ ☐ **See Wound Record**
Mobility / MS ☐ Independent ☐ Full ROM ☐ **See TLR mobility record**	☐ Edema ☐ Limited ROM ☐ Weakness/ Atrophy ☐ Spasms ☐ Cast ☐ Traction Devices used: ☐ Walker ☐ Wh[illegible]chair ☐ Cane ☐ Abnormal CSM (color, sensation, mobility)

Pain
Location:_____ Int[illegible]sity (0-10): _____ ☐ Managed ☐ **see Nursing Notes**

IV/Parenteral therapy/ Subcu[illegible]/CVAD ([illegible] administration record) ☐ Inflammation ☐ Pain ☐ Redness ☐ Dressing intact ☐ No signs of infection

Safety Precautions
Arm Bands ☐ ID ☐ A[illegible]gy ☐ Cross match ☐ Call Light/Bell within reach ☐ Brakes on bed ☐ Bed in lowest position

Psychosocial: Coping [illegible]lls or Concer[illegible]s
☐ Appropriate ☐ Flat affe[illegible] ☐ A[illegible]dant ☐ Anger ☐ See Suicide Assessment form ☐ See Behavior Management Record
☐ Other_____

Other System Component	Assessment
_____	_____
_____	_____
_____	_____
_____	_____

On rounds the patient was seen resting comfortably, breathing easily, no signs of distress, no signs of discomfort, call bell within reach, clear path to the washroom and door, lighting available or accessible, side rails up (if applicable), walking aids within reach (if applicable). If the patient is awake, asked if needs to go to the washroom or liner/pads needs to be changed and is asked if there is pain or discomfort. Other:

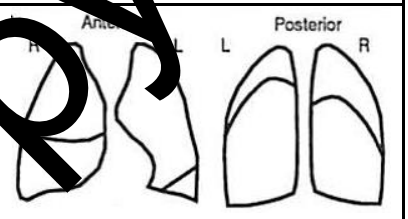
Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID

☐ **See Nursing Notes**

Assessment Date/Time: _____ **Signature:** _____

SYSTEMS ASSESSMENTS

NIGHT

NORMAL FINDINGS	ABNORMAL SIGNS
CNS ☐ Orientation to time, place, person ☐ Alert ☐ Calm ☐ **See Neurological Vital Signs Record**	☐ Lethargic ☐ Confused ☐ Disoriented ☐ Drowsy ☐ Restless ☐ Agitated ☐ Withdrawn ☐ Dizziness ☐ Unsteadiness ☐ Pupils unequal ☐ Speech slurred
CVS ☐ Heart Rate regular	☐ Heart murmur ☐ Arrhythmia ☐ Tachycardia ☐ Bradycardia ☐ Cyanosis ☐ Palpitations ☐ Calf cramping ☐ Delayed Capillary refill >2 sec. Edema: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Location _____ ☐ Generalized
Resp ☐ Chest sounds clear ☐ Regular	☐ SOB ☐ SOBOE ☐ Cough ☐ Sputum ☐ Slow ☐ Rapid ☐ Irregular ☐ Labored ☐ Shallow ☐ Stridor ☐ Chest Tube ☐ Trach. ☐ O_2 _____ L/min Via:_____ **Breath Sounds** A: Absent W: Wheezing D: Decreased C: Crackles B: Bronchial BV: Bronchial Vesicular 
GI ☐ Bowel sounds normal x 4 quadrants ☐ Soft ☐ **See Bowel Care Record**	☐ Nausea ☐ Vomiting ☐ NPO ☐ NG ☐ Diarrhea ☐ Constipation ☐ Flatulence ☐ Feeding tube ☐ Hypoactive ☐ Hyperactive ☐ Absent ☐ Ostomy ☐ Firm ☐ Distended ☐ Tender ☐ Stool incontinence
GUR ☐ Voids without difficulty ☐ Clear and amber	☐ Burning ☐ Frequency ☐ Hesitancy ☐ Hematuria ☐ Retention ☐ Foul Odor ☐ Urostomy ☐ Urine incontinence ☐ Catheter in situ Colour _____ Character_____ ☐ Anuric
Integ ☐ Intact, even-toned, warm ☐ Good turgor	☐ Pallor ☐ Flushed ☐ Cyanosis ☐ Impaired skin integrity ☐ Diaphoretic ☐ Dry ☐ Rash ☐ Pressure injury risk tool completed ☐ Erythema ☐ Bruising ☐ Jaundice ☐ Dressing/Incision/Wound dry and intact _____ ☐ **See Wound Record**
Mobility / MS ☐ Independent ☐ Full ROM ☐ **See TLR mobility record**	☐ Edema ☐ Limited ROM ☐ Weakness/ Atrophy ☐ Spasms ☐ Cast ☐ Traction Devices used: ☐ Walker ☐ Wheelchair ☐ Cane ☐ Abnormal CSM (color, sensation, mobility)

Pain
Location:_____ Intensity (0-10): _____ ☐ Managed ☐ **see Nursing Notes**

IV/Parenteral therapy/ Subcut/ CVAD (IV administration record) ☐ Inflammation ☐ Pain ☐ Redness ☐ Dressing intact ☐ No signs of infection

Safety Precautions
Arm Bands ☐ ID ☐ Allergy ☐ Cross match ☐ Call Light/Bell within reach ☐ Brakes on bed ☐ Bed in lowest position

Psychosocial: Coping Skills or Concerns
☐ Appropriate ☐ Flat affect ☐ Ambivalent ☐ Anger ☐ See Suicide Assessment form ☐ See Behavior Management Record
☐ Other_____

Other System Component	Assessment
_____	_____
_____	_____
_____	_____
_____	_____

On rounds the patient was seen resting comfortably, breathing easily, no signs of distress, no signs of discomfort, call bell within reach, clear path to the washroom and door, lighting available or accessible, side rails up (if applicable), walking aids within reach (if applicable). If the patient is awake, asked if needs to go to the washroom or liner/pads needs to be changed and is asked if there is pain or discomfort. Other:

Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID	Time: / ID

☐ **See Nursing Notes**

Assessment Date/Time:_____ **Signature:** _____