# COMPREHENSIVE NURSING ASSESSMENT

To be completed: 1) At the time of admission prior to the delegation of any nursing tasks, 2) Within 48 hours of a significant change in the resident's physical or mental status, 3) Within 48 hours of return from a hospitalization or 15 day or greater stay in any skilled facility, & 4) When a new RN assumes the DN/CM role

Resident Name: _____ DOB: _____ Date Completed: _____

45-day Nursing Review Due: _____

| **ALLERGIES:** | **DIAGNOSES:** |
|---|---|
| | |

| **VITAL SIGNS** | | | | | |
|---|---|---|---|---|---|
| *BP* | *P* | *R* | *T* °*F* | *HT* *ft* *in* | *WT* *lbs* |

| | **ASSESSMENT – *Explain ALL answers that are not within normal limits*** | **COMMENTS** |
|---|---|---|
| **NUTRITION** | Diet: ☐ Regular ☐ NAS ☐ NCS ☐ Mechanical Soft ☐ Pureed<br>Recent weight change: ☐ No ☐ Yes<br>Supplements: ☐ No ☐ Yes<br>Conditions affecting eating, chewing, or swallowing: ☐ No ☐ Yes<br>Monitoring required at mealtimes: ☐ No ☐ Yes<br>Fluids. Monitoring: ☐ No ☐ Yes → ☐ Increased ☐ Restricted<br>Mucous membranes: ☐ Moist ☐ Dry<br>Skin turgor: ☐ Good ☐ Fair ☐ Poor | |
| **ELIMINATION** | Bladder Incontinence: ☐ None ☐ Occasional (less than daily) ☐ Daily<br>Bowel Incontinence: ☐ None ☐ Occasional (less than daily) ☐ Daily<br>Incontinence management techniques: ☐ No ☐ Yes<br>Bowel sounds present: ☐ Yes ☐ No<br>Constipation: ☐ No ☐ Yes<br>Ostomies: ☐ No ☐ Yes | |
| **SENSORY** | Vision: ☐ Normal ☐ Impaired → Corrective device: _____<br>Hearing: ☐ Normal ☐ Impaired → Hearing aid: ☐ No ☐ Yes | |

**Resident:** _____ **Date Completed:** _____

| | | |
|---|---|---|
| **MUSCULOSKELETAL** | Mobility: ☐ Normal ☐ Impaired → Assistive Devices: ☐ No ☐ Yes<br>ROM: ☐ Full ☐ Limited<br>Motor Development: ☐ Head Control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors<br>ADLs: (S=self; A=assist; T=total) Eating: ____ Bathing: ____ Dressing: ____ | |
| **SKIN** | ☐ Normal ☐ Pale ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other<br>Skin Intact: ☐ Yes ☐ No (if no, a wound assessment **must** be completed)<br>Special Care or Monitoring: ☐ No ☐ Yes | |
| **NEURO** | Sensation: ☐ Intact ☐ Diminished/Absent<br>Pain: ☐ None ☐ Less Than Daily ☐ Daily<br>→ If there is pain indicate the site, cause, & treatment.<br>Verbal Response: ☐ A/O x _____ ☐ Confused ☐ Inappropriate<br>☐ Incomprehensible ☐ No Response<br>Aphasia: ☐ None ☐ Expressive ☐ Receptive<br>Memory Deficits: ☐ No ☐ Yes<br>Impaired Decision-making: ☐ No ☐ Yes<br>Sleep Aids: ☐ No ☐ Yes<br>Sleep Pattern: _____<br>Seizures: ☐ No ☐ Yes | |
| **CIRCULATION** | History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension<br>Pulse: ☐ Regular ☐ Irregular<br>Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm<br>☐ Cool ☐ Dry ☐ Diaphoretic<br>Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes | |
| **RESPIRATION** | Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored<br>Breath Sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)<br>Shortness of Breath: ☐ No ☐ Yes (indicate triggers)<br>Respiratory Treatments: ☐ None ☐ Oxygen ☐ Aerosol/Nebulizer ☐ CPAP/BIPAP | |
| **DENTAL** | ☐ Own Teeth ☐ Dentures<br>Dental Hygiene: ☐ Good ☐ Fair ☐ Poor | |

**Resident:** _____

| | | |
|---|---|---|
| **PSYCHOSOCIAL** | Self Injurious Behavior: ☐ No ☐ Yes<br>Aggressive Behavior: ☐ No ☐ Yes<br>→ Frequency of disruptive behavior: _____<br>Behavior: ☐ Calm ☐ Lethargic ☐ Angry ☐ Resists Care ☐ Other<br>Answers Questions: ☐ Readily ☐ Slowly ☐ Inappropriately<br>Delusions and/or Hallucinations: ☐ No ☐ Yes | |
| **MEDICATIONS & TREATMENTS** | Has a 3-way check (orders, medications, and MAR) been conducted for all of the resident's medications and treatments, including OTCs and PRNs? ☐ Yes ☐ No<br>Were any discrepancies identified? ☐ No ☐ Yes<br>Are medications stored appropriately? ☐ Yes ☐ No<br>Has the caregiver been instructed on monitoring the effectiveness of drug therapy, drug reactions, side effects, and how and when to report problems that may occur? ☐ Yes ☐ No (explain)<br>Are vital signs required related to a medication or diagnosis? ☐ No ☐ Yes (specify)<br>Is lab monitoring required related to a medication or diagnosis (hypoglycemic, anticoagulant, psychotropic, seizure, etc)? ☐ No ☐ Yes (specify)<br>Have arrangements been made to obtain these labs? ☐ Yes ☐ No (explain) | |
| **HIGH RISK MEDICATIONS** | Is the resident taking any high risk drugs? ☐ No ☐ Yes (specify)<br>Has the caregiver received instruction on special precautions for all high risk medications (such as hypoglycemic, anticoagulants, etc) and how and when to report problems that may occur? ☐ Yes ☐ No ☐ N/A | |
| **SAFETY NEEDS** | Is the environment safe for the resident? ☐ Yes ☐ No<br>(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture & assistive devices.) | |
| **REVIEW OF RAT** (RESIDENT ASSESSMENT TOOL) | | |
| **COMMENTS** | | |

RN's Signature: _____ Date Completed: _____

Print Name: _____ Information Source: _____