SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

q RUH q SCH q SPH Other _Homecare___

NAME: **PLANTE, Clara**
HSN: **825 545 737**
D.O.B.: **15/08/19**XX (89 years old at the time the video was created)

MEDICAL FLOW SHEET - DAYS

Date: _January 6, ´

CNS: ***Normal*** Assessment Ø ***Alert, Up ad lib, Calm, Oriented to Person, Place, Time, Follows Commands, Speech Clear, No Pain, Sensation Intact***

q **WNL** (within normal limits) x **WNL except**:
LOC: q restless q drowsy q lethargic
q aphasic q dysphasic q unresponsive
Disorientation:
q person q place q time
q confused q inappropriate
Pain _Pain to (R) arm and shoulder when moving the same. Pt states "6/10"_____
_____ x see MAR
q Epidural q PCA q HDC
Mobility: q with assist q bedrest
Activity/Tolerance independent with 4WW or cane
_____
Movement and Sensation sensation decreased to lower limbs
Other +++ HCH _____
_____
_____

RESP: ***Normal Assessment*** Ø ***Respirations Unlaboured & Symmetric, Regular Rhythm & Depth, Cough Not Productive, Not Intubated***

q **WNL** x **WNL except:**
Respirations: q SOB x SOBOE
Abnormal Breath Sounds air entry decreased to (R) lower lobe. Slight wheeze on inspiration_____
Cough none noted_____
DB&C q recommended_____
Secretions none_____
Suctioned not applicable_____
ETT/Trach Care/Site _____
Other ? COPD - ex-smoker_____

GI/GU: ***Normal Assessment*** Ø ***Abdomen Soft, No Nausea or Vomiting, Tolerating Oral Diet, No Diarrhea or Constipation, Voiding Without Difficulty, Urine Clear, No Bladder Distention, No Vaginal/Penile Drainage, Continent of Urine/Stool***

CVS: Normal Assessment Ø Skin: Color Within Normal Limits, Warm & Dry, Heart Rhythm Regular, Peripheral Pulses Present, No Edema

q **WNL** x **WNL except:**
Color: x pale q dusky q cyanotic
q flushed
Temp: x cool q hot q diaphoretic
Peripheral Pulses PPPx4, regular rhythm_____
Edema blaterally to lower extremities_____
Leg/Ankle Exercises q recommended_____
IV/HDC Site Condition not applicable_____
Other slight dusky colour bilaterally to lower extremities_____

q **WNL** x **WNL except:**
q Nausea q Vomiting q NPO
NG Suction _____
Enteral Feeding _____
PGJ Site/Drsg _____
Abdomen: q firm q distended q tender
q abn. bowel sounds BSx4, normal_____
Stool: q diarrhea q constipation
Incontinent of: q stool x urine
Catheter _____
Vag/Penile Drainage _____
Other Occasionally incontinent recently; occasionally constipated
Currently no pain with voiding or odour, urine slightly cloudy

PSYCH/SOC: ***Normal Assessment*** Ø ***Behavior Appropriate, Stable Emotional State, Coping Patterns Appropriate, Family Involved***

q **WNL** x **WNL except:**
Family/Visitors Seldom_____
Coping Pattern sleeping poorly_____
q See Teaching Plan q See Discharge Plan
Other upset about worsening eye sight_____
_____

INTEG: ***Normal Assessment*** Ø ***Skin, Clear, (free of Rashes, Reddened Areas, Open Areas or Bruises***

q **WNL** x **WNL except:**
Skin Care/Condition/Positioning q poor skin care, skin dry
_____
Incisions/Dressings/Wounds/Drains _____
Various small bruises over arms and legs, scar to (R) humerus and
And near (R) deltiod_____
_____
_____
Other poor hygiene practices, reddened and yeasty under breasts bliat

Assessment Time: 1530h_____ Charted @: 1545h_____ Signature: _I. Healem, RN_____
Review-Time: _____ Signature: _____