MONTHLY NURSING SUMMARY

DIRECTIONS: Select appropriate responses and complete fields as indicated. Record comments/notes on reverse side.

AMBULATION: ❑ Wheelchair (❑ Most of day ❑ Short periods) ❑ Walker (❍ Alone ❍ Assisted) ❑ Bed ❑ Chairbound ❑ Cane ❑ Crutch ❑ Ambulates (❍ Alone ❍ Assisted: ❑ One ❑ Two) ❑ Independent without supportive device ❑ Amputation
If assisted: ❍ One ❍ Two ❑ Uses prosthesis ❑ Other_____

POSITIONING: ❑ Every 2 hours ❑ While in bed ❑ Chair ❑ Repositions self ❑ Assisted ❑ Other_____

TRANSFERRING: ❑ No assistance needed ❑ Setup help only ❑ Assist of one ❑ Assist of two ❑ Supervision needed ❑ Total dependence ❑ Mechanical lift used

MENTAL STATUS: ❑ Alert ❑ Oriented x 3 ❑ Confused ❑ Fluctuates ❑ Poor memory ❑ Wanders ❑ Semi-comatose ❑ Comatose ❑ Hallucinates ❑ Delusional ❑ Changes noted_____

EMOTIONAL: ❑ Withdrawn ❑ Friendly ❑ Quiet ❑ Anxious ❑ Noisy ❑ Easily upset ❑ Hostile ❑ Cooperative ❑ Refuses care ❑ Behavior issues_____

SKIN: ❑ Dry ❑ Dry and fragile ❑ Intact ❑ Pressure injuries (See Pressure Injury Flow Sheets) ❑ Rash ❑ Abrasion(s) ❑ Bruise(s) ❑ Skin tear(s) ❑ Surgical wound(s) ❑ Other skin problems_____

EDEMA: ❍ No ❍ Yes Degree_____ Location_____

BLADDER: ❍ Continent ❍ Incontinent ❑ Assist to bathroom ❑ Indwelling catheter, size_____ ❑ Intermittent catheter ❑ Urostomy ❑ Irrigation_____ Urine color_____ Consistency_____ Amount_____ ❑ Bladder training ❑ Scheduled toileting ❑ Prompted voiding

BOWELS: ❑ Regular ❍ Continent ❍ Incontinent ❑ Frequent laxatives ❑ Enemas ❑ Suppositories ❑ Prone to constipation ❑ Diarrhea/loose stools ❑ Ostomy ❑ Bowel training

BRIEFS: ❑ Worn during sleep ❑ Worn while awake ❑ Worn at all times ❑ Not used/needed ❑ Independent ❑ Needs Assist

EATING HABITS: ❑ Good appetite ❑ Usually good appetite ❑ Usually poor appetite ❑ Eats with assistance ❑ Feeds self ❑ Fed by staff ❑ Eats in dining room ❑ Eats in room ❑ NG tube ❑ G-tube ❑ J-tube ❑ TPN ❑ Other_____ ❑ Problems chewing ❑ Problems swallowing

SLEEP PATTERN: ❑ Sleeps all night ❑ Awakens frequently ❑ Needs nap ❑ Needs rest ❑ Difficulty resting ❑ Requires HS medication for sleep ❑ Other_____

PAIN: ❍ No ❍ Yes (See Pain Flow Sheets) Location_____

VISION: ❑ Good ❑ Adequate w/glasses ❑ Poor ❑ Blind ❑ Cataracts (❑ Left ❑ Right) ❑ Uses magnifying glass ❑ Other _____

HEARING: ❑ Good ❑ Poor (❑ Left ❑ Right) ❑ Deaf ❑ Adequate w/hearing aid (❑ Left ❑ Right) ❑ Refuses hearing aid(s) ❑ No hearing aid(s)

SPEECH: ❑ Clear ❑ Difficulty ❑ Aphasia ❑ Slurred ❑ Normal ❑ Mute ❑ Trach ❑ Uses voice box

ORAL HYGIENE: ❑ Dentures (❑ Upper ❑ Lower) ❑ Implants ❑ Has own teeth ❑ Edentulous ❑ Needs assistance ❑ Needs total staff care ❑ Self care ❑ Caries ❑ Oral lesions Condition of mouth_____

SOCIAL: ❑ Good family/friend relationships ❑ Poor family/friend relationships ❑ Frequent visitors ❑ Few visitors ❑ No visitors ❑ Socializes w/others ❑ Withdrawn ❑ Other_____

GROOMING: ❑ Self care ❑ Needs assistance ❑ Total care

HYGIENE: ❑ Bath 2x/week & PRN ❑ Bed bath ❑ Tub bath ❑ Shower ❑ Whirlpool ❑ Shampoo weekly ❑ Moisturizing lotion routine/PRN ❑ Independent ❑ Staff Assist: (❑ One ❑ Two)

NAILS: Fingers: ❑ Self care ❑ Needs frequent cutting ❑ Break easily ❑ Cut PRN by staff
Toes: ❑ Self care ❑ Needs frequent cutting ❑ Break easily ❑ Cut PRN by staff ❑ Sees Podiatrist PRN

CONTRACTURES/ LIMITED ROM: ❑ None ❑ Hand_____ ❑ Arm_____ ❑ Leg_____ ❑ Foot_____ ❑ Fingers_____ ❑ Shoulder_____ ❑ Other_____

THERAPY: ❑ PT ❑ ST ❑ OT ❑ Respiratory ❑ Restorative nursing ❑ Psychological ❑ Recreational

VITALS: Temp._____ Pulse_____ Resp._____ B/P_____ ❑ Rt arm ❑ Lt arm Weight_____

RESPIRATORY: ❑ No issues ❑ SOB on exertion ❑ SOB when sitting/at rest ❑ SOB when lying flat ❑ Trach care ❑ Oxygen ❑ Suctioning ❑ Other_____

FALLS since last Monthly Summary ❍ No ❍ Yes _____ Major injury ❍ No ❍ Yes _____

DIET/TEXTURE:_____

ALLERGIES (food and medications):_____

Nurse Signature/Title:_____ **Date:**_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

MONTHLY NURSING SUMMARY

COMMENTS/ADDITIONAL NOTES

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed