WEEKLY NURSING SUMMARY

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

1. **Mobility:** ❑ Wheelchair (❑ Most of Day ❑ Short Periods) ❑ Walker (❑ Alone ❑ Assisted) ❑ Bed or Chair Bound ❑ Dangle ❑ Cane or Crutch (❑ Alone ❑ Assisted) ❑ Ambulates (❑ Alone ❑ Assisted: ❑ One ❑ Two) ❑ Amputation ❑ Independent without Supportive Device (If Assisted: ❑ One ❑ Two)
2. **Positioning:** ❑ Every 2 Hours ❑ While in Bed ❑ Chair ❑ Self ❑ Assisted ❑ Other__________
3. **Transferring:** ❑ No Physical Help Needed ❑ Set up Help Only ❑ Assist of One ❑ Assist of Two ❑ Supervised ❑ Limited Assist ❑ Extensive Assist ❑ Total Dependence ❑ Mechanical Lift ❑ Transfer Board
4. **Mental Status:** ❑ Alert ❑ Oriented ❑ Confused ❑ Changes Often ❑ Poor Memory ❑ Unaware ❑ Unchanged in Last 30 Days ❑ Changes Noted __________
5. **Emotional:** ❑ Withdrawn ❑ Friendly ❑ Quiet ❑ Anxious ❑ Noisy ❑ Easily Upset ❑ Expresses According to Situation ❑ Hostile ❑ Cooperative ❑ Resists Care ❑ Other__________
6. **Skin Condition:** ❑ Good ❑ Fair ❑ Dry ❑ Dry & Fragile ❑ Free of Any Open Areas ❑ Pressure Injuries (See Flow Sheets) ❑ Abrasions ❑ Skin Tear(s) This Past Week ❑ Bruises ❑ Other Skin Problems__________
7. **Edema:** ❍ No ❍ Yes ❑ Chronic ❑ Acute Degree__________ Location__________
8. **Bladder:** ❍ Continent ❍ Incontinent ❑ Assist to Bathroom ❑ Indwelling Catheter: Size__________ Last Changed__________
   Urine Color__________ Consistency__________ Amount__________ ❑ Treated for UTI During Past Week
   ❑ Bladder Training ❑ Scheduled Toileting ❑ Prompted Voiding ❑ Other __________
   Briefs: ❑ Worn During Sleep ❑ Worn While Awake ❑ Worn at All Times ❑ Not Used
9. **Bowel:** ❍ Continent ❍ Incontinent ❑ Uses Laxatives ❑ Softeners ❑ Enemas ❑ Suppositories ❑ Ostomy ❑ Bowel Retraining
   Briefs: ❑ Worn During Sleep ❑ Worn While Awake ❑ Worn at All Times ❑ Not Used
10. **Eating:** ❑ Good Appetite ❑ Poor Appetite ❑ Intake 75% or More ❑ Substitutes/Supplements ❑ Other__________ ❑ Feeds Self ❑ Feeds with Assistance ❑ Fed ❑ Eats in Dining Room ❑ Eats in Room
11. **Enteral Feeding:** ❑ NG Tube ❑ G-Tube ❑ J-Tube Formula__________ Amt/day__________ Cal/day__________
    Water/Day__________ ❑ Total Nutritional Intake per Enteral Feeding ❑ Tolerated Without Regurgitation
    ❑ If Not Tolerated, Why__________ Any Changes This Month__________
12. **Respiratory:** O_2 @ Liters _______/Min. ❑ Not Short of Breath on Oxygen ❑ Short of Breath on Exertion ❑ Short of Breath Lying Flat ❑ Saturation Readings (as ordered) High__________ Low__________ ❑ Other__________
13. **Sleep:** ❑ Poor ❑ Sleeps Through Night ❑ Needs Nap ❑ Needs Rest ❑ Difficulty Resting ❑ Awakens Frequently ❑ Requires HS Medication for Sleep ❑ Other __________
14. **Vision:** ❑ Unchanged Past Week ❑ Good ❑ Adequate w/Glasses ❑ Adequate w/Contacts ❑ Uses Magnifying Glass ❑ Poor ❑ Blind ❑ Cataracts ❑ Other__________
15. **Pain:** ❍ No ❍ Yes (See Pain Flow Sheets)
16. **Hearing:** ❑ Unchanged Past Week ❑ Good ❑ Poor (❑ Left ❑ Right) ❑ Deaf ❑ Adequate w/Hearing Aid (❑ Left ❑ Right) ❑ No Hearing Aid(s)
17. **Speech:** ❑ No Change Past Week ❑ Difficulty ❑ Aphasia ❑ Slurred ❑ Clear ❑ Low Tone ❑ Normal ❑ Mute ❑ Trach ❑ Uses Voice Box
18. **Oral Hygiene:** ❑ Dentures (❑ Upper ❑ Lower) ❑ Edentulous ❑ Self Care ❑ Needs Assistance ❑ Needs Total Staff Care ❑ Has Own Teeth
    Condition of Mouth/Gums__________
19. **Grooming:** ❑ Self Care ❑ Needs Prompts ❑ Needs Assistance ❑ Total Care
20. **Change(s) in Medication This Week:** ❍ No ❍ Yes __________
21. **Psychotropic Medication(s):** ❍ Not Used ❍ Used Name of Medication(s)__________
    Side Effects Observed: ❑ None ❑ Cognitive Impairment ❑ Postural (orthostatic) Hypotension ❑ Pseudo-Parkinsonism
    ❑ Akathisia ❑ Tardive Dyskinesia Additional Comments:__________
22. **Restraints:** ❍ Not Used ❍ Used-Frequency__________ Type__________ Reason__________ Location__________
23. **Alarms:** ❍ Not Used ❍ Used-Frequency__________ Type__________ Reason__________
24. **Diet:**__________ Current Weight__________
25. **Infection(s):** ❍ No ❍ Yes, Specify__________

▶ **Nurse Signature/Title:**__________ ▶ **Date:**__________

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

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ADDITIONAL NOTES/COMMENTS

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