NURSE ASSISTANT NOTES

DATE:

NIGHT SHIFT

❑ Repositioned Q 2 Hrs. ❑ Side Rails ❑ Postural Supports
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ AM Care ❑ Oral Hygiene
Slept: ❑ Well ❑ Fair ❑ Poor ❑ Other:_____
Additional Comments:_____
_____
Signature/Title:_____

DAY SHIFT

❑ Bath ❑ Tub ❑ Shower ❑ Partial ❑ Bed Bath ❑ Complete
❑ Oral Hygiene ❑ Shampoo ❑ Shave ❑ Nail Care
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
BREAKFAST: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
LUNCH: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Exercises ❑ Therapy
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

EVENING SHIFT

DINNER: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Other:_____
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ PM Care ❑ Oral Hygiene
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

DATE:

NIGHT SHIFT

❑ Repositioned Q 2 Hrs. ❑ Side Rails ❑ Postural Supports
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ AM Care ❑ Oral Hygiene
Slept: ❑ Well ❑ Fair ❑ Poor ❑ Other:_____
Additional Comments:_____
_____
Signature/Title:_____

DAY SHIFT

❑ Bath ❑ Tub ❑ Shower ❑ Partial ❑ Bed Bath ❑ Complete
❑ Oral Hygiene ❑ Shampoo ❑ Shave ❑ Nail Care
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
BREAKFAST: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
LUNCH: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Exercises ❑ Therapy
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

EVENING SHIFT

DINNER: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Other:_____
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ PM Care ❑ Oral Hygiene
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

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

NURSE ASSISTANT NOTES

DATE:

NIGHT SHIFT

❑ Repositioned Q 2 Hrs. ❑ Side Rails ❑ Postural Supports
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ AM Care ❑ Oral Hygiene
Slept: ❑ Well ❑ Fair ❑ Poor ❑ Other:_____
Additional Comments:_____
_____
Signature/Title:_____

DAY SHIFT

❑ Bath ❑ Tub ❑ Shower ❑ Partial ❑ Bed Bath ❑ Complete
❑ Oral Hygiene ❑ Shampoo ❑ Shave ❑ Nail Care
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
BREAKFAST: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
LUNCH: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Exercises ❑ Therapy
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

EVENING SHIFT

DINNER: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Other:_____
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ PM Care ❑ Oral Hygiene
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

DATE:

NIGHT SHIFT

❑ Repositioned Q 2 Hrs. ❑ Side Rails ❑ Postural Supports
INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ AM Care ❑ Oral Hygiene
Slept: ❑ Well ❑ Fair ❑ Poor ❑ Other:_____
Additional Comments:_____
_____
Signature/Title:_____

DAY SHIFT

❑ Bath ❑ Tub ❑ Shower ❑ Partial ❑ Bed Bath ❑ Complete
❑ Oral Hygiene ❑ Shampoo ❑ Shave ❑ Nail Care
TRANSFER: ❑ Assisted ❑ Lifted ❑ Self
❑ Repositioned Q 2 Hrs. ❑ W/C ❑ Ambulatory
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INCONTINENT: ❑ BM ❑ Urine ❑ At Times ❑ Always
CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Exercises ❑ Therapy
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

EVENING SHIFT

DINNER: ❑ Fed ❑ Assisted ❑ Self Consumed _____ %
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CONTINENT: ❑ BM ❑ Urine ❑ Catheter
❑ Postural Supports ❑ Side Rails ❑ Other:_____
Special Equipment:_____
Pressure relief devices, Heel protectors, Handrolls, etc.
❑ Alert ❑ Confused ❑ Disoriented ❑ Agitated ❑ Other_____
CONDITION CHANGE NOTED: ❑ No ❑ Yes – Report to Charge Nurse
Special Measures:_____
_____
❑ Fluids Encouraged ❑ Special Skin Care ❑ PM Care ❑ Oral Hygiene
Assist Needed with ADLs: ❑ Maximum ❑ Moderate ❑ Minimal ❑ None
Additional Comments:_____
_____
Signature/Title:_____

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