LORENZO WALKER INSTITUTE OF TECHNOLOGY
PRACTICAL NURSING - PRACTICE CHARTING FORM

DATA COLLECTION

Date: _____

Indicators: Time						
PSYCHOLOGICAL - Behavior, appearance / affect appropriate to situation, memory intact; two-way conversation.						
PSYCHOSOCIAL/SPIRITUALITY - Communicates needs openly. Socializes appropriately with significant others.						
RESPIRATORY - Respirations unlabored and symmetrical; regular rhythm and depth; no cough; no abnormal breath sounds.						
CARDIOVASCULAR - Heart rate and rhythm regular, BP WNL, capillary refill <3 seconds; peripheral pulses palpable bilaterally and equal; no edema.						
GI - Abdomen soft, bowel sounds present x 4; no pain with palpation; no nausea and vomiting, diarrhea, constipation.						
GU - No complaints of pain, frequency, or difficulty voiding; urine clear without odor.						
MUSCULOSKELETAL - Functional ROM all limbs, normal strength bilaterally. Dorsiflexion, plantar flexion present and appropriate for patient.						
NEUROLOGICAL - Alert, oriented x 3; behavior appropriate to situation; speech clear and appropriate; sensation intact without numbness. Glasgow Coma Scale = 15						
ENT (Ears, Nose, Throat, Eyes) - Grossly intact and functional; no complaints of pain or drainage.						
SKIN - Skin warm, dry, intact; no areas of redness, breakdown. Skin color appropriate to patient's pigmentation. Braden Scale ≥ 16.	Braden Score: ____					
FLUID BALANCE - Without signs and symptoms of dehydration or fluid overload.						
NUTRITION INTAKE - PO ≥ 50% all meals. Able to chew and swallow. Diet Type: _____						
PAIN - Pain is controlled. Document pain level (0-10) Comfort goal =_____						
DRESSING - Dressing clean, intact. Dressing dry unless moist dressing ordered. (i.e., Vaseline gauze, wet to dry.)						
INCISION - Site clean, edges approximated with no drainage; surrounding tissue free of signs of redness, tenderness, swelling, increased site temp; sutures/staples/ steri-strips intact if present.						
RN INITIAL WHEN 24 HR ASSESSMENT DONE						
INITIALS:						

✓ = WNL (Meets expected outcomes)
* = Deviation from normal or change from previous assessment (see Nursing Progress Note or Admission Assessment Form for documentation)
→ = No change from prior assessment; to be used in your shift only (see Nursing Progress Note for prior documentation)
Blank = Not assessed.
N/A = Not applicable.

NURSING PROGRESS NOTE

Date/ Time	Problem/ Focus	PLAN/INTERVENTION/EVALUATION