Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

SCHWARTZ/REISMAN
EMERGENCY CENTRE

Emergency Nursing Care Record

Emergency Department
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

MS 560 **Front** (Rev 10.2016)

Affix Patient Label

DATACM
PROOF #3
October 28.2016

Time (HH:MM)	Progress Notes

MS560

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Date ____________ (YYYY MM DD) Time ____________ (HH.MM)

Room ____________

Presenting Health Problem

☐ Seen by MD/NP/PA prior to RN assessment

Allergies: ☐ NKA

Health History:

- **Airway** ☐ Patent ☐ Compromised
- **Breathing**
  ☐ No respiratory distress ☐ Mild distress
  ☐ Moderate distress ☐ Severe distress
- **Breath Sounds** ☐ N/A
  ☐ Equal, clear bilaterally ☐ Crackles ☐ Wheezes
  ☐ Other ____________
- **Circulation** Skin colour ______ Edema ______
  Skin temperature ______ Diaphoresis ______
- **Radial Pulse**
  ☐ Strong ☐ Regular ☐ Weak ☐ Irregular
- **Hydration**
  ☐ Well hydrated ☐ Mild dehydration
  ☐ Moderate dehydration ☐ Severe dehydration
- **Neurologic** (See Neuro Vital Sign Record Page 3)
- **Abdomen** ☐ N/A
  Bowel Sounds ______ Distention ______
  Guarding ______ Rigidity ______
- **Genito-Urinary** ☐ N/A
  Dysuria ______ Hematuria ______
  Frequency ______ Flank pain ☐ Right ☐ Left
- **Gynecologic** ☐ N/A
  Last menstrual period ______ (YYYY MM DD) Gravida/Para ______
  Vaginal bleeding Amount ______ Duration ______
- **Pain** ☐ N/A Pain score ______ /10
  Location ______ Radiation ______
  Quality ______ Time of onset ______ (HH:MM)
  Provoked by/Alleviated by ______
- **Skin Integrity** ☐ N/A
  ☐ Intact ☐ Pressure injury Stage 1-4, Unstageable ______
  ☐ Other Location ______

- **Symptoms** ☐ N/A
  Nausea ______ Vomiting ______
  Diarrhea ______ Last bowel movemt ______ (YYYY MM DD)
- **Social Situation** Language Spoken ______
  ☐ Lives with family / friend ☐ Lives alone ☐ Has CCAC
  ☐ Other ______
  Clothing/Belongings/ Own Medications given to:
  ☐ With patient ☐ Family ☐ Security ☐ Other ______

Falls Risk ☐ No
Falls in the last 6 months ______ ALOC ______
Urinary/bowel frequency or urgency ______ Impaired mobility ______
☐ Yes - clinical intuition or 2 or more criteria present
☐ Additional high risk safety measures implemented as applicable

- **ISAR (For all Patients greater than 65)** ☐ N/A

	Yes	No
1) Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?		
2) In the last 24 hours, have you needed more help than usual?		
3) Have you been hospitalized for one or more nights during the past six months?		
4) In general, do you have problems with your vision?		
5) In general, do you have serious problems with your memory?		
6) Do you take six or more medications every day?		
Positive test is 2 or more	Total	/6

- **Confusion Assessment Method (CAM) Screen for Delirium**

1) Acute change in mental status and behaviour fluctuates during the day ☐
2) Difficulty focusing attention ☐

3) Disorganized thinking ☐
4) Altered Level of Consciousness ☐

Positive if all items in Box 1 yes and at least one item in Box 2 yes.
☐ **Positive** ☐ **Negative**

Initial Assessment by Print Name ____________ **Signature** ____________ **Initials** ______

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Interventions

Time (HH:MM)	Intravenous Initiation	Gauge	Intravenous Location	Initials
	Site #1			
	Site #2			
	Site #3			

Time (HH:MM)	Interventions	Size	Site / Comments / Drainage	Initials
	Urinary Catheter			
	Gastric Tube			
	Central Line			
	Arterial Line			

CBGM

Time (HH:MM)	Value	Initial

Intravenous Intake

Time (HH:MM)	Site #	Bag #	Solution	Volume	Rate	End Time (HH:MM)	Initials

Intake/Output

Time (HH:MM)	Intake	Output	Initials

Medications Administered

Time (HH:MM)	Medication	Dose	Route	Initials	Time (HH:MM)	Effect	Initials

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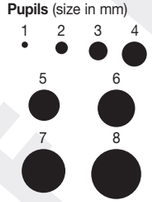
Vital Signs

☐ See Procedural Sedation Patient Care Record Sheet for all applicable medications and vital signs form MS 719

Time (HH:MM)	Heart Rate	Cardiac Rhythm	Blood Pressure	Respiratory Rate	SpO_2	Oxygen LPM %	Temperature	Pain	Eyes	Verbal	Motor	Glasgow Coma Scale	Pupils L Size mm	Pupils L React + / -	Pupils R Size mm	Pupils R React + / -	Strength (N - normal W - weak A - absent) Arm R	Strength Arm L	Strength Leg R	Strength Leg L	Initials

Pupils (size in mm)



Eyes
4 = Spontaneous
3 = To voice
2 = To pain
1 = None
S = Swollen shut

Verbal
5 = Oriented
4 = Disoriented
3 = Inappropriate words
2 = Incomprehensible sounds
1 = None
T = ET Tube/Trach

Motor
6 = Obeys commands
5 = Localizes pain
4 = Withdraws to pain
3 = Flex to pain
2 = Extend to pain
1 = None

Discharge / Transfer Summary

Date (YYYY MM DD)	**Time** (HH:MM)	**Discharged By/To:**	**Follow-Up Plan:**
	☐ Not witnessed by RN *(Leave Time Blank)*	☐ RN *(initials)* _____ ☐ Emergency Department MD/NP/PA ☐ Consulting Service *(specify)* _____ ☐ Place/Unit transferred to: _____	☐ CCAC ☐ Fracture Clinic _____ ☐ Family MD/NP ☐ US outpt. ☐ CT outpt. ☐ Clinic ☐ Other _____

Patient's condition on discharge from ED:
☐ Alert, orientation at baseline ☐ Appropriately dressed for the weather – clothing provided if needed ☐ Aware of destination address ☐ Able to access home/shelter – has keys and/or support person at home/shelter to receive patient ☐ Home at Last (HAL) (age greater than 55 years) ☐ Able to ambulate safely and/or gait steady and/or needed mobility devices available (i.e. walker) ☐ mobility at baseline ☐ Receiving facility contacted _____
☐ Pick up arranged with _____

Mode of Transportation:
☐ Ambulatory, capable of leaving ED safely and independently ☐ Taxi chit provided ☐ Private ambulance ☐ Other _____

Written Instructions / Equipment/Supplies:
☐ Prescription and able to fill prescription ☐ Copy of chart ☐ Labs ☐ Diagnostic Reports ☐ ECG ☐ Supplies Given _____
☐ Additional Comments

Health Teaching: ☐ Return if symptoms worsen ☐ Other _____

Discharge/Transfer Summary by Print Name _____ **Signature** _____ **Initials** _____

Print Name	Signature	Initials

MS560

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