YAYASAN PAHLAWAN TUANKU TAMBUSAI
UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
FAKULTAS: 1. ILMU KESEHATAN; 2. KEGURUAN DAN ILMU PENDIDIKAN; 3. TEKNIK; 4. HUKUM;
5. EKONOMI DAN BISNIS; 6. ILMU HAYATI; 7. AGAMA ISLAM
Alamat: Jl. Tuanku Tambusai No. 23 Bangkinang-Kampar-Riau Telp. 081318787713, 085263513813
Website : http://universitaspahlawan.ac.id; e-mail:info@universitaspahlawan.ac.id

KEPUTUSAN REKTOR UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
NOMOR : 190 /KPTS/UPTT/KP/IX/ 2022

TENTANG

PENUNJUKAN/ PENGANGKATAN DOSEN MENGAJAR SEMESTER GANJIL PRODI S1 KEPERAWATAN, S1 GIZI, S1 KESEHATAN MASYARAKAT, PRODI D IV KEBIDANAN, S1 KEBIDANAN, PENDIDIKAN PROFESI BIDAN, D III KEPERAWATAN DAN D III KEBIDANAN FAKULTAS ILMU KESEHATAN UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI TAHUN AKADEMIK 2022/ 2023

REKTOR UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI

Menimbang : a. bahwa untuk kelancaran proses pembelajaran semester ganjil Program Studi S1 Keperawatan, S1 Gizi, S1 Kesehatan Masyarakat, S1 Kebidanan, D IV Kebidanan, Pendidikan Profesi Bidan, D III Kebidanan dan D III Keperawatan Fakultas Ilmu Kesehatan Universitas Pahlawan Tuanku Tambusai Tahun Akademik 2022/ 2023;

b. bahwa berdasarkan pertimbangan sebagaimana dimaksud pada huruf a diatas, perlu ditetapkan dengan Keputusan Rektor Universitas Pahlawan Tuanku Tambusai;

Mengingat : 1. Undang-Undang No. 16 Tahun 2001 tentang Yayasan sebagaimana yang telah diubah dengan Undang-undang No 28 Tahun 2004 tentang Yayasan;
2. Undang-Undang No. 20 Tahun 2003 tentang Sistem Pendidikan Nasional;
3. Undang-Undang No. 12 Tahun 2012 tentang Pendidikan Tinggi;
4. Peraturan Pemerintah No.4 Tahun 2014 tentang Penyelenggaraan Pendidikan Tinggi dan Pengelolaan Perguruan Tinggi;
5. Peraturan Menteri Riset, Teknologi dan Pendidikan Tinggi Republik Indonesia No. 49 Tahun 2015 tentang Kelas Jabatan di Lingkungan Kementerian Riset, Teknologi dan Pendidikan Tinggi;
6. Peraturan Menteri Riset, Teknologi dan Pendidikan Nomor 16 Tahun 2018 tentang Pedoman Tata Cara Penyusunan Statuta Perguruan Tinggi Swasta;
7. Keputusan Menteri Riset, Teknologi dan Pendidikan Tinggi No.97/KPT/I/2017 tanggal 20 Januari 2017 tentang Izin Universitas Pahlawan Tuanku Tambusai;
8. Akta Notaris Ratu Helda Purnamasari, SH., MKn. No. 20. tanggal 18 September 2021 tentang Perubahan Badan Hukum Yayasan Pahlawan Tuanku Tambusai;
9. Keputusan YPTT Riau No. 01/KPTS/YPTT/2007 tentang Peraturan TataTertib Ketenagakerjaan (Pekerja, Karyawan dan Dosen) di lingkungan Yayasan Pahlawan Tuanku Tambusai;

MEMUTUSKAN

Menetapkan	:	
Pertama	:	Menunjuk/mengangkat Dosen Mengajar Semester Ganjil Prodi S1 Keperawatan, S1 Gizi, S1 Kesehatan Masyarakat, S1 Kebidanan, D IV Kebidanan, Pendidikan Profesi Bidan, D III Kebidanan dan D III Keperawatan Fakultas Ilmu Kesehatan Universitas Pahlawan Tuanku Tambusai Tahun Akademik 2020/ 2021 sebagaimana tersebut dalam lampiran 1, 2, 3, 4, 5, 6, 7 dan 8 Keputusan ini;
Kedua	:	Nama-nama sebagaimana tersebut dalam lampiran keputusan ini, dipandang cakap dan mampu untuk melaksanakan tugas-tugas yang dibebankan dan bertanggung jawab kepada Dekan Fakultas Ilmu Kesehatan Universitas Pahlawan Tuanku Tambusai;
Ketiga	:	Segala biaya yang timbul akibat dikeluarkan Surat Keputusan ini akan dibebankan kepada kas Universitas Pahlawan Tuanku Tambusai;
Keempat	:	Keputusan ini berlaku untuk semester ganjil Tahun Akademik 2022/2023, dengan ketentuan apabila dikemudian hari terdapat kekeliruan dalam penetapannya, akan diadakan perbaikan dan perubahan sebagaimana mestinya.

Ditetapkan di : Bangkinang
Pada Tanggal : 01 September 2022

Universitas Pahlawan Tuanku Tambusai
Rektor,

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI

Prof. Dr. Amir Luthfi

Tembusan disampaikan kepada Yth:
1. Yayasan Pahlawan Tuanku Tambusai
2. Fakultas Ilmu Kesehatan Universitas Pahlawan Tuanku Tambusai
3. Bendahara Universitas Pahlawan Tuanku Tambusai

LAMPIRAN 6 KEPUTUSAN REKTOR UNIVERSITAS PAHLAWAN
NOMOR : 190 /KPTS/UPTT/KP/IX/2022
TANGGAL : 01 SEPTEMBER 2022

PENGANGKATAN DOSEN MENGAJAR SEMESTER GANJIL PROGRAM STUDI D III KEPERAWATAN
FAKULTAS ILMU KESEHATAN UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
TAHUN AKADEMIK 2022/ 2023

Semester I Kelas A

NO	SKS	T	P	K	MATA KULIAH	DOSEN PENGAMPU	DOSEN PENGAJAR
1	2	2	-	-	Agama	Nasril, Lc, M.Pd	Nasril, Lc, M.Pd
2	2	2	-	-	Pancasila	Dr. Musnar Indra Daulay, M.Pd	Dr. Musnar Indra Daulay, M.Pd
3	2	2	-		Kewarganegaraan	Dr. Musnar Indra Daulay, M.Pd	Dr. Musnar Indra Daulay, M.Pd
4	2	1	1	-	Bahasa Indonesia	Miftahul Ilmi, M.Pd	Miftahul Ilmi, M.Pd
5				-	Ilmu Biomedik Dasar		
6	2	1	1		Anatomi dan Fisiologi	Sri Hardianti,SST,M.Si	Sri Hardianti,SST,M.Si
	1	1			Fisika	Dr. Kasman Edi Putra, M.Si	Kasman Edi Putra, M.Si
	1	1			Biokimia	Dr. Kasman Edi Putra, M.Si	Kasman Edi Putra, M.Si
7	2	2	-		Psikologi	Niken Refanthira, M.Psi	Niken Refanthira, M.Psi
8	2	2			Antropologi Kesehatan	Nurfajrin Afriana,SKM, M.Kes	Nur Fajrin Afriana,SKM, M.Kes
9	2	2	-		Konsep Dasar Keperawatan (KDK)	Ns.Erma Kasumayanti, M.Kep	Ns Erma Kasumayanti, M.Kep
10	2	2	-	-	Bahasa Inggris	Hannisa Haris, M.Pd	Hannisa Haris, M.Pd
	20	18	2				

Semester III Kelas A

NO	SKS	T	P	K	MATA KULIAH	DOSEN PENGAMPU	DOSEN PENGAJAR
1	2	2	-	-	Metedeologi Penelitian	Ade Qurniati, SKM, Msi	Ade Qurniati, SKM, Msi
2	2	2	-	-	Dokumentasi Keperawatan	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
3	2	2	-	-	Komunikasi Dalam Keperawatan	M.Nizar Syarif, M.Kes	M. Nizar Syarif Hamidi, M.Kes
4	2	2	-	-	Manajemen Keperawatan	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
5	3	2	1	-	KMB 1	Ns. Riani, S.Kep, M.Kes	Ns. Riani, S.Kep,M.Kes
6	2	2	-	-	Keperawatan HIV/AIDS	Milda Hastuti,SST, M.Kes	Milda Hastuti,SST, M.Kes
7	2	2	-	-	Promosi Kesehatan	M. Nizar Syarif, M.Kes	M. Nizar Syarif Hamidi, M.Kes
8	2	2	-	-	Home Care	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
9	2	2	-	-	Keperawatan Dasar II	Ns. Gusman Virgo,S.Kep MKL	Ns. Gusman Virgo,S.Kep MKL
10	3	-	-	3	PKK I		Ns. Ridha Hidayat, M.Kep
	22	18	1				

Semester III Kelas B

NO	SKS	T	P	K	MATA KULIAH	DOSEN PENGAMPU	DOSEN PENGAJAR
1	2	2	-	-	Metedeologi Penelitian	Yoana Agnesia, SKM,M.Si	Yoana Agnesia, SKM,M.Si
2	2	2	-	-	Dokumentasi Keperawatan	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
3	2	2	-	-	Komunikasi Dalam Keperawatan	Ns. Nila Kusumawati, S.Kep, M.PH	Ns. Nila Kusumawati, S.Kep, M.PH
4	2	2	-	-	Manajemen Keperawatan	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep (2sks)
5	3	2	1	-	KMB 1	Ns. Gusman Virgo S.Kep,MKL	Ns. Gusman Virgo, S.Kep, M.KL
6	2	2	-	-	Keperawatan HIV/AIDS	Ade Qurniati, SKM, Msi	Ade Qurniati, SKM, Msi
7	2	2	-	-	Promosi Kesehatan	Nurfajrin Afriana,SKM, M.Kes	Nur Fajrin Afriana,SKM, M.Kes
8	2	2	-	-	Home Care	Yoana Agnesia, SKM,M.Si	Yoana Agnesia, SKM,M.Si
9	2	2	-	-	Keperawatan Dasar II	Ns. Gusman Virgo S.Kep,MKL	Ns. Gusman Virgo S.Kep,MKL
10	3	-	-	3	PKK I	Ns. Erma Kasuma Yanti, M.Kep	Ns. Erma Kasuma Yanti, M.Kep
	22	18	1	3			

Semester V Kelas A

NO	SKS	T	P	K	MATA KULIAH	DOSEN PENGAMPU	DOSEN PENGAJAR
1	4	-	-	1	Kep. Jiwa	Ns. Nia Aprila, M.Kep	Ns. Nia Aprila, M.Kep
		2	1	-		Hariet Rinancy,M.Kep	Hariet Rinancy,M.Kep
2	4	2	-	2	Keperawatan Keluarga/PKK Keluarga/PBL	Ns. Indrawati, S.Kep, MKL	Ns.Indrawati,S.Kep, MKL
3	3	2	-	1	Keperawatan Gerontik/PKK Gerontik	Ns. Yenny Safutri,M.Kep	Ns. Yenny Safutri,M.Kep
4	4		2	-	KMB II	Ns. Riani, S.Kep, M.Kes	Ns. Riani, S.Kep, M.Kes
5	2	2	-	-	Bahasa Inggris III	Hanisa Haris, M.Pd	Hanisa Haris, M.Pd
6	2	-	-	2	Keperawatan Komunitas II/PBL	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
	19	18	1	6			

Semester V Kelas B

NO	SKS	T	P	L	MATA KULIAH	DOSEN PENGAMPU	DOSEN PENGAJAR
1	4	2	1	1	Kep. Jiwa	Ns. Nia Aprila, M.Kep	Ns. Nia Aprila, M.Kep
2	4	2	-	2	Keperawatan Keluarga/PKK Keluarga/PBL	Ns. Indrawati, S.Kep, MKL	Ns.Indrawati,S.Kep, MKL
3	3	2	-	1	Keperawatan Gerontik/PKK Gerontik	M.Nizar Syarif, M.Kes	M. Nizar Syarif Hamidi, M.Kes
4	4		2	-	KMB II	Ns. Gusman Virgo, M.Kep	Ns. Gusman Virgo, M.Kep (2 sks)
5	2	2	-	-	Bahasa Inggris III	Hanisa Haris, M.Pd	Hanisa Haris, M.Pd
6	2	2	-	2	Keperawatan Komunitas II/PBL	Ns. Ridha Hidayat, M.Kep	Ns. Ridha Hidayat, M.Kep
	19	10	3	6			

Universitas Pahlawan Tuanku Tambusai
Rektor,

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI

Prof. Dr. AMIR LUTHFI

RENCANA PEMBELAJARAN SEMESTER (RPS)

BAHASA INGGRIS III

Dosen:

Hannisa Haris, M.Pd

PROGRAM STUDI DIII KEPERAWATAN
FAKULTAS ILMU KESEHATAN
UNIVERSITAS PAHLAWAN
2022/2023

RENCANA PEMBELAJARAN SEMESTER (RPS)

1. **Identitas Mata Kuliah**

Nama Program Studi	: DIII Keperawatan
Nama Matakuliah	: Bahasa Inggris III
Kelompok Matakuliah	: Mata Kuliah Keterampilan dan Keahlian Tambahan
Jumlah SKS	: 2 SKS
Jenjang	: Diploma
Semester	: III
Prasyarat	: *General English*
Status (wajib/pilihan)	: Wajib
Nama dosen	: Hannisa Haris, M.Pd

2. **Deskripsi Mata Kuliah**

Mata kuliah ini memberikan kesempatan kepada mahasiswa untuk memperdalam kemampuan bahasa inggris yang berhubungan dengan empat kemampuan dasar bahasa inggris, yaitu *listening, speaking, writing,* dan *reading* dengan pokok bahsan: *grammar, reading, comprehension, conversation, listening comprehension, translation* dan *writing*, sehingga pada akhirnya mahasiswa mampu berkomunikasi dalam bahasa inggris dengan baik khususnya dalam bidang keperawatan. Capaian pembelajaran dalam RPS ini akan dicapai melalui pendekatan *Student Centre Learning* dengan metode pembelajaran, kuliah, penugasan, dan diskusi. Bahan diskusi dapat diperoleh dari buku sumber yang telah direkomendasikan oleh dosen dan referensi lain yang relevan.

3. **Capaian Pembelajaran Matakuliah (CPM)**

Pada akhir perkuliahan ini diharapkan mahasiswa dapat mampu untuk:

- mengucapkan istilah-istilah medis dan keperawatan;
- dan mengkomunikasikan bahasa inggris dengan tata bahasa yang baik dan benar untuk pengembangan profesi kesehatan.

4. Deskripsi Rencana Pembelajaran

Minggu ke	Capaian Pembelajaran		Bahan Kajian	Bentuk Pembelajaran	Topik	Waktu	Tugas dan Penilaian	Rujukan
	Sikap/Nilai dan Pengetahuan	Keterampilan						
1	- Menguasai phrase-phrase bahasa inggris yang digunakan untuk memperkenalkan diri antara perawat dan pasien.	- Melakukan percakapan menggunakan phrase- phrase yang berhubungan dengan cara memperkenalkan diri antara perawat dan pasien.	1. *How to introduce yourself to patients;* 2. *How to introduce yourselfyou're your colleague.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog; - Menjawab pertanyaan secara lisan dan tertulis.	*Establishing a relationship (nurse-patient)*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop
2	- Menguasai nama-nama profesi di rumah sakit dan cara menanyakan nama kepada pasien.	- Mempraktekan percakapan tentang interaksi perawat dengan beberapa profesi dirumah sakit seperti doktor ahli bedah,	1. *Names of profession in hospital.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.	*Profession in hospital*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

		ahli gigi dan lain- lain.						
3-4	- Mengetahui nama-nama bangsal di rumah sakit; - Mampu menggunakan nama-nama bangsal di rumah sakit dalam percakapan antara dokter, perawat dan pasien. - Memahami percakapan yang berhubungan dengan topik *"On Monday, Mark is admitted to hospital and arrives in the Surgical Ward with Julie.*	- Mempraktekan percakapan tentang interaksi tenaga medis di bangsal dalam bahasa inggris.	1. *Names of department in hospital;* 2. *Names of wards in hospital;* 3. *Conversation in topic "On Monday, Mark is admitted to hospital and arrives in the Surgical Ward with Julie. They meet the Charge Sister and Sister Joanna, who takes them to a room. Mary, the Ward Help, is in the room cleaning the beside tables. There are 2 beds in the room but both are empty."*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog; - Menjawab pertanyaan secara lisan dan tertulis.	*Wards and departments in hospital.*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

	They meet the Charge Sister and Sister Joanna, who takes them to a room. Mary, the Ward Help, is in the room cleaning the beside tables. There are 2 beds in the room but both are empty."							
5-6	- Memahami ungkapan-ungkapan yang digunakan untuk menentukan arah di rumah sakit. - Memahami percakapan yang berhubungan	- Mempraktekan percakapan tentang menentukan arah dirumah sakit.	1. *Prepositional of place;* 2. *Useful expression to ask and show the direction;* 3. *Conversation in topic "How do I get to surgical ward, miss?"*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog; - Menjawab pertanyaan secara lisan dan tertulis.	*Asking and showing rooms in a hospital*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

	dengan arah dirumah sakit.							
7	- Memahami ungkapan-ungkapan yang digunakan untuk berkonsultasi , treatment dan intervention antara pasient, perawat dan dokter.	1. Mempraktekan beberapa ungkapan tentang keluhan pasient dalam bahasa inggris; 2. Mempraktekan beberapa ungkapan yang digunakan dalam memberikan treatment dan konsultasi dalam bahasa inggris.	1. *Useful expression to ask the present complain of patient;* 2. *Treatment and closing the consultation.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog; - Menjawab pertanyaan secara lisan dan tertulis.	*Consultation and nursing intervention*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop
8	**UTS**					2 X 50 menit		-
9	- Memahami cara mengkonversi farenhiet ke selsius dalam bahasa	1. Mempraktekan cara mengubah farenhiet kedalam	1. *Temperature equivalents and conversion;* 2. *Abbreviation.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal	*Convert Fahrenheit into Celsius*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

	inggris - Memahami singkatan-singkatan dalam istilah kesehatan atau abbrevition.	celcious 2. Menggunakan istilah singkatan-singkatan/abrevation dalam kalimat.		yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.				
10	- Memahami ungkapan-ungkapan yang digunakan untuk menanyakan waktu dan schedule dokter di rumah sakit; - Memahami percakapan yang berhubungan dengan waktu dan schedule dokter.	1. Menggunakan ngkapan-ungkapan yang berhubungan dengan schedule dan waktu; 2. Mempraktek percakapan tentang schedule dokter frank.	*1. Time expression* 2. *Conversation in topic "When is doctor. Frank's schedule?"*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog; - Menjawab pertanyaan secara lisan dan tertulis.	*Telling time and Doctor's schedule*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

11	1. Menguasai nama-nama alat kesehatan dalam bahasa inggris dan menggunakanya dalam percakapan. Antara dokter dan perawat.		1. *Medical instruments are used for measuring vital sign.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.	*Medical equipment*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop
12	- Menguasai nama-nama anggota tubuh dalam bahasa inggris dan menggunakannya dalam percakapan. - Memahami beberapa ungkapan tentang rasa sakit dan	Menggunakan ungkapan-ungkapan yang berhubungan dengan bagian tubuh pasien dalam bahasa inggris	1. *Part of body;* 2. *Patient's expression about symptoms and physical problems.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.	*Parts of body and health problems*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop

	masalah kesehatan dalam bahasa inggris.	Menggunakan beberapa ungkapan tentang masalah kesehatan yang dialami pasien.						
13	- Memahami beberapa ungkapan dalam menjelaskan prosedur dan memberikan instruksi dan ekspresi selama implementasi.	- Menggunakan beberapa ungkapan tentang menjelaskan prosedur dan memberikan instruksi dan ekspresi selama implementasi dalam bahasa inggris	1. *Explaining the procedure expressions;* 2. *Giving instructions and expressions during the implementation;*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.	*Checking Vital Sign*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop
14	- Memahami ungkapan-	- Menggunakan ungkapan-	1. *Questioner to fill in admission*	- Mahasiswa membaca & memahami materi;	*Admission to a hospital*	2 X 50 menit	Di akhir pembelajaran	- LCD

	ungkapan dan istilah yang di gunakan dalam pendaftaran pasien dirumah sakit dalam bahasa inggris. - Memahami percakapan yang berhubungan ungkapan-ungkapan dan istilah yang di gunakan dalam pendaftaran pasien dirumah sakit dalam bahasa inggris.	ungkapan yang digunakan untuk mengisi formulir pendaftaran dirumah sakit dalam bahasa inggris; - Menggunakan kata Tanya dalam kalimat yang berhubungan dengan istilah-istilah kesehatan; - Mempraktekan percakapan dengan topic *"filling admission form"*	*form;* 2. *Question words;* 3. *Conversation in topic "filling admission form".*	- Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Menjawab pertanyaan secara lisan dan tertulis.			diberikan tugas dan review materi.	- Laptop

15	– Memahami ungkapan-ungkapan dan istilah yang di gunakan dalam mebuat laporan keperawatan; – Memahami percakapan yang berhubungn dengan ungkapan-ungkapan dan istilah yang digunakan dalam membuat laporan keperawatan – Memahami wacana *nursing documentation*	– Menjawab beberapa pertanyaan berdasarkan wacana yang diberikan tentnag dokumentasi keperawatan – Menggunakan ungkapan-ungkapan yang berhubungan dengan laporan keperawatan – Mempraktekan percakapan tentang dokumentasi keperawatan	1. *Reading text about nursing documentations;* 2. *Conversation about nursing documentation;* 3. *The example of nursing report.*	- Mahasiswa membaca & memahami materi; - Dosen menjelaskan; - Mahasiswa mendiskusikan & menanyakan hal hal yang belum diketahui; - Mempraktekan dialog/monolog;	*Nursing Documentation*	2 X 50 menit	Di akhir pembelajaran diberikan tugas dan review materi.	- LCD - Laptop
16	**UAS**					2 X 50 menit		

5. Daftar Referensi

Ardiansyah, 2000. *Let's Speak English Nurse*, Jakarta : EGC.

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Miyamasu, F. 2014. *History-Taking in English.* Medical English Communication Center. https://www.md.tsukuba.ac.jp/MECC/self-study.html.

Murphy, R. 1992. *English Grammar in Use:2nd Edition*. NY: Cambridge University.

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ABSENSI PERKULIAHAN

SEMESTER V

TINGKAT III

MATA KULIAH

BAHASA INGGRIS III

UNIVERSITAS
PAHLAWAN

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
FAKULTAS ILMU KESEHATAN
PROGRAM STUDI DIII KEPERAWATAN
TAHUN AJARAN 2022/2023

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
FAKULTAS ILMU KESEHATAN
PROGRAM STUDI KEPERAWATAN

BATAS MATERI KULIAH

Mata Kuliah : BAHASA INGGRIS III
Semester / SKS : 5 / 2
Kelas/Tahun Akd : A / 2022/2023 Ganjil

Dosen Pengampu : HANNISA HARIS, S.Pd, M.Pd
Dosen Pengajar :

NO	HARI/TGL	MATERI	PARAF DOSEN	P. KETUA KELAS
1	20 September 2022	Establishing a relationship (nurse - patient)		
2	21 September 2022	Proffesion in hospital		
3	27 September 2022	Wards and departments in hospital		
4	4 Oktober 2022	wards and departments in hospital		
5	11 Oktober 2022	Asking and showing room in a hospital		
6	18 Oktober 2022	Asking and showing room in a hospital		
7	26 oktober 2022	Consultation and nursing intervention		
8	9 November 2022	UTS		
9	16 November 2022	Convert Fahrenheit into Celcius		
10	23 November 2022	Telling time and Doctor's Schedule		
11	8 November 2022	Medical equipment		
12	14 Desember 2022	Parts of body and health problems		
13	23 Desember 2022	Checking vital sign.		
14	24 Desember 2022	Admission to a hospital		
15	2 Desember 2022	Nursing Documentation		
16	13 Januari 2023	UAS.		

DAFTAR HADIR KULIAH

PROGRAM STUDI KEPERAWATAN - FAKULTAS FAKULTAS ILMU KESEHATAN

Mata Kuliah : BAHASA INGGRIS III
Semester / SKS : 5 / 2
Kelas / Tahun Akd : A / 2022/2023 Ganjil

Dosen Pengampu : HANNISA HARIS, S.Pd, M.Pd
Dosen Pengajar :

Validation ID: 20221-FIK-14401-016

NO	NIM	NAMA MAHASISWA	PERTEMUAN KE / HARI / TANGGAL																Ket
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
1	2014401001	AISYAH ROSADI										A		1					
2	2014401003	DONI HERMAWAN										A							
3	2014401004	FIKRI RIJA PRIANSYAH																	
4	2014401006	MUHAMMAD AFRI YANSYAH										A		4					
5	2014401009	AMALIYA MAYUS																	
6	2014401010	DESY RATNA										A							
7	2014401011	DINDA ZALIANTI BASRI												1					
8	2014401012	ELSA BERLIANA PUTRI																	
9	2014401013	GILANG AR RACHMANSYAH										A							
10	2014401015	MUHAMMAD RADITO MAULANA																	
11	2014401016	SAPURA																	
12	2014401017	SASMI AMALIAH										S							
13	2014401018	SYAHRIZA																	
14	2014401019	WESTAMA NAORIANDI										A							
15	2014401020	DEWI SARTIKA																	
16	2014401021	MELSY HAFIZAH												1					
17	2014401022	AFRI YOLANDA SARI																	
18	2014401023	CINDY PUSPITA AYU																	
19	2014401024	YESI PRATAMA																	
20	2014401026	ANDI SAPUTRA										A							

21	2014401027	AMAL RISKY																	
22	2014401028	PUTRI INDRIANI MIRAZA																	
23	2014401029	MELLY SUSANA																	
24	2014401031	M. ZIKRIL FAJAR ADITIA																	
25	2014401032	RENI INDAH OKTARI																	
26	2014401033	SISKA AMELIA PUTRI																	
27	2014401042	MAULANA MHD ZIKRI																	
28	2014401052	JULITA CICILIA																	
29	2014401053	WIDIA UTAMI																	
PARAF DOSEN																			
TANGGAL PERTEMUAN																			
JUMLAH MAHASISWA YANG HADIR HARI INI																			

Mengetahui,

Ketua Program Studi,

RIDHA HIDAYAT, S.Kep, M.Kep, Ners

Bangkinang, 21 JANUARI 2023

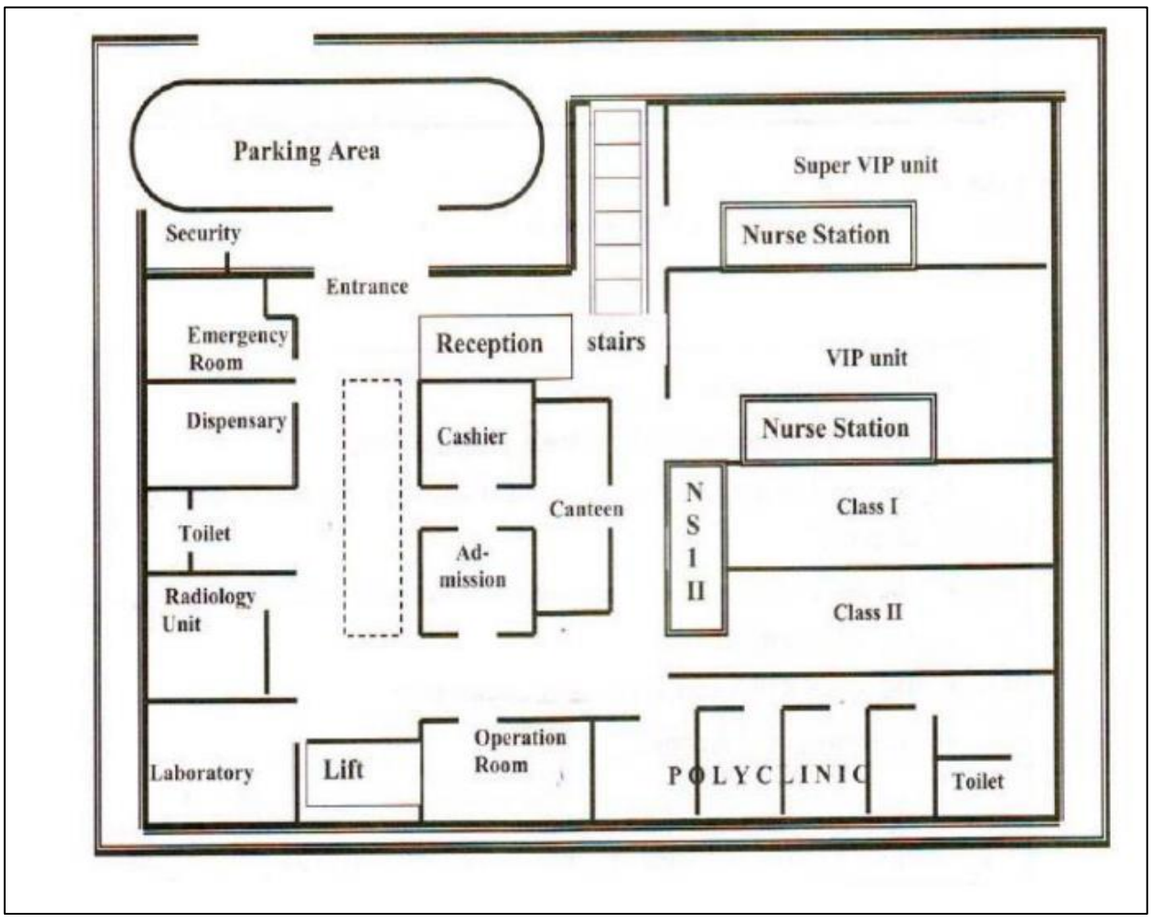
Dosen Pengajar,

Hamsa Tamsi M.Pd.

CATATAN :
* Jumlah tatap muka / pertemuan mahasiswa tidak boleh kurang dari 80%
* Absen harus di tandangangi tidak boleh di cheklist
* Pakain untuk mahasiswa : tidak boleh memakai sandal, kaos oblong, sandal, anting, kalung, gelang
* Pakaian untuk mahasiswi : Tidak boleh memakai sandal, kaos ketat dan baju transparan

MID TERM
DIPLOMA IN NURSING
FACULTY OF HEALTH SCIENCES
UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI

This is the site map of the first floor in a hospital



Direction: Refer to the site map above. Make a communication exchange to show the direction. The starting points are as follows.

1. The security to operation room.
2. The class II to laboratory.
3. The emergency room to the lift.
4. The entrance to the class 1.
5. The emergency room to admission.

FINAL SEMETER EXAMINATION
DIPLOMA IN NURSING
FACULTY OF HEALTH SCIENCES
UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
2022/2023

Course : English
Time Allocation : 60 minutes

Directions:

1. Write your name and your student ID (NIM) on the answer sheet.
2. You are not allowed to use your Phone or dictionary during the examination.
3. Once the supervisor notified that you cheated someone's answer, your score will not be proceeded.

Choose the correct answer!

The dialog is for question number 1-2

Nurse : Hello, Good Morning, Mr. Syahrul!
Patient : Hi, (1) _____!
Nurse : (2) I'm Nurse Rafika. I'll take care of you today.
May I address you with Mr. Arul?
Patient : Yes, sure!
Nurse : Well, I need to visit other patients. If you need anything, please just press the call button, I'll help you.
Patient : Alright, Thank you.
Nurse : You're welcome.

1. a. Good Night
   b. Good Afternoon
   c. Good Day
   d. Good Morning

2. I'm Nurse Rafika. I'll take care of you today.
   The underlined utterance is an expression of …
   a. Greetings
   b. Introducing yourself
   c. Addressing Someone
   d. Pre-closing

The dialog is for question number 3-5

Nurse Katty: Hi, what your name?
New Nurse : My name is Sarah.
Nurse Katty: I'm Katty. I haven't see you before.
New Nurse : I'm a new nurse.
Nurse Katty: (3) _____
New Nurse : I'm from London.
Nurse Katty: How long have you been in this country?
New Nurse : I have been here for 2 weeks.
Nurse Katty: (4) _____
New Nurse : I live in My Sibling's house. It's not far away from here.
Nurse Katty: Nice to meet you!
New Nurse : (5) _____

3. a. Where is she from?
   b. Where am I from?
   c. Where are they from?
   d. Where are you from?

4. a. Where do you live?
   b. Where do I live?
   c. Where does she live?
   d. Where does he live?

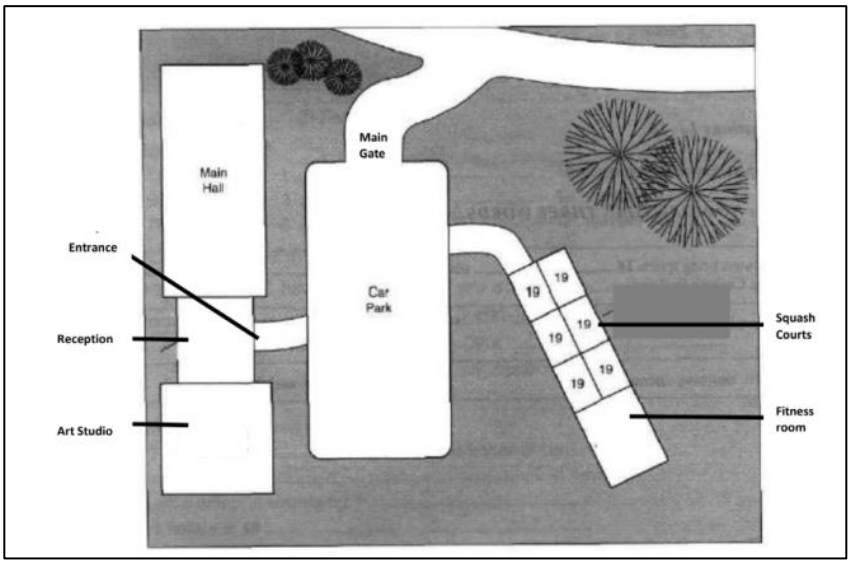
5. a. Good bye
   b. Sure
   c. Nice to meet you too
   d. See you

6. In *Indonesia*, **Dentist** is ….
   a. Dokter beda
   b. Dokter THT
   c. Dokter Gigi
   d. Dokter Umum

7. In English, *Apoteker* is ….
   a. Therapist
   b. Physician
   c. Phlebotomist
   d. Pharmacist

8. A: ‘Where can a mother go to visit her premature baby?’
   B: ‘She can go to ….’
   a. A neonatal intensive care unit (NICU)
   b. The surgical ward
   c. The dermatological ward
   d. The medical ward

9. A:’ Where do patients usually go if they have a heart attack?’
   B: ‘They go to ….’
   a. The gynecological ward
   b. The surgical ward
   c. The cardiology ward
   d. The medical ward



10. Where is the reception?
    a. It is beside the fitness room.
    b. It is in front of the main gate.
    c. It is between the main hall and the art studio.
    d. It is in the car park.

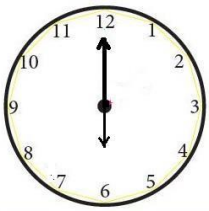
11. **A**: ‘I’m looking for nurse station. How can I get there?’
    B: <u>‘Go straight ahead, then turn left.’</u>
    The underlined utterance is an expression of …

    a. Asking for direction
    b. Asking for information

c. Giving direction
d. Giving information

12. What is 40°C in Fahrenheit?
    a. 59 Fahrenheit
    b. 104 Fahrenheit
    c. 25 Fahrenheit
    d. 6 Fahrenheit

13. What is 60°F in Celsius?
    a. 10 Celsius
    b. 77 Celsius
    c. 15,5 Celsius
    d. 34 Celsius

14. 

    What time is it?
    a. It's three o'clock
    b. It's eleven o'clock
    c. It's six o'clock
    d. It's one o'clock

15. 

    What time is it?
    a. It's half past nine
    b. It's half past ten
    c. It's half nine
    d. It's nine o'clock

16. To measure patient's body temperature, we can use …

a. Stopwatch
b. Stethoscope
c. Sphygmomanometer
d. Thermometer

17. To check patient's high blood pressure, or hypertension, we can use …
    a. Stethoscope & Stopwatch
    b. Thermometer & Sphygmomanometer
    c. Stethoscope & Sphygmomanometer
    d. Tympanic Digital Thermometer

18. In English, *terasa sakit* is …
    a. painful
    b. hurt
    c. injured
    d. itch

19. In Indonesia, a swelling is …
    a. penyakit
    b. pingsan
    c. luka
    d. pembengkakan

20. **Patient :**'I have a <u>sore throat'</u>
    Nurse : 'Do you feel pain when swallowing?'
    Patient : 'Yes, it's painful."
    What does the underlined word mean?
    a. Sakit gigi
    b. Demam
    c. Sakit tenggorokan
    d. Sakit perut

The dialog is for question number 21-23

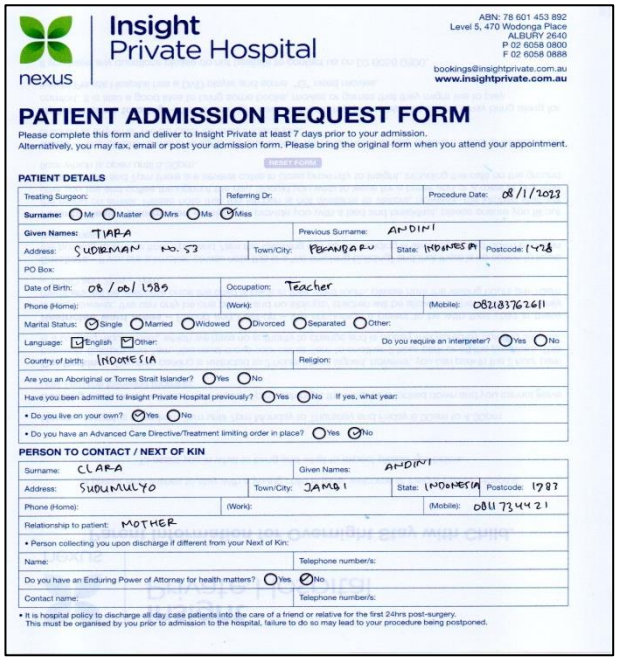
Nurse : 'Good afternoon, Miss Laura'
Patient : 'Good afternoon'
Nurse : '<u>It's time for me to measure your temperature</u>. Would you mind putting this thermometer under your tongue?'
Patient : 'Sure'
Nurse : 'Please, wait at least 3 minutes.'
Patient : 'It's 3 minutes already'
Nurse : 'OK, Fine. That's it.'

21. When does the nurse measure the patient's temperature?
    a. She measures the patient's temperature in the morning.
    b. She measures the patient's temperature in the afternoon.
    c. She measures the patient's temperature at noon.
    d. She measures the patient's temperature in the evening.

22. When will the nurse remove the thermometer?
    a. She will remove it in about thirty seconds.
    b. She will remove it in about two seconds.
    c. She will remove it in about three minutes.
    d. She will remove it in about three hours.

23. <u>It's time for me to measure your temperature</u>
    The underlined utterance is an expression of …
    a. Giving an opinion
    b. Explaining the procedures
    c. Giving instruction
    d. Nurse response

Read the following admission form for question number 24



Insight Private Hospital
nexus

ABN: 78 601 453 892
Level 5, 470 Wodonga Place
ALBURY 2640
P 02 6058 0800
F 02 6058 0888
bookings@insightprivate.com.au
www.insightprivate.com.au

PATIENT ADMISSION REQUEST FORM

Please complete this form and deliver to Insight Private at least 7 days prior to your admission.
Alternatively, you may fax, email or post your admission form. Please bring the original form when you attend your appointment.

RESET FORM

PATIENT DETAILS

Treating Surgeon:	Referring Dr:	Procedure Date: 08/1/2023
Surname: ○ Mr ○ Master ○ Mrs ○ Ms ✓ Miss		
Given Names: TIARA	Previous Surname: ANDINI	
Address: SUDIRMAN NO. 53	Town/City: PEKANBARU	State: INDONESIA Postcode: 1728
PO Box:		
Date of Birth: 08/06/1989	Occupation: Teacher	
Phone (Home):	(Work):	(Mobile): 082183762611
Marital Status: ✓ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Other:		
Language: ☑ English ☐ Other:		Do you require an interpreter? ○ Yes ○ No
Country of birth: INDONESIA	Religion:	
Are you an Aboriginal or Torres Strait Islander? ○ Yes ○ No		
Have you been admitted to Insight Private Hospital previously? ○ Yes ○ No If yes, what year:		
• Do you live on your own? ✓ Yes ○ No		
• Do you have an Advanced Care Directive/Treatment limiting order in place? ○ Yes ✓ No		

PERSON TO CONTACT / NEXT OF KIN

Surname: CLARA	Given Names: ANDINI	
Address: SUDIRMULYO	Town/City: JAMBI	State: INDONESIA Postcode: 1787
Phone (Home):	(Work):	(Mobile): 0811 73442 1
Relationship to patient: MOTHER		
• Person collecting you upon discharge if different from your Next of Kin:		
Name:	Telephone number/s:	
Do you have an Enduring Power of Attorney for health matters? ○ Yes ✓ No		
Contact name:	Telephone number/s:	

• It is hospital policy to discharge all day case patients into the care of a friend or relative for the first 24hrs post-surgery. This must be organised by you prior to admission to the hospital, failure to do so may lead to your procedure being postponed.

24. What is her job?
    a. She is a teacher
    b. She is a chef
    c. She is an employee
    d. She is a police officer

Read the following patient's information for question number 25

> Mr. Jhon is a 50 year old businessman who was admitted to the hospital with pneumonia. His vital signs have been stable this morning. Mr. Kirby says he feels very 'washed out' today. This morning, he ate all of his breakfast and walked to the bathroom with the help of a nursing assistant. Mr. Jhon currently has a headache, which rates as a 7 on a 1-10 scale. He thinks it started after he read too much without his glasses. Upon physical examination, the nurse notes nothing unusual. The nurse has administrated Tylenol, 650 mg, which is on his 'prn' medication orders. 30 minutes later, He says his headache is better and is now a 2 on 1-10 scale. The nurse lets him know to use the call light if the headache returns or he has any concerns or needs.

25. The following statements are TRUE according to the text, except ….
    a. Mr. Jhon's vital signs is stable.
    b. Mr. Jhon feels 'washed out'.
    c. Mr. Jhon states he has a headache.
    d. Mr. Jhon states he has a toothache.
    e. She is a police officer

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
PROGRAM STUDI D III KEPERAWATAN
TAHUN AJARAN 2022/2023

DAFTAR NILAI

Mata Kuliah : **Bahasa Inggris III**
Semester : **Semester V**
Dosen : **Hannisa Haris M.Pd**
Angkatan :

NO	NIM	NAMA	NILAI		KETERANGAN
			MUTU	LAMBANG	
1	2014401022	AFRI YOLANDA SARI	4	A	
2	2014401001	AISYAH ROSADI	4	A	
3	2014401027	AMAL RISKY	4	A	
4	2014401009	AMALIYA MAYUS	4	A	
5	2014401026	ANDI SAPUTRA	3,7	A-	
6	2014401023	CINDY PUSPITA AYU	4	A	
7	2014401010	DESY RATNA	4	A	
8	2014401020	DEWI SARTIKA	4	A	
9	2014401011	DINDA ZALIANTI BASRI	4	A	
10	2014401003	DONI HERMAWAN	3,7	A-	
11	2014401012	ELSA BERLIANA PUTRI	4	A	
12	2014401004	FIKRI RIJA PRIANSYAH	3,3	B+	
13	2014401013	GILANG AR RACHMANSYAH	4	A	
14	2014401052	JULITA CICILIA	4	A	
15	2014401031	M. ZIKRIL FAJAR ADITIA	4	A	
16	2014401042	MAULANA MHD ZIKRI	3,3	B	
17	2014401029	MELLY SUSANA	3,3	B	
18	2014401021	MELSY HAFIZAH	4	A	
19	2014401006	MUHAMMAD AFRI YANSYAH	3,3	B-	
20	2014401015	MUHAMMAD RADITO MAULANA	4	A	
21	2014401028	PUTRI INDRIANI MIRAZA	4	A	
22	2014401032	RENI INDAH OKTARI	4	A	
23	2014401016	SAPURA	4	A	
24	2014401017	SASMI AMALIAH	4	A	
25	2014401033	SISKA AMELIA PUTRI	4	A	
26	2014401018	SYAHRIZA	4	A	
27	2014401019	WESTAMA NAORIANDI	4	A	
28	2014401053	WIDIA UTAMI	4	A	
29	2014401024	YESI PRATAMA	4	A	

Keterangan Nilai :

Nilai Absolut	Nilai Mutu	Kategori
85 - 100	4	A
80 - 84	3,7	A-
75 - 79	3,3	B+
70 - 74	3, 0	B
65 - 69	2,7	B-
60 - 64	2,3	C+
55 - 59	2, 0	C
45 - 54	1, 0	D
< 45	0	E

Bangkinang, 21 Januari 2023
Ketua Prodi D III Keperawatan

Dosen Pengajar

(Hannisa Haris M.Pd)

(Ns. RIDHA HIDAYAT, M. Kep)

[REVISED EDITION]

English For The Professional Nurse

Book 1

Indah Dwi Pratiwi & Risa Herlianita

Editor
Risa Herlianita

2011

SCHOOL OF NURSING
MUHAMMADIYAH UNIVERSITY OF MALANG

FOREWORD

Nowadays, competence in English has become an urgent need for nurses who are involved in medical services. It is due to the fact that they are required to have the ability to communicate with the other people in their field including doctors and patients.

English for Professional Nurse Book 1 is prepared for the demands of professional nursing also include English Competence. This book provides nurse students to improve their English skills in listening, reading, speaking and writing.

The contents of this book are based on the standard and fundamental nursing procedures taught in previous year, so that the contents are not something strange for the nurses. This course book is certainly help to facilitate the student to acquire the ability to perform their duties in an environment where English is used and needed. I wish that this book will be studied and practiced easily to achieve the competence of Nursing English.

I hope that by the use of this book, the nursing students will be able to learn and practice English according to their professional skills. By mastering English for Professional Nurse Book 1, it will improve their quality of human resources and they will have added value so that job opportunities will be widely open for them to reach a bright future.

Author

CONTENT

Chapter 1

Establishing A Relationship

Learning Objectives

After studying this chapter, student should be able to:

1. Introduce himself/herself to patients

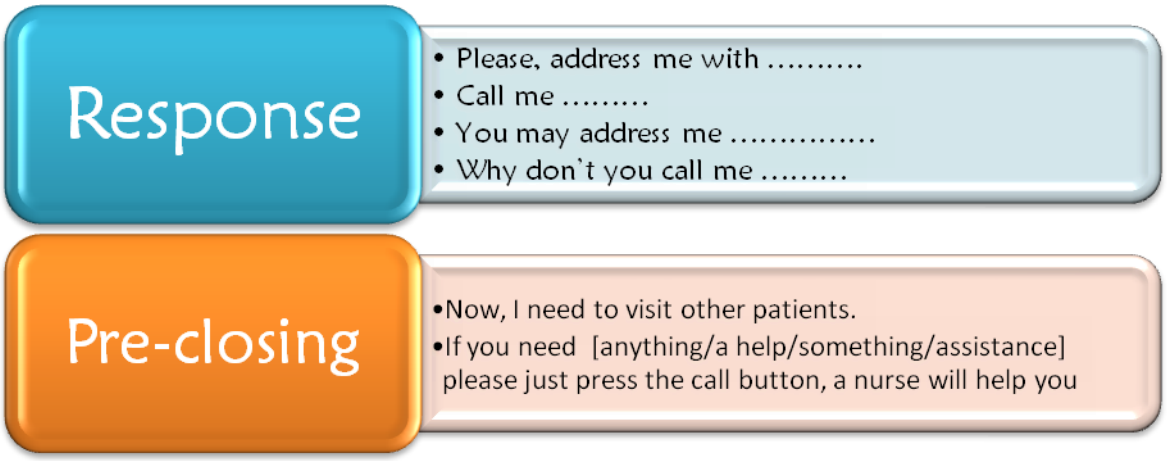
Vocabulary

Case history

Mrs. Julia had a stroke (cerebrovascular accident) about 18 months ago. Her family looks after her at home. Nurse from home care help her with a twice a day visit. She has come into the care home while her family has a short holiday. The stroke has left Mrs. Julia with *left-sided paralysis* and poor balance. She doesn't have *dysphasia*. But because the left side of her face is also paralysis, she also has *slurred speech* and *dribbled saliva*. She has a problem with non-verbal communication because her facial expression is affected.

Useful Expressions

Greetings	• Hello, • Assalamu'alaikum, • Good [Morning/Afternoon/Evening] Mr./Miss/Mrs…
Introducing yourself and initiating nursing interventions	• I'm nurse ..... (your name) • I'll take care of you today
Addressing someone	• How can I address you? • Is it "Miss or Mrs. ……? • May I address you with ……?



ACTIVITY – TASK 1

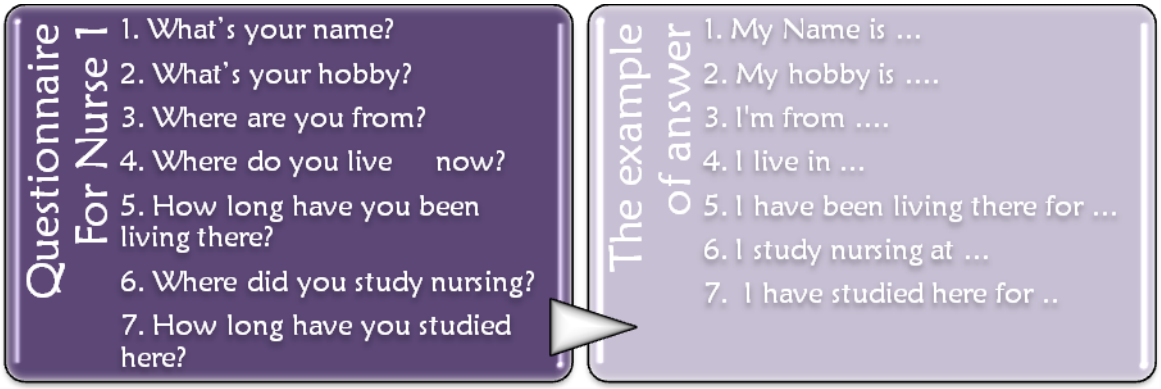
Introducing yourself to a colleague

Fill in the blanks with suitable expressions, and then practice with your partner

Nurse Mellissa : Hi, what's your name?
New Nurse : .....
Nurse Mellissa : I'm Mellissa. I haven't see you before
New Nurse : .....
Nurse Mellissa : Where are you from?
New Nurse : .....
Nurse Mellissa : How long have you been in this country?
New Nurse : .....
Nurse Mellissa : How do you like this country?
New Nurse : .....
Nurse Mellissa : Nice to meet you.
New Nurse : .....

ACTIVITY – TASK 2

Do this in pairs. Ask your partner more about her/his personal information. Use this questionnaire. After asking your partner, take turn to answer his/her question. Use the same.



Chapter 2

ASKING AND SHOWING ROOM IN HOSPITAL

Learning Objectives

After studying this chapter, student should be able to:

1. Use expressions related to giving directions correctly
2. Give directions to a certain place in or out of hospital

Vocabulary

Surrounded by	Right	Dead end	Turn
In the middle of	Left	One way	U-turn
Directly opposite	Intersection	Straight ahead	Corridor
On the right-hand side of	Parallel to	Roundabout	Sidewalk
On the left-hand side of	Corner	Close to	

Useful Expressions

Visitor/Patient: How to ask for direction

Could you tell me how to get to ....?
Can you tell me where .... is?
I'm looking for .... How can i get there?
Excuse me, can you tell me the way to ..., please?

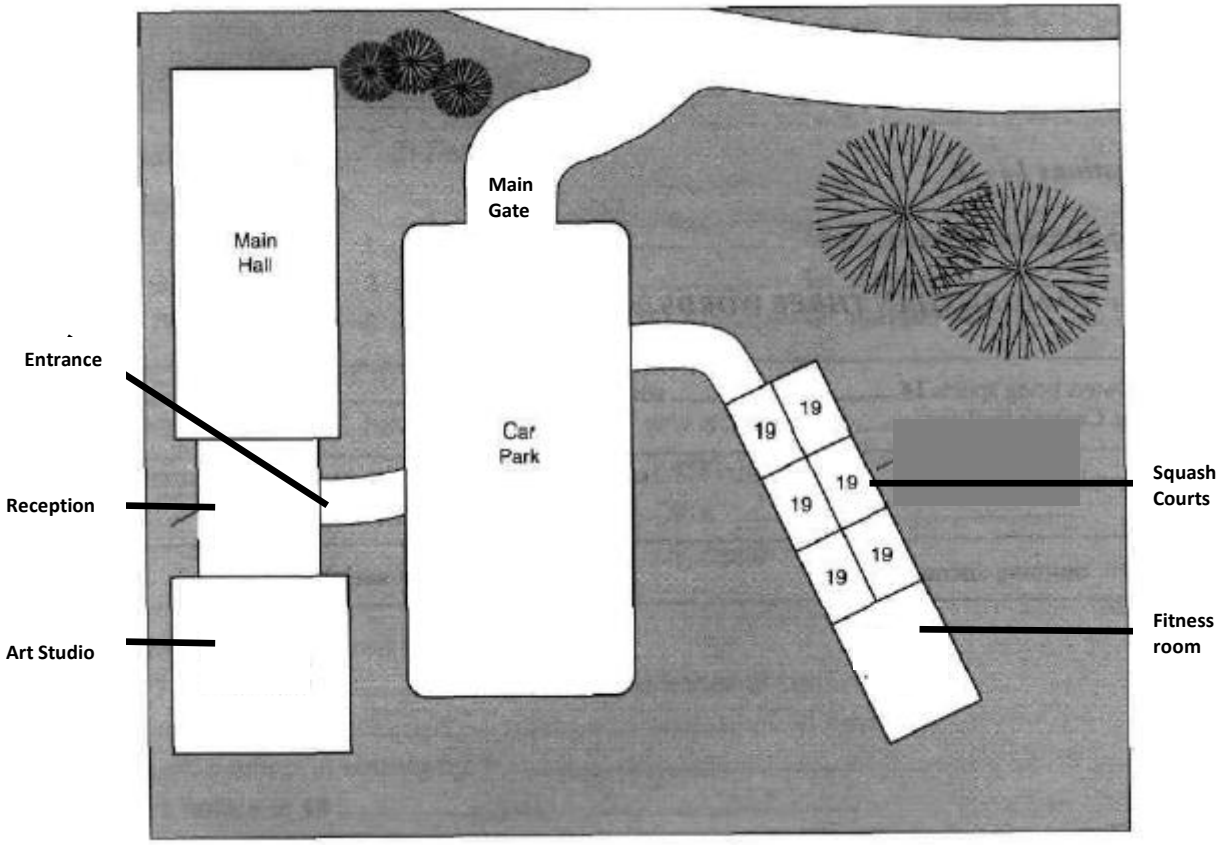
How to give simple directions

- *Walk down .....*
- *Go along this .....*
- *Go up stairs .....*
- *Until you find .....*
- *Then turn right/left .....*
- *Take the first turn on the right.*
- *Take the second road on the left.*
- *Then turn left/right at the next T junction*
- *Turn left at the traffic light.*

Showing a place or room

It is .....
on the left/right side of .....
next to .....
near .....
at the opposite of .....
at the corner of .....
just before .....
across from .....

ACTIVITY – TASK 1

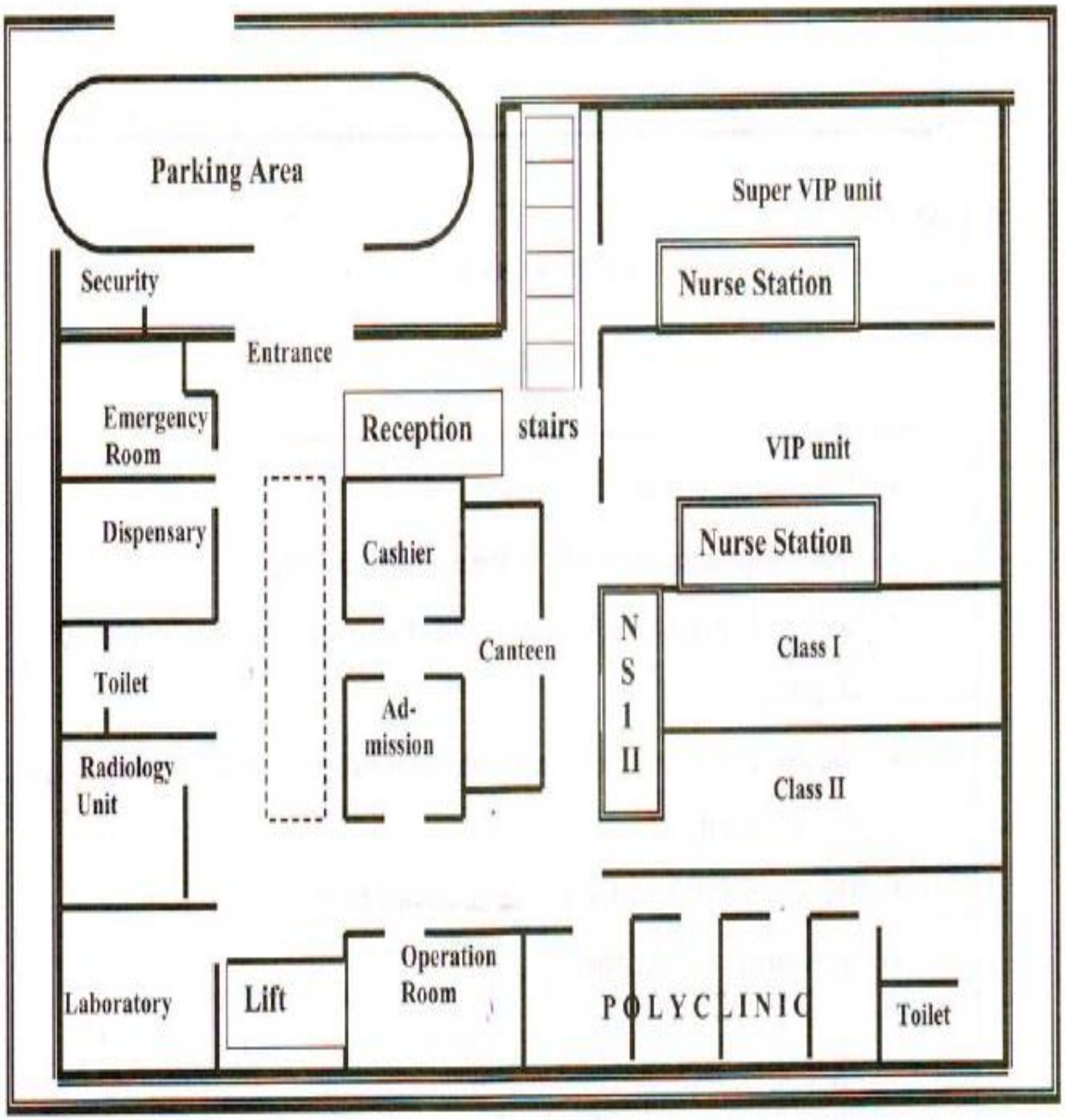


- Make group of four
- Each group decides a place based on the map above
- Tell the place one by one in front of the other groups, and then let them guess the place
- The fastest group who raise their hands become the group which has a chance to answer/guess it
- The winner is the group which has the highest point
- Other groups take their turn

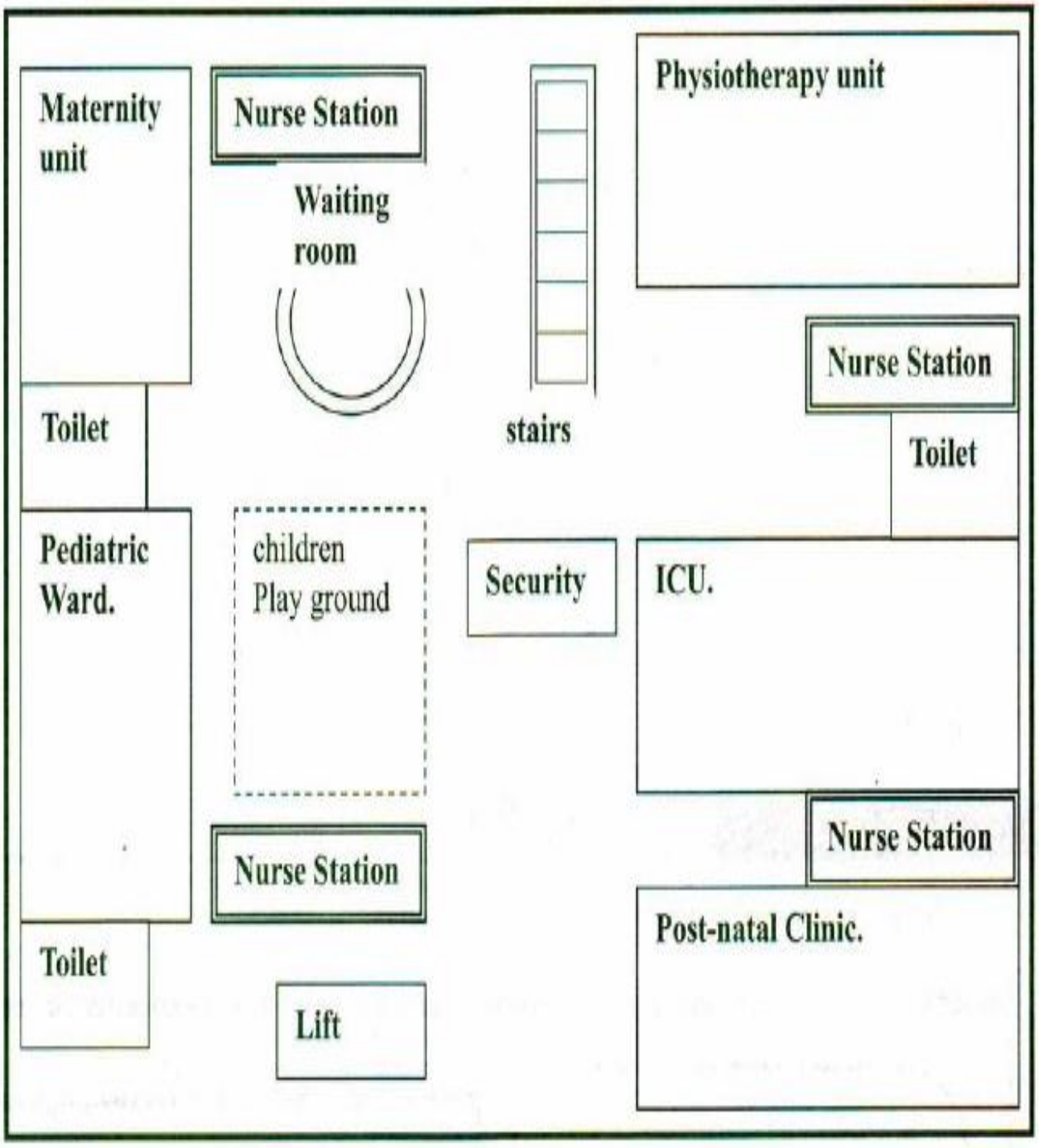
For example: *From the Main Gate, go straight through car park until you find an entrance. Then you you turn left. The room is a wide one.*

ACTIVITY – TASK 2

This is the site map of the first floor in a hospital.



This is The 2nd floor of a hospital.



Refer to the site map above. Make a communication exchange to show the direction. The starting points are as follows.

1. The security to maternity unit
2. The nurse station in ICU to the canteen
3. The security to the toilet (between dispensary and radiology)
4. The emergency room to the lift
5. The polyclinic to the pediatric ward (on the 2nd floor)
6. The waiting room to the children playground (on the 2nd floor)
7. The operation room to ICU (opposite the physiotherapy unit)
8. The entrance to the Class 1
9. The nurse station (near the lift on 2nd floor) to the laboratory
10. The emergency room to admission

Chapter 3

PARTS OF THE BODY AND HEALTH PROBLEM

Learning Objectives

After studying this chapter, student should be able to:

1. Express the location of the pain in the body

Vocabulary

Study the vocabulary and its description listed below!

VERB	NOUN	ADJECTIVE
to have + noun	an ache	sprained
to ache	a pain	stiff
to hurt	a bruise	sore
to throb	a rash	painful
to itch	a cut	dizzy
to irritate	a scar	fainted
to injure	a swelling	injured
	a graze	
	a sting	
	a bite	

Description of "ache, pain, hurt, injured, throb and itch"

ache (v): *merasa sakit yang tidak terlalu, tetapi berlangsung terus menerus*
Examples:

- I'm aching all over
- Her eyes ache from lack of sleep

ache (n): *rasa sakit*
Examples:

- Mom, I've got a tummy ache
- Muscular aches and pains can be soothed by a relaxing massage
- Bellyache/stomachache: sakit perut

Pain (n): *suatu rasa yang dialami tubuh akibat suatu penyakit atau luka atau tindakan tertentu*
Examples:

- She was clearly in a lot of pain

- He felt a sharp pain in his knee
- Patients suffering from acute pain
- The booklet contains information on pain relief during labor
- This cream should help to relieve the pain

painful (adj): *terasa sakit*
Examples:
- Is your back still painful?
- My ankle is still too painful to walk on

hurt (v): *menyebabkan terasa sakit secara fisik, terluka*
Examples:
- He hurt his back playing squash
- Did you hurt yourself?
- My back is really hurting me today
- Strong light hurts my eyes

Injured (adj): *melukai, luka, menyebabkan luka*
Examples:
- He injured his knee when playing hockey
- She injured herself during training

throb (v): *terasa sakit berdenyut-denyut*
Examples:
- His head throbbed painfully
- My feet were throbbing after the long walk home

throb (n): *sakit yang berdenyut*
Examples:
- My headache faded to a dull throbbing

sore (adj): *sakit, perih (bias karena infeksi atau gerakan yang berlebihan)*
Examples:
- I have a sore throat
- His feet were sore after the long walk
- My stomach is still sore after the operation

Itch (v): *gatal*
Examples:
- I itch all over
- Does the rash itch?
- This sweater really itches

Useful expression

- ✖ Would/Can you show me/point at the location of your pain?
- ✖ Show me where the location of your pain is?

- Where is the pain?
- Is it (your pain) in your + (part of the body)?
- Do you feel pain in your + (part of the body)?

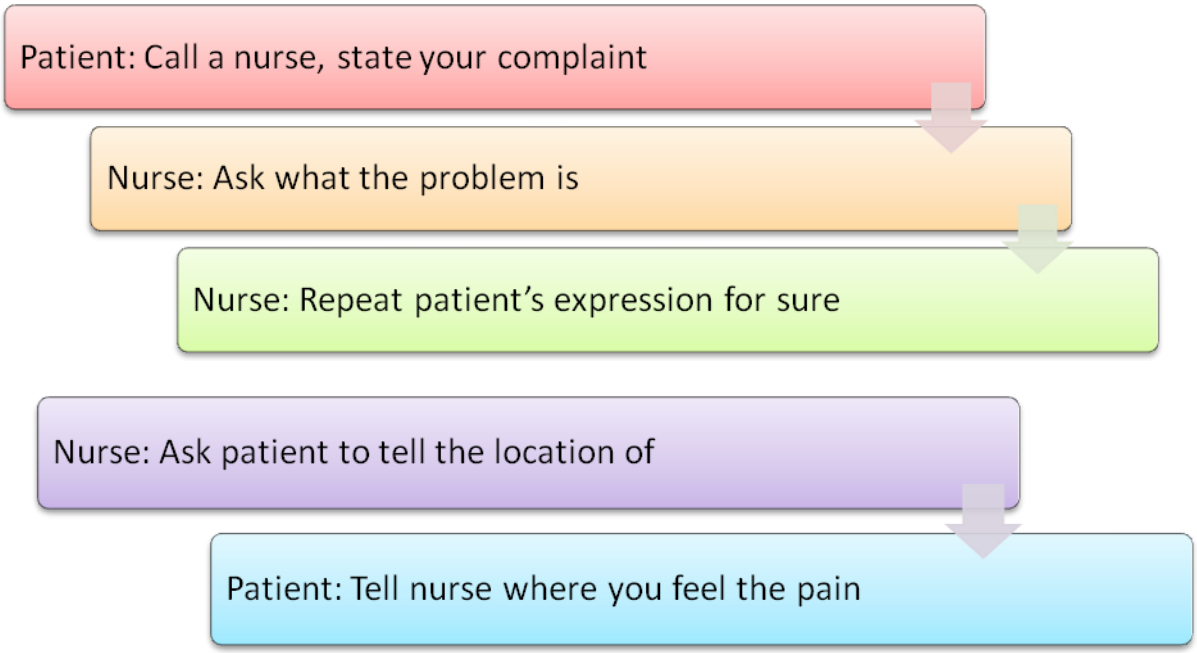
ACTIVITY – TASK 1

Translate into communicative English using the words given below

1. (pain) Saya merasakan sakit sekali di lutut saya
   _____
2. (hurt) Pergelangan kaki saya nyeri
   _____
3. (throb) Kepala saya pusing berdenyut-denyut
   _____
4. (itch) Punggung saya terasa gatal
   _____
5. (injured) Jari tangan saya terluka
   _____
6. (sore) Tenggorokan saya sakit
   _____
7. (hurt) Sinar yang sangat terang akan menyakitkan mata
   _____
8. (ache) Kaki saya sakit karena terlalu banyak berlari
   _____
9. (pain) Saya merasa sakit disini
   _____
10. (painful) Punggung saya terasa sakit sekali
    _____

ACTIVITY – TASK 2

Make a conversation between a nurse and a patient



Chapter 4

ASKING - REPORTING HEALTH PROBLEMS AND DIAGNOSING

Learning Objectives

After studying this chapter, student should be able to:

1. Ask questions about patient's health problem
2. Report about the nursing diagnose
3. Report the symptoms of a health problem

Vocabulary

Break	*Waterworks*	*In a bad shape*	*Dribble*
Bother	*Constipation*	*Not in any shape*	*Clammy*
Bowel movement	*Lassitude*	*Bloated*	

Useful expression

Nurse's questions to check the patient's complaint/condition

1. What's your problem?
2. How are you feeling today?
3. What makes you call me?
4. What's your chief complaint?
5. What's troubling you?
6. What's the matter with you?
7. What's wrong with you?
8. What seems to be bothering you?

Patient's expressions about symptoms and physical problem

1. I have + (a part of the body + ache)
   - a toothache
   - a headache
   - a stomachache
   - a backache

2. I have (a sore + parts of the body)

a sore throat
a sore foot
a sore arm
a sore knee

3. I have/get + kinds of physical problems

the measles
the flu
a cold
a bloody vomit and stool
a bowel movement
a bad cough
a fever

4. I feel + kinds of physical problems

dizzy
slick
fever
cold and clammy
unwell
in bad shape

5. I experience + kinds of physical problems

lassitude
low back pain
difficulty breathing
cold and clammy

6. I suffer from + kinds of certain illness

cancer
constipation

7. I sprained my (possessive) + joints/bones problems

ankle
broke
collarbone
hurt
leg
arm

Nurse's report/diagnose/how to report about patient's condition/complaint

Reporting

- **He/She complains about** his/her + part of the body
  has + health problem
  suffers from + health problem

Diagnosis

- **He/She may have .....** + disease/health problem
  seems to have

ACTIVITY – TASK 1

Make a conversation between a nurse and a patient

Case.

A patient suspected with a gastric peptic ulcer. The symptoms are burning and gnawing felt in the upper part of the abdomen. The pain confines in the lower chest. The pains come and go.

Conversation 1

Patient: Call a nurse, state your complaint

Nurse: Ask what the problem is

Nurse: Repeat patient's expression for sure, and tell the patient that you will report his/her condition to specialist

Conversation 2

Doctor: Call a nurse; ask about the patient's complaint

Nurse: Tell the doctor about the symptoms and your diagnosis

Chapter 5

SHARING OBSERVATION

Learning Objectives

After studying this chapter, student should be able to:

Help patients identify and express feeling

Vocabulary

Pale	Daydream	Suffocate	Bouncy
Tense	Tired	Moan	Stiff
Painful	Rigid	Groan	Sigh
Afraid of...	Gasp	Contempt	Bruise
Tender	Swollen		

Useful Expression

Study and practice these useful expressions

- You look .....
- Your (part of the body) looks ..... | uncomfortable | when ..... (v-ing) / with your (parts of the body)
- You seem to have + (a problem with + a part of the body)
  + (a health problem: such as a stomachache, a chest pain)

ACTIVITY – TASK 1

Practice the substitution drill below

1. You look .....
   - *tense*
   - *stiff*
   - *happy*
   - *sad*
   - *etc.*
2. Your..... looks.....

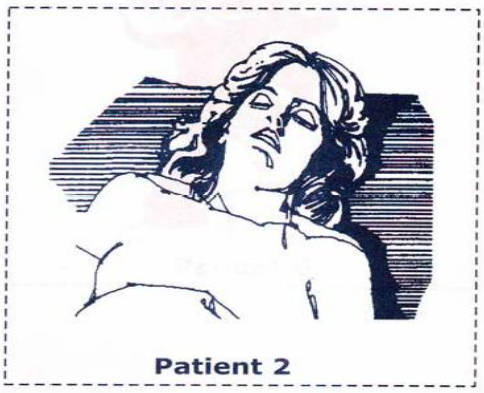
skin	*sallow*
eyes	*reddish*
nail	*yellowish*

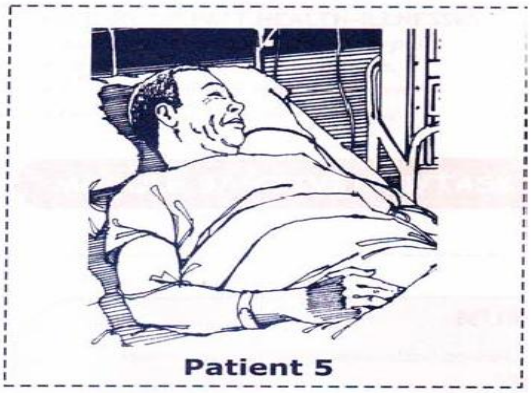
3. You seem uncomfortable when .....
   - *walking*
   - *moving your hand*
   - *changing your clothes*
4. You look uncomfortable with your .....
   - *legs*
   - *position*
   - *stomach*
   - *chest*

ACTIVITY – TASK 2

- Make into groups consist of 6 participants
- Cut pictures available in supplementary material below
- Observe their expressions
- Share your observations to each of them
- Show each picture to the class, and tell your observations

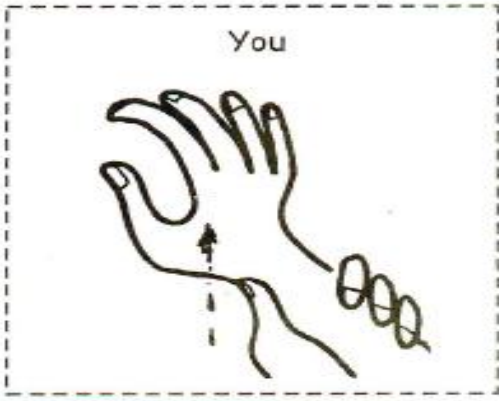

Patient 1


Patient 2

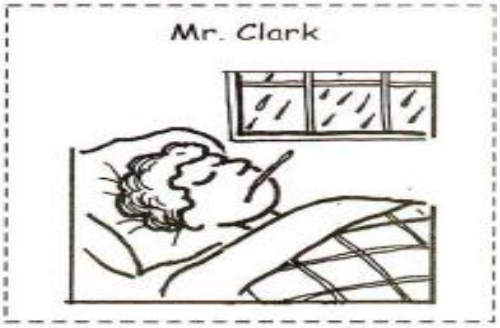

Patient 5

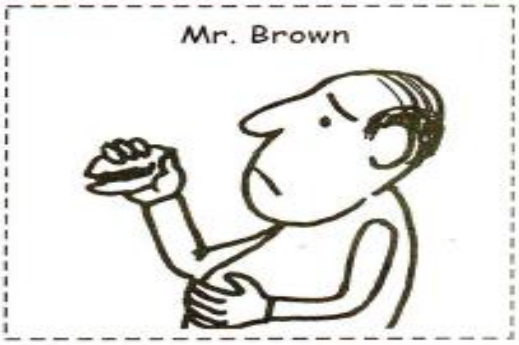

Patient 6

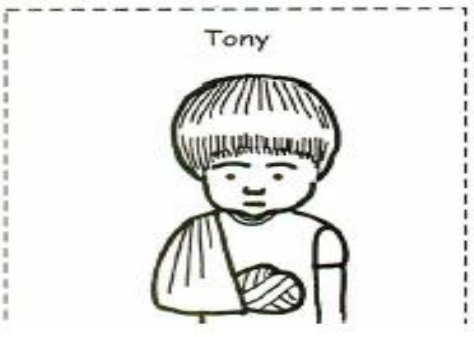

Mrs. Bush


You


Our Grandma


Mr. Clark


Mr. Brown


Tony

NCLEX-RN (1)

Chapter 6

1. A nurse is caring for a client receiving total parenteral nutrition (TPN). The nurse implements which action to decrease the risk of infection?
    1. Assesses vital signs at four-hour intervals
    2. Instructs the client to perform a Valsava maneuver during intravenous tubing changes
    3. Administers acetaminophen before changing the central line dressing
    4. Uses aseptic technique in handling the TPN solution and tubing

2. A home care nurse provides medication instructions to a client. To ensure safe administration of medication in the home, nurse:
    1. Demonstrates the proper procedure to take prescribed medications
    2. Allows the client to verbalize and demonstrate correct administration procedures
    3. Instructs the client that it is all right to double up on medication if a dose has been missed
    4. Conducts pill counts on each home visit

3. A nurse has inserted a nasogastric tube (NGT) into the stomach of a client and prepares to check for accurate tube placement. The nurse avoids which least reliable method for checking tube placement?
    1. Aspirating the tube with a 50 ml syringe to obtain gastric contents
    2. Measuring the pH of gastric aspirate
    3. Placing the end of the tube in water to check for bubbling
    4. Instilling 10 to 20 ml of air into the tube while auscultating over the stomach

4. A client is scheduled for a colonoscopy and the physician has provided detailed information to the client regarding the procedure. The nurse brings the informed consent to the client to obtain the client's signature and discovers that the client cannot write. What is the nurse's appropriate action?
    1. Contact the physician
    2. Send the client for the procedure without a signed informed consent
    3. Explain the procedure to the client with another nurse present and send the client for the procedure without a signed informed consent
    4. Obtain a second nurse to also act as a witness and ask the client to sign the form with an X

5. A nurse has documented an entry regarding client care in the client's medical record. When checking the entry, the nurse realizes that incorrect information was documented. How does the nurse correct the record?
    1. Covers up the incorrect information completely using a black pen and writes in the correct information

2. Uses correction fluid to cover up the incorrect information and writes in the correct information
3. Erases the error and writes in the correct information
4. Draws one line to cross out the incorrect information and then initials the changes

6. A nurse has administered an injection to a client. After the injection, the nurse accidentally drops the syringe on the floor. Which nursing action is appropriate in this situation?
   1. Carefully pick up the syringe from the floor and gently recap the needle
   2. Carefully pick up the syringe from the floor and dispose of it in a sharp container
   3. Obtain a dust pan and mop to sweep up the syringe
   4. Call the housekeeping department to pick up the syringe

7. A nurse is in the process of giving a client a bed bath. In the middle of the procedures, the unit secretary calls the nurse on intercom to tell the nurse that there is an emergency phone call. The appropriate nursing actions is to:
   1. Leave the client's door open so that the client can be monitored and the nurse can answer the phone call
   2. Finish the bath before answering the phone call
   3. Immediately walk out of the client's room and answer the phone call
   4. Cover the client, place the call light within reach, and answer the phone call

8. A nurse is preparing to ambulate a client. The best and safest position for the nurse in assisting the client is to stand:
   1. Behind the client
   2. In front of the client
   3. On the unaffected side of client
   4. On the affected side of the client

9. A nurse has an order to discontinue the nasogastric tube of an assigned client. After explaining the procedure to the client, the nurse raises the bed to a semi Fowler's position, places a towel across the chest, clears the tube with normal saline, clamps the tube, and removes the tube:
   1. During inspiration
   2. After the client takes deep breath and holds it
   3. As the client breathes out
   4. After expiration, but before inspiration

10. A nurse notes redness, warmth, and a purulent drainage at the insertion site of a central venous catheter in a client receiving total parenteral nutrition (TPN). The nurse notifies the physician of this finding because:
   1. Infections of a central venous catheter site can lead to septicemia
   2. The client is experiencing an allergy to the TPN solution
   3. The TPN solution has infiltrated and must be stopped
   4. The client is allergic to the dressing material covering the site

IELTS - READING

Chapter 7

READING PASSAGE 1
Question 1-7
Look at the three restaurant advertisements on the following page.
Answer the questions below by writing the letters of the appropriate restaurants (A-C) in boxes 1-7 on your answer sheet.

Example	*Answer*
It stops serving lunch at 2.30 pm.	*B*

1. It is open for breakfast.
2. It is open every night for dinner.
3. It is only open for lunch on weekdays.
4. It has recently returned to its previous location.
5. It welcomes families.
6. It caters for large groups.
7. It only opens at weekends.

DINING OUT

A

Aboyne
The original
Luigi's Italian Restaurant
is now back in Aboyne
231 Beach Road, Aboyne
(ample parking available)
Open:
Luncheon 12 to 3 pm
Dinner 6 to 10 pm
TUESDAY TO SUNDAY
Entrees $5.50 Mains $8.00
Free ice cream for the kids
Special functions
Up to 120 people
Reservations: Phone 9763 3501

B

Mermaids
Seafood
Italian & Seafood Cuisine
Lunch: Tuesday – Friday 12 noon – 2.30 pm
Dinner: 7 nights 6.00 pm – 11.30 pm
Tel & Fax: 9784 1234
54 Shore Street Kempton

C

RIVIERA CRUISING BOAT CLUB
Breakfast by the water
$5.00
Saturday & Sunday
8.00 am to 11.00 am
- Australian
- Continental
- American

At Riviera Cruising Boat Club
9753 5544
The Quay, Gateside

Questions 8-13

Read the information given in 'New Electricity Account Payment Facilities' on the following page and look at the statements below (Questions 8-13)

In boxes 8-13 on your answer sheet write

TRUE *if the statement is true*

FALSE *if the statement is false*

NOT GIVEN *if the statement is not given in the passage*

Example Answer

You must pay your account by mail. FALSE

8. If you want a receipt, you should send your payment to the Southport address.
9. You may pay your account at branches of the Federal Bank.
10. You must pay the full amount, instalments are not permitted.
11. The Coastside Power Office is open on Saturday mornings.
12. You may pay your account by phone using your credit card.
13. There is a reduction for prompt payment.

NEW ELECTRICITY ACCOUNT PAYMENT FACILITIES

AVAILABLE FROM') JULY 1998

After 1 July 1998, you may pay your electricity account in any of the following ways:

1. Payments via mail:
   (A) No receipt required:
   Mail payments to:
   Coastside Power
   Locked Bag 2760
   Southport NSW 3479
   (B) Receipt required:
   Mail payments to:
   Coastside Power
   PO Box 560
   Northbridge NSW 3472
2. Agency payments (payments directly to the bank):
   Payments can be made at any branch of the Federal Bank by completing the deposit slip attached to your account notice.
   NB: This facility is no longer available at South Pacific Bank branches.
3. Payments directly to Coastside Power Office:
   Payments can be made directly to Coastside Power Office at 78-80 Third Avenue, Northbridge. Office hours are Monday to Friday, 8.30 am to 4.30 pm.
   Payment may be by personal cheque, bank cheque or cash.

Note: Payments cannot be made by phone.

READING PASSAGE 2

You should spend about 20 minutes on Question 14-27 which are based in Reading Passage 2 on the following pages.

Question 14-18

Reading passage 2 has six paragraphs B-F from the list of headings below.

Write the appropriate numbers (i-ix) in boxes 14-18 on your answer sheet.

Note: There are more headings than paragraphs, so you will not use them all.

List of Headings

i. Ottawa International Conference on Health Promotion
ii. Holistic approach to health
iii. The primary impotenace of environmental factors
iv. Healthy lifestyles approach to health
v. Changes in concepts of health in Western society
vi. Prevention of diseases and illness
vii. Ottawa Charter for Health Promotion
viii. Definition of Health in medical terms
ix. Socio-ecological view of health

Example	*Answer*
Paragraph A	i

14. Paragraph B

15. Paragraph C

16. Paragraph D

17. Paragraph E

18. Paragraph F

CHANGING OUR UNDERSTANDING OF HEALTH

A. The concept of health holds different meanings for different people and groups. These meanings of health have also changed over time. This change is no more evident than in Western society today. When notions of health and health promotion are being challenges and axpanded in new ways.
B. For much of recent Western history, health has been viewed in the physical sense only. That is, good health has been connectes to the smooth mechanical operation of the body. While ill health has been defined as the absence of disease or illness and is seen in medical terms. According to this view, creating health for people means providing medical care to treat or prevent disease and illness. During this period, there was an emphasis on providing clean water, improved sanitation and housing.
C. In the ;ate 1940s the World Health Organisation challenged this physically and medically oriented viw of health. They stated that 'health is a complete state of physical, mental and social well-being and is not merely the absence of disease'(WHO, 1946). Health and the person were seen more holistically (mind/body/spirit) and not just in physical terms.
D. The 1970s was a time of focusing on the prevention of disease and illness by emphasising the importance of the lifestyle and behaviour of the individual. Spesific behaviours which were seen to increase risk of disease, such as smoking. Lack of fitness and unhealthy eating habits, were targeted. Creating health meant providing not only medical health care, but health promotion programs and policies which would help people maintain healhty behaviours and lifestyles. While this individualistic healthy lifestyles approach to health worked for some (the wealthy members of society). People experiencing poverty, unemployment, underemployment or little control over the conditions of their daily lives benefited little from this approach. This was largely because both the healthy lifestyles approach and the medical approach to health largely ignored the social and environmental conditions affecting the health of the people.
E. During 1980s and 1990s there has been a growing swing away from seeing lifestyle risks as the root cause of poor health. While life style factors still remain important, health is being viewed also in terms of the social, economic and environmental contexts in which people live. This broad approach to health is called the socio-ecological view of health. The broad socio-ecological view was endorsed at the first International Conference of Health Promotion hel in 1986. Ottawa, Canada, where people from 38 countries agreed and declared that:

> The fundamental conditions and resources for health are peace, shelter, education, food, a viable income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic requirements (WHO, 1986)

It is clear from this statement that creation of health is about much more than encouraging healthy individual behaviours and lifestyles and providing appropriate medical care. Therefore, the creation of health must include addressing issues such as poverty, pollution, urbanisation, natural resource depletion, social alienation and poor working conditions. The social economic

and environmental contexts which contribute to the creation of health do not operate separately or independently of each other. Rather, they are interacting and interdependent, and it is the complex interrelationships between them which determine the conditions that promote health. A broad socio-ecological view of health suggest that the promotion of health must include a strong social, economic and environmental focus.

F. At the Ottawa Conference in 1986, a charter was developed which outlined new directions for health promotion based on the socio-ecological view of health. This charter, known as the Ottawa Charter for Health promotion, remain as the backbone of health action today. In exploring the scope of health promotion it states that:

> Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmfull to it (WHO, 1986).

The Ottawa Charter brings practical meaning and action to this broad notion of health promotion. It presents fundamental strategies and approaches in achieving health for all. He overall philosophy of health promotion which guides these fundamental strategies and approaches is one of 'enabling people to increase control over and to improve their health' (WHO, 1986).

Questions 19-22

Using NO MORE THAN THREE WORDS from the passage, answe the following questions. Write your answers in boxes 19-22 on your answer sheet.

19. In which year did the WHO define health in terms of mental, physical and social well-being?
20. Which members of society benefited most from the healthy lifestyles approach to health?
21. Name the three broad areas which relate to people's health according to the socio-ecological view of health.
22. During which decade were lifestyle risks seen as the major contributors to poor health?

Question 23-27

Do the following statements agree with the information in Reading Passage 2?
In boxes 23-27 0n your answer sheet write

YES	*if the statement agrees with the information*
NO	*if the statement contradicts with the information*
NOT GIVEN	*if there is no information on this in the passage*

23. Doctors have been instrumental in improving living standards in Western society.
24. The approach to health during the 1970s included the introc=duction of health awareness programs.
25. The socio-ecological view of health recognises that lifestyle habits and the provision of adequate health care are critical factors governing health.
26. the principles of the Ottawa Charter are consideres to be out of date in the 1990s.
27. In recent years a number of additional countries have subscribed to the Ottawa Charter.

About IELTS

This is a test designed to assess the English language skills of non-English speaking students seeking to study in an English speaking country.

Benefits of studying for IELTS

By studying for IELTS you will not only be preparing for the test but also for your future as a student in an English speaking environment. The test is designed to assess your ability to understand and produce written and spoken language in an educational context. The book makes reference to the ways in which university study is organized in many English speaking countries and the types of academic tasks you will be expected to perform.

These include:

1. Reading and understanding written academic or training language
2. Writing assignments in an appropriate style for university study or within a training context
3. Listening to and comprehending spoken language in both lecture format as well as formal and informal conversational style
4. Speaking to colleagues and lecturers on general and given topics in formal and informal situations

Description of the test

There are two versions of the IELTS test:

1. **General Training Module:** for students seeking entry to a secondary school or to vocational training courses
2. **Academic Module:** for students seeking entry to a university or institution of higher education offering degree and diploma courses

The Listening Module

Question types	Requirements	Situation types
You will meet a variety of question types which may include: 1. multiple choice 2. short answer questions 3. sentence completion 4. notes/summary/flow chart/table completion 5. labeling a diagram which has numbered parts 6. matching	You must listen to four separate sections and answer questions as you listen. You will hear the tape *once only.* There will be between 38 and 42 questions. The test will take about 30 minutes. There will be time to read the questions during the test and time to transfer your answers on to the answer sheet at the end of the test. The level of difficulty of the texts and tasks increases through the paper.	The first two sections are based on social situations. There will be a conversation between two speakers and then a monologue. The second two sections are related to an educational or training context. There will be a conversation with up to four speakers and a lecture or talk of general academic interest.

Chapter 8

IELTS - LISTENING

SECTION 1 *Questions 1-12*

Questions 1-5

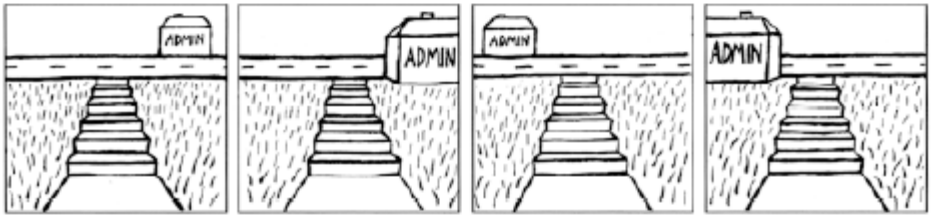
Circle the appropriate letter

Example What are the students looking for?

(A) Main Hall C Old Hall

B Great Hall D Old Building

1 Where is the administration building?

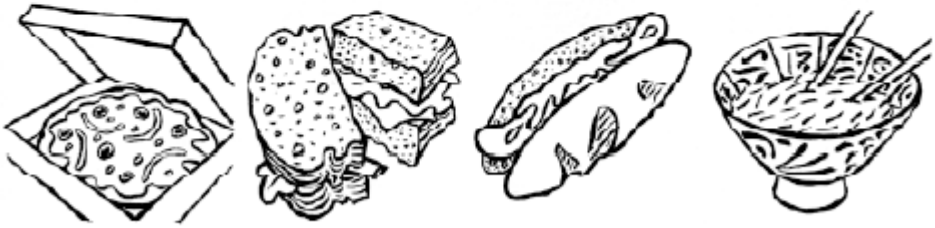


A B C D

2 How many people are waiting in the queue?

A 50 B 100 C 200 D 300

3 What does the woman order for lunch?



A B C D

4 What does the woman order to drink?

A B C D

5 How much money does the woman give the man?

A $2.00 B $3.00 C $3.50 D $5.00

Questions 6-10

*Complete the registration form using **NO MORE THAN THREE WORDS.***

Name of student:	**(6)** .....
Address:	**(7)** Flat 5/ .....
Town:	**(8)** .....
Tel:	**(9)** .....
Course:	**(10)** .....

Questions 11-12

11 What did the man buy for her to eat?

A B C D

12 What must the students do as part of registration at the university?

A Check the notice board in the Law Faculty.
B Find out about lectures.
C Organise tutorial groups.
D Pay the union fees.

SECTION 2 *Questions 13-21*

Complete the notes. Write ***NO MORE THAN THREE WORDS*** *for each answer.*

STUDENT BANKING

Recommended Banks	*Location*
Barclays	Realty Square
National Westminster	Example: ***Preston Park***
Lloyds	City Plaza
Midland	**(13)** .....

Note: May not be allowed all facilities given to resident students.

Funding

- Must provide (14) ..... I can support myself.
- Services will depend on personal circumstances and discretion of Bank Manager.

Opening an account

- Take with me: (15) ..... and letter of enrolment.
- Recommended account: (16) .....
- Bank supplies: (17) ..... and chequecard which guarantees cheques.

Other services

- Cashcard: (you can (18) ..... cash at any time.)
- Switch/Delta cards: (take the money (19) ..... the account.)

Overdraft

- Must have (20) .....
- Sometimes must pay interest.

Opening times

- Most banks open until (21) ..... during the week.
- Some open for a limited time on Saturdays.

SECTION 3 *Questions 22-31*

Questions 22-25

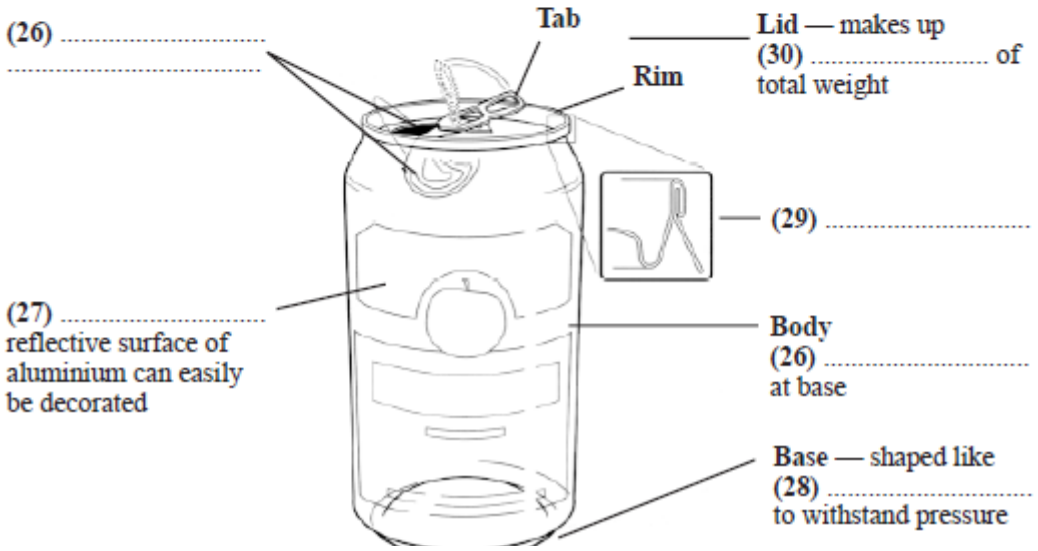
*Complete the factsheet. Write **NO MORE THAN THREE WORDS** for each answer.*

FACTSHEET - Aluminium Cans

- (22) ..... produced every day in the US — more cans produced than nails or (23) .....
- each can weighs 0.48 ounces — thinner than two (24) .....
- can take more than 90 pounds of pressure per square inch — over (25) ..... the pressure of a car tyre

Questions 26-31

*Label the aluminium can. Write **NO MORE THAN THREE WORDS** for each answer.*



SECTION 4 *Questions 32-42*

Questions 32-42

*Complete the lecture notes. Use **NO MORE THAN THREE WORDS** for each answer.*

Purpose of the mini lecture

To experience	To find out about
(32)	**(33)**.....

The three strands of Sports Studies are:

a **Sports psychology**

b **Sports (34)** .....

c **Sports physiology**

a **The psychologists work with**

a The psychologists work with **(35)** .....

They want to discover what **(36)** .....

b Sports marketing looks at **(37)** .....

Sport now competes with **(38)** .....

Spectators want **(39)** .....

c Sports physiology is also known as **(40)** .....

Macro levels look at **(41)** .....

Micro level looks at **(42)** .....

Chapter 9

IELTS - SPEAKING

The Speaking Module

Requirements	Assessment criteria
You will have to talk to an examiner for about 15 minutes. The interview will be recorded. It is in 5 parts: **1** Introduction — Basic introductions **2** Extended discourse — You will talk at some length about general topics of relevance or interest which will involve explanation and description. **3** Elicitation — You will be given a cue card which describes a situation or problem. You must ask the examiner questions to obtain information. **4** Speculation and attitudes — You will be asked to talk about your plans or proposed course of study. You should demonstrate your ability to speculate or defend a point of view. **5** Conclusion — The interview comes to an end.	You will be assessed on the following criteria: • ability to communicate effectively • ability to use appropriate vocabulary and structures • ability to ask questions • ability to take initiative in a conversation • general fluency • structural accuracy • intelligibility

	Interaction
Part 1 Introduction and interview 4-5 minutes	The candidate has the opportunity to speak on familiar topics. The examiner asks a number of questions to which the candidate should reply as fully as possible.
Part 2 Individual long turn 3-4 minutes	The candidate is asked to give a short talk for 1-2 minutes on a topic chosen by the examiner. The candidate has a minute to prepare and then speaks on the topic without stopping.
Part 3 Two-way discussion 4-5 minutes	The candidate is presented with more abstract questions broadly linked to the topic introduced in Part 2, and is encouraged to engage in extensive discussion
11-14 minutes	

THE CANDIDATE'S ROLE

Part 1

The examiner will ask you some questions about yourself and your interests, studies or working life. You should:

- reply by offering a full and appropriate response in each case, taking the initiative where possible.
- always offer more than *yes* or *no* as an answer as your examiner can only rate what he or she hears, and you need to make the very best of this chance to show off your skills.
- use Part 1 to overcome any nerves and demonstrate your basic fluency.

Part 2

The examiner will give you a topic, which is also written on a card, and will hand you some paper and a pencil to make notes. You have a minute to think about what you are going to say. You should:

- think about the topic for a moment and decide how you are going to tackle it.
- use the preparation time wisely by jotting down some key ideas (but do not try to write out a speech).
- make the talk interesting and lively.

Part 3

The examiner will invite you to discuss a number of issues, broadly related in theme to the Part 2 topic. You should:

- try to give informed, interesting and appropriate responses, but remember there is no right or wrong answer.
- use this part of the test to demonstrate your control of language, your ability to express abstract ideas and to support your opinions appropriately.
- show a willingness to provide extended replies.

PRACTICE

Please come in and sit down - over here. First, let me take a look at your passport.
... it's for security purposes only.
Thank you. My name is *(interviewer's name)*. What is your name?
Where do you come from?
Tell me about your family. What do your family members do for a living?
What do you and your family like to do together?
Where do you live now?
What kind of place do you live in (a house or a flat)?
Describe the neighborhood that you live in at the moment.
Have you ever had a full-time job? If you have, tell me about it.
What are (or were) the advantages and disadvantages of this job?
Have you ever had a part-time or casual job?
Did you enjoy your time at school? Tell me what you liked and what you didn't like.
Are you studying at the moment? If so, what are you studying and where?
What do you find most difficult about your study and why?
What is your favorite pastime? Why do you enjoy doing this?
Do you prefer indoor or outdoor activities? Why?
Do you belong to any clubs? If so, why did you join?
Do you read much? What do you like to read?
What else do you like to do in your spare time?

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[Revised Edition]

Book 2

English for the Professional Nurse

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School of Nursing | Muhammadiyah University of Malang

PREFACE

Nowadays, competence in English has become an urgent need for nurses who are involved in medical services. It is due to the fact that they are required to have the ability to communicate with the other people in their field including doctors and patients. English for Professional Nurse Book 2 is prepared for the demands of professional nursing also include English Competence. This book provides nurse students to improve their English skills in listening, reading, speaking and writing.

The contents of this book are based on the standard and fundamental nursing procedures taught in previous year, so that the contents are not something strange for the nurses. This course book is certainly help to facilitate the student to acquire the ability to perform their duties in an environment where English is used and needed. I wish that this book will be studied and practiced easily to achieve the competence of Nursing English.

I hope that by the use of this book, the nursing students will be able to learn and practice English according to their professional skills. By mastering English for the Professional Nurses Book 2, it will improve their quality of human resources and they will have added value so that job opportunities will be widely open for them to reach a bright future.

Author

CONTENT

CHAPTER 1
GENERAL ASSESSMENT

Learning Objectives

After completed this chapter, students will be able to:

1. Use expressions for collecting demographic data
2. Use questions to collect current and past health-illness data

Part 1 → Collecting Demographic Data Elements

Vocabulary

Surname
Next of kin
Assess
Assessment

Useful Expression

a) Implementation step
Study these expressions to initiate communication

Explaining what you are going to do immediately.

- It is time for me to …….
- I just want to …….
- I would like to …….
- I am going to …….
- I need to …….

interview you
assess your health condition

b) Question to collect demographic data elements
Study and practice these useful expressions

Question To Ask	
NAME	What is your name? What is your complete name? What is your surname?
AGE	How old are you?
ADDRESS	What is your address? Where do you live?
PHONE	Your phone number, please What is your phone number? Do you have a mobile phone number?

MARITAL STATUS	Are you married?
HEALTH INSURANCE	Do you have any health insurance?
OCCUPPPATION & TITLE	What is your occupation? Do you have any academic title? What is your title? What do you do?
NEXT OF KIN	Who is your next of kin?
REASON FOR CONTACT*)	What brings you in this hospital? Who sends you to this hospital? What makes you come to this hospital?

*) It is a reason that makes you come to hospital. It can be a chief complaint, medical checkup.

ACTIVITY 1 → ROLE PLAYS
Task. Pair Work

- *Interview your partner*
- *Fill in the blanks with his/her personal demographic data*

Name	:	
Age	:	
Sex	:	
Address	:	
City, State	:	
Phone	:	
Religion	:	
Marital Status	:	
Health Insurance	:	
Current Occupation and Title	:	
Next of Kin	:	
Reason for contact	:	
Date, time of contact	:	

Part 2 → Current-Health and Illness Status
Useful Expressions: Assessment step
Study these questions

CURRENT HEALTH STATUS

- What do you think about your health?
- Would you tell me about your health condition recently?

Sample of patient's response: "I'm usually healthy, have usual cold, and have to take medicine for high blood pressure"

ELIMINATION PATTERN

- Would you tell me about your ……?
- How many times a day do you do your ……?
- Do you have any problem with your ……?
  - *bowel movement?*
  - *waterworks?*
- Is the stool formed or loosed?
- Is your waterworks sluggish?

Part 3 → History of Past Health and Illnesses

Useful Expressions
Assessment Step: Asking Common Communicable Disease

- Have you ever had + **a kind of disease**……?
  Response: Yes, I have/No, I haven't
- How old were you when you got it?
  Response: I was about ……years old
- Are you allergic to……(a certain food/medication)
  (*Example*: Are you allergic to penicillin/antibiotic)

Kinds of diseases: measles-mumps-chicken pox-rubella-rheumatic-fever-diphtheria-scarlet fever-polio-tuberculosis

Assessment Step: Asking about Immunizations

- Have you ever been immunized against + (**a kind of disease**)?
- Have you ever got……+ (**a kind of disease**)…….immunizations?
  Example: Have you ever got polio immunizations?

ACTIVITY 2 → ROLE PLAYS

Task. Pair Work
Assess your partner current health condition by using question listed above

CHAPTER 2
DIMENSION OF SYMPTOMS

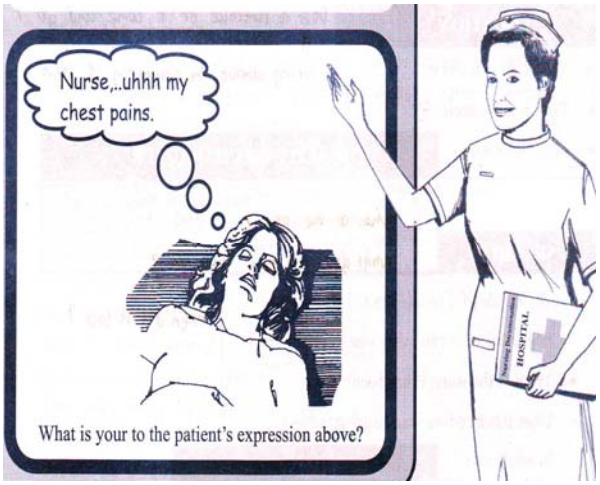
Learning objectives

After completed this chapter, students will be able to:

1. Give communicative response to patient's complaint
2. Ask the dimensions of symptoms

Vocabulary

Dull
Stabbing
Sharp
Aching
Aggravating factors
Alleviating factors



Useful expressions

Task. *Study and practice these useful expressions*

LOCATION
- Where do you feel it?
- Does it move around?
- Show me where.

QUALITY OR CHARACTER
- What is it like? Is it sharp, dull, stabbing, aching?
- Do you feel ….?
- What does the pain look like?
- When did it last?

SEVERITY
- On a scale of 0 to 10, with ten the worst, how would you rate what you feel right now?
- What was the worst it has been?
- Does this interfere your usual activities? In what ways?

TIMING
- When did you first notice it?
- How long does it last?
- How often does it happen?

SETTING
- Does it occur in a particular place or under certain circumstances?
- Have you taken anything for it?
- Does it appear in particular time?

TASK

1. *Make a complete conversation to explore the dimensions of symptom*
2. *Take one case only*

Case 1
A patient with anorexia nervosa expresses:

- I don't want to have a lot of meal
- I don't want to be plump
- My arms and legs are getting fat
- I have difficulty in bowel motion
- I feel nausea
- I want to vomit
- Food makes my stomach upset
- I am afraid of being fat

Case 2
A patient suspected with appendicitis expresses:

- I feel pain around my navel
- I feel pain around here (in the lower right spot of my abdomen)
- I feel a sharp pain
- Don't touch my stomach, it increases my pain
- I feel feverish
- I feel nausea
- I vomit
- I lose my appetite
- I vomit frequently after meals
- I have recurrent pain in my lower part of my stomach
- It becomes more painful if I do the squatting bowel motion

"Success is climbing a mountain, facing the challenge of obstacles, and reaching the top of mountain"

CHAPTER 3
PATIENT ASSESSMENT

Learning Objectives

After completed this chapter, students will be able to:

Use expressions for assessing the head, face and neck

Nursing Notes

Inspection, palpation, percussion and auscultation are examination techniques that enable the nurse to collect a broad range of physical data about patients.

1. *Inspection*
   The process of observation, a visual examination of the patient's body parts to detect normal characteristic or significant physical signs
2. *Palpation*
   Involves the use of the sense of touch. Giving gentle pressure or deep pressure using your hand is the main activity of palpation
3. *Percussion*
   Involves tapping the body with fingertips to evaluate the size, borders, and consistency of body organs and discover fluids in body cavities.
4. *Auscultation*
   Listening to sounds produced by the body

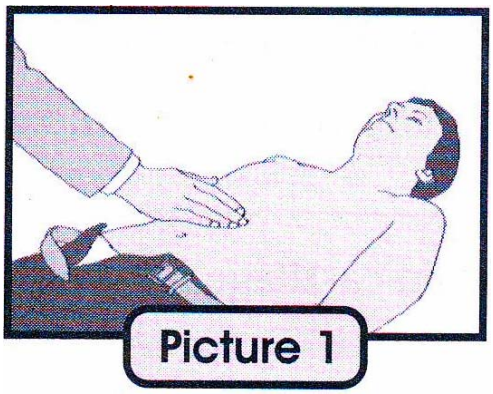
Task 1

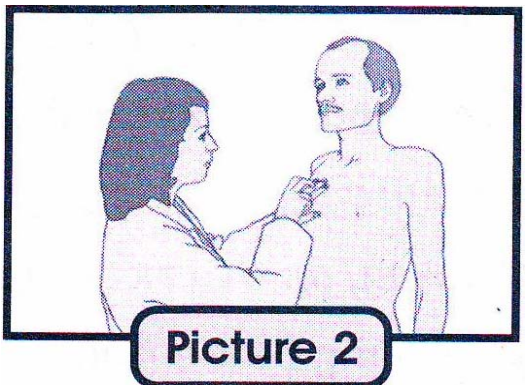
Mention what activity you do for each case listed below.

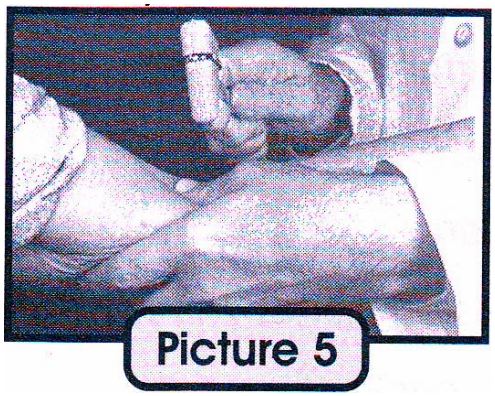
No	Activity	Technique
1	Examining patient's respiratory	
2	Inspecting the mouth and throat	
3	Asking patient to stand up to find whether there is scoliosis or not	
4	Pressing her middle finger of non-dominant hand firmly against the patient's back. With palm and fingers remaining off the skin, the tip of the middle finger of the dominant hand strikes the other, using quick, sharp stroke	
5	Observing the color of the eyes	
6	Observing the movement of air through the lungs	
7	Testing deep tendon reflexes using hammer	
8	Checking the tender areas with her hand	

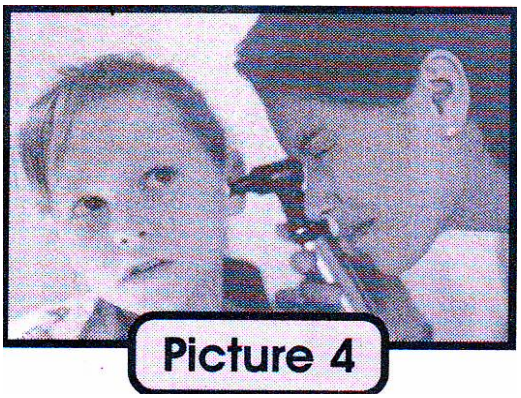
9	Pressing abdomen deeply to check the condition of underlying organ	
10	Preparing a good lighting, then he observes the body parts	

Task 2. *What kind of examination technique?*









Useful Expressions
Implementation step

Explaining what you are going to do immediately

- Now I am going to …
- It's time for me to…
- Now I want to…

press your… + (parts of the body) gently
examine your…+ (parts of the body) gently

artery
cheeks
neck

Instruction

- Would you…?
- Now I want you to…?

	remove + your…	wig
	put off	hairpieces

- Please +

	rise your eyebrows
	frown your forehead
	smile
	puff your cheeks
	shrug your shoulder
	flex your neck with chin toward
	bend your neck, with ear toward shoulder
	take a sip of water from this glass

Task 3. Whole class and pair work

- *Practice these instructions*
- *Listen to teacher's instruction and act them out*
- *Then, practice these in pairs*

1. Raise your eyebrows
2. Close your eyes tightly
3. Frown
4. Smile
5. Puff your cheeks
6. Shrug your shoulder
7. Flex your neck with chin toward
8. Bend your neck, with ear toward shoulder
9. Take a sip of water from this glass

Task 4. Pair work

- *Make a complete conversation on acts of assessing head, face and neck*
- *Use the expression above*

CHAPTER 4
CHECKING VITAL SIGN

Learning Objective

After completed this chapter, students will be able to:

- Communicate about implementation of checking vital signs
- Give some instructions during implementation of checking vital sign

Vocabulary

Pulse rate
Rhythm or regularity
Tension
Beats per minute
Patient's chart
Normal pulse rhythm
Bradycardia
Tachycardia
Bounding
Thread/weak

Medical Terms	Colloquial expression
Dyspnea	*Breathlessness, out of breath, short of breath, fighting for breath*
Expectorate	*To bring up/cough up phlegm/spit*
Expiration	*Breathing out*
Inspiration	*Breathing in*
Respiration	*Breathing*
Sputum	*Phlegm*

Useful Expression

Task 1. Explaining the procedures

It's time for me …
I just want …
I would like …
I am going …
to measure your blood pressure
to count your pulse
to check your respiration
to measure your temperature
to put this cuff (around your upper arm)
to insert this (thermometer) into your armpit
to put this (thermometer) into your mouth

Task 2. Giving instructions and expressions during the implementation

Would you …
Would you mind *) Please
Now, I want you to…

lie down on the couch
lie flat on the bed
roll your sleeve up
give me your right/left hand
raise your arm
take a deep breath
breathe in … breathe out
roll yourself into side lying position

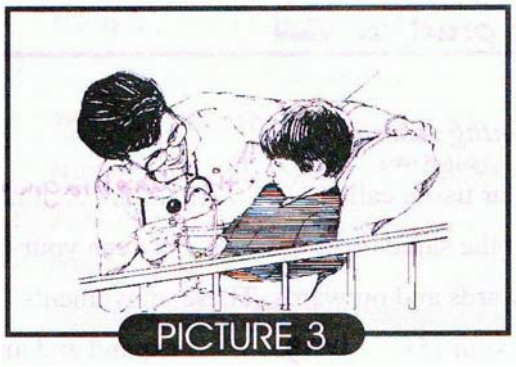
Task 3. Nurse response

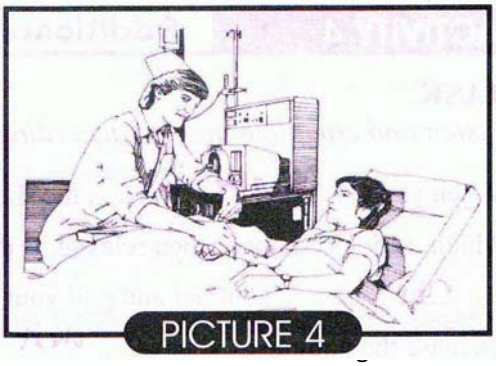
- OK, fine. That's it
- Fine/good
- All is done
- Finished

*) change the following verb into V-ing from

Task 4. Pair Work

- *The illustration below show the implementation of checking vital signs*
- *Choose one picture then, make a conversation exchange and give appropriate instructions when you want to check patient's vital signs according to the illustration*
- *Take only one kind implementation of vital signs checking*





CHAPTER 5
DISCHARGE INSTRUCTION

Learning Objective

After completed this chapter, students will be able to:

- Give instructions and suggestions according to the patient's health problem
- Deliver a therapeutic communication

Vocabulary

Avoid
Contraindicated
Indicated
Suggest
Pus
Suture
Sponge
Splint
Swollen
Numb
Paralysis
Convulsion
Patch
Hazardous equipment
Rub
Greasy
Rash
Tightness

Useful Expression

Pattern 1: Recommendation

Pattern	Example
Should Must Be + required essential important indicated have to …	• You should take the complete (entire) dose prescribed • These tablets contain antibiotic. It is required you to take the complete dose prescribed
Had better + bare infinitive Advice Suggest	• You'd better take your medicine regularly • I advise you to see a doctor soon • I suggest you to drink a lot of water

Pattern 2: Prohibition

Pattern	Example
Should not Must not May not + …	You should not drink this antibiotic with milk
Should + avoid + ing Have to + avoid + ing Had better not + bare infinitive	You should avoid drinking alcohol

Instruction Chart 1

WOUND CARE (CUTS, ABRASIONS, BURNS)

1. Keep the area clean and dry
2. Keep wound covered with a clean dressing, change the dressings daily
3. Keep the injured part at rest and elevate for 12 hours
4. Watch for redness, pus, or increased soreness. Contact your doctor if this occurs
5. Have your wounds checked and your sutures removed as advised by the emergency physician in … days.

Instruction Chart 2

HEAD INJURY

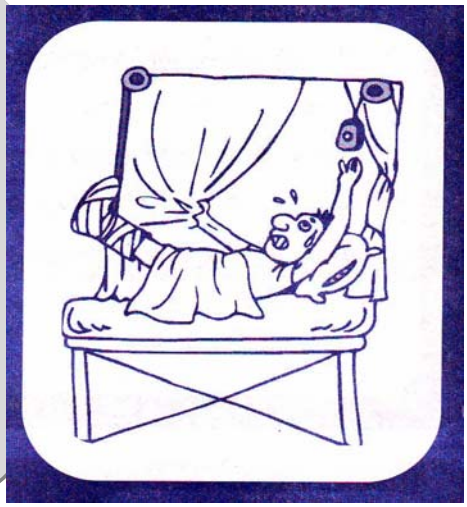
The first 24 hours after a head injury are the most important, although after effects may appear much later. It is important that a responsible person awakens the patient every 2 hours for the first 24 hours and watches for the following symptoms. If any of these occurs, call your doctor or return to the emergency department

1. Persistent headache, nausea or vomiting more than twice
2. Weakness, numbness or paralysis of the arm or legs
3. Blood or clear fluid from the ears and nose
4. Blurred vision, unequal pupils (one larger than the other)
5. Convulsion

Instruction Chart 3

CAST/SPLINT CARE

1. Do not apply any weight or pressure on a new cast or splint for the first 24 – 48 hours
2. Keep the cast/splint clean and dry
3. Elevate the injured part for 48 hours on pillows above your heart
4. Do not put foreign objects inside the cast
5. Wiggle your fingers or toes inside the cast every hour
6. If your fingers or toes become extremely swollen, cold, blue or numb, or the pain increases markedly, loosen the ace bandage of the splint, or if it cast, call your doctor or return to the Emergency Department.



Task. Give appropriate suggestion and advice

SIMULATION

Make a conversation between a nurse and a patient.

Situation:
A patient has just got a medical treatment in outpatient clinic. Now you have to give discharge instruction to your patient.

Steps:

1. Greet the patient; tell him/her that after getting the treatment he/she may go home. And you'll give some advice
2. Explain the medical suggestions and advices.

CHAPTER 6
NCLEX-RN (2)

1. A client is ready to be discharged to home health care for continued intravenous (IV) therapy in the home. Home care instructions regarding care of the IV have been given to the client. The best way to evaluate the client's ability to care for the IV site is to:
    1 Ask the client to verbalize IV site care
    2 Ask the client to change the IV dressing
    3 Review the entire discharge plan with the client again
    4 Demonstrate the dressing change again for the client one last time before discharge

2. A client is being discharged from the hospital with a peripheral intravenous (IV) site for continued home IV therapy. In planning for the discharge, the nurse teaches the client which of the following to help prevent phlebitis and infiltration?
    1 Gently massage the area around the site daily
    2 Cleanse the site daily with alcohol
    3 Keep the cannula stabilized or anchored properly with tape
    4 Immobilize the extremity until the IV is discontinued

3. A home care nurse is making home visits to an older client with urinary incontinence who is very disturbed by the incontinence episodes. The nurse assesses the client's home situation to determine environmental barriers to normal voiding. The nurse determines that which item may be contributing to the client's problem?
    1 Presence of hand railing in the bathroom
    2 Having an bathroom on each floor of the home
    3 Nightlight present in the hall between the bedroom and bathroom
    4 Bathroom located on the second floor, bedroom on the first floor

4. A nurse is preparing to administer continuous intravenous (IV) fluid replacement through a peripheral IV site to a client with a diagnosis of dehydration. Which item is essential for the nurse to assess before initiating the IV fluid?
    1 Usual sleep patterns
    2 Ability to ambulate
    3 Body weight
    4 Intake and output

5. A home care nurse is assessing an older client's functional abilities and ability to perform activities daily living (ADLs). The nurse focuses the assessment on:
    1 Self-care needs, such as toileting, feeding and ambulating
    2 The normal everyday routine in the home
    3 Ability to do light housework, heavy housework and pay the bills
    4 Ability to drive a car

6. A nurse is caring for a client who is receiving total parenteral nutrition (TPN). The nurse plans for which nursing intervention to prevent infection in the client?
    1 Using strict aseptic technique for intravenous site dressing changes
    2 Monitoring serum blood urea nitrogen (BUN) levels
    3 Weighing the client daily
    4 Encouraging fluid intake

7. A nurse is preparing to administer a feeding to a client receiving nutrition through a nasogastric tube. The nurse takes which most important action before administering the feeding: p
    1 Measuring intake and output
    2 Weighing the client
    3 Adding blue food coloring to the formula
    4 Determining tube placement

8. A client with a peripheral intravenous (IV) site calls the nurse to the room and tells the nurse that the IV site is swollen. The nurse inspects the IV site and notes that it is also cool and pale and that the IV has stopped running. The nurse documents in the client's record that which of the following has probably occurred?
    1 Infiltration
    2 Phlebitis
    3 Thrombosis
    4 Infection

9. A nurse is providing home care instructions to a client who will be receiving intravenous (IV) therapy at home. The nurse teaches the client that the most important action to prevent an infection at the IV site is to:
    1 Assess the IV site carefully everyday for redness and edema
    2 Redress the IV site daily, cleansing it with alcohol
    3 Carefully wash hands with antibacterial soap before working with the IV site or equipment
    4 Change IV tubing and fluid containers daily

10. A nurse prepares to assist a postoperative client to progress from a lying to a sitting position to prepare for ambulation. Which nursing action is appropriate to maintain the safety of the client?
    1 Assist the client to move quickly from the lying position to the sitting position
    2 Assess the client for signs of dizziness and hypotension
    3 Elevate the head of the bed quickly to assist the client to a sitting position
    4 Allow the client to rise from the bed to a standing position unassisted

CHAPTER 7
IELTS – LISTENING (3)

SECTION 1 *Questions 1–10*

Questions 1–4

Complete the notes below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

NOTES ON SOCIAL PROGRAMME

Example	*Answer*
Number of trips per month:	**5** .....

Visit places which have:

- historical interest
- good **1** .....
- **2** .....

Cost:	between £5.00 and £15.00 per person
Note:	special trips organised for groups of **3** ..... people
Time:	departure – 8.30 a.m. return – 6.00 p.m.
To reserve a seat:	sign name on the **4** ..... 3 days in advance

Questions 5–10

Complete the table below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

WEEKEND TRIPS			
Place	**Date**	**Number of seats**	**Optional extra**
St Ives	**5**	16	Hepworth Museum
London	16th February	45	**6** .....
7	3rd March	18	S.S. *Great Britain*
Salisbury	18th March	50	Stonehenge
Bath	23rd March	16	**8** .....
For further information: Read the **9** ..... or see Social Assistant: Jane **10**			

SECTION 2 *Questions 11–20*

Questions 11–13

Complete the sentences below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

RIVERSIDE INDUSTRIAL VILLAGE

11 Riverside Village was a good place to start an industry because it had water, raw materials and fuels such as …… and …… .

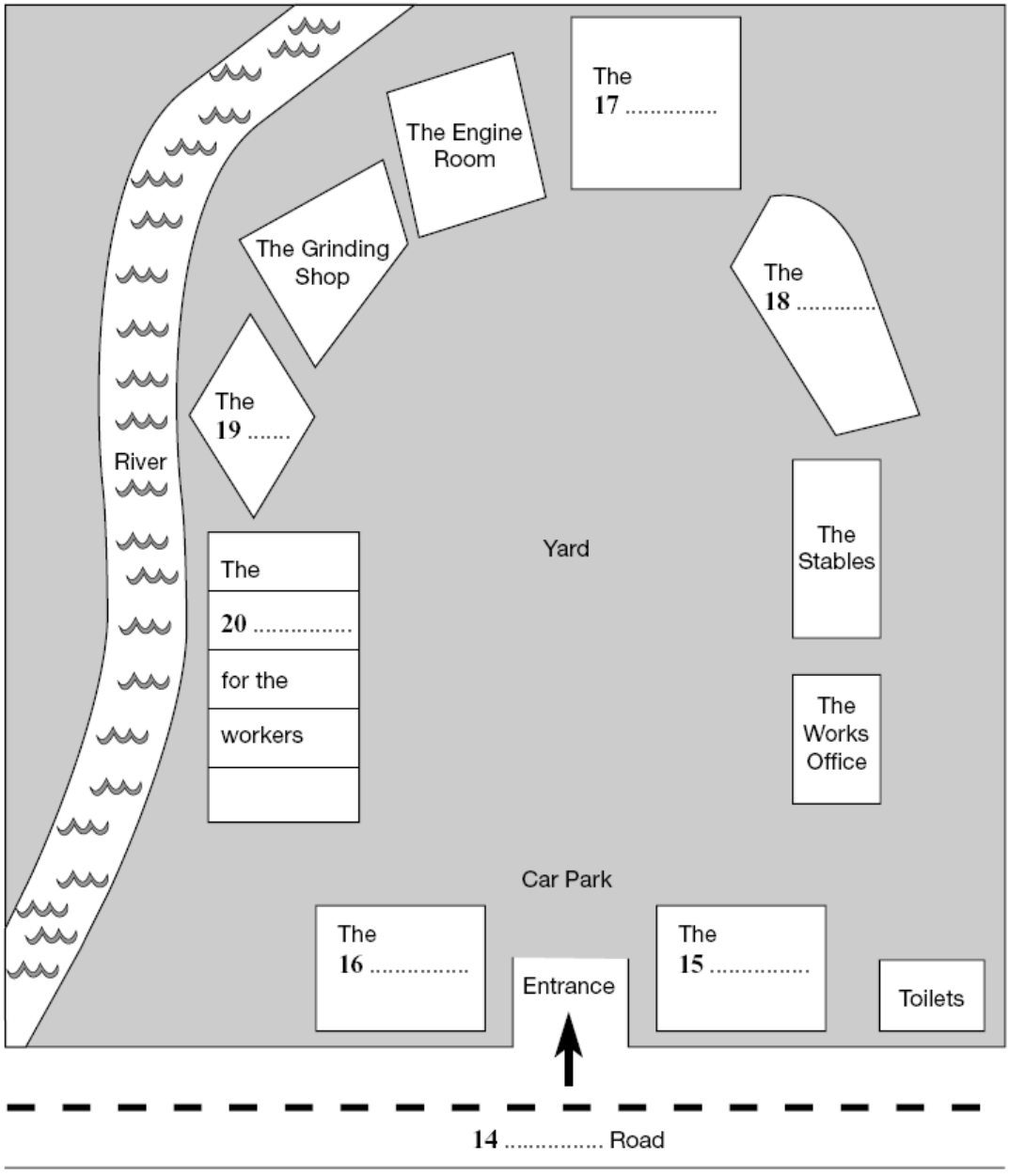
12 The metal industry was established at Riverside Village by …… who lived in the area.

13 There were over …… water-powered mills in the area in the eighteenth century.

Questions 14–20

Label the plan below.

*Write **NO MORE THAN TWO WORDS** for each answer.*



SECTION 3 *Questions 21–30*

Questions 21 and 22

*Choose the correct letter, **A**, **B** or **C**.*

Example

Melanie could not borrow any books from the library because

A the librarian was out.
B she didn't have time to look.
C the books had already been borrowed.

21 Melanie says she has not started the assignment because

A she was doing work for another course.
B it was a really big assignment.
C she hasn't spent time in the library.

22 The lecturer says that reasonable excuses for extensions are

A planning problems.
B problems with assignment deadlines.
C personal illness or accident.

Questions 23–27

What recommendations does Dr Johnson make about the journal articles?

*Choose your answers from the box and write the letters **A–G** next to questions 23–27.*

A	must read
B	useful
C	limited value
D	read first section
E	read research methods
F	read conclusion
G	don't read

Example	*Answer*
Anderson and Hawker:	**A**

Jackson: **23** .....

Roberts: **24** .....

Morris: **25** .....

Cooper: **26** .....

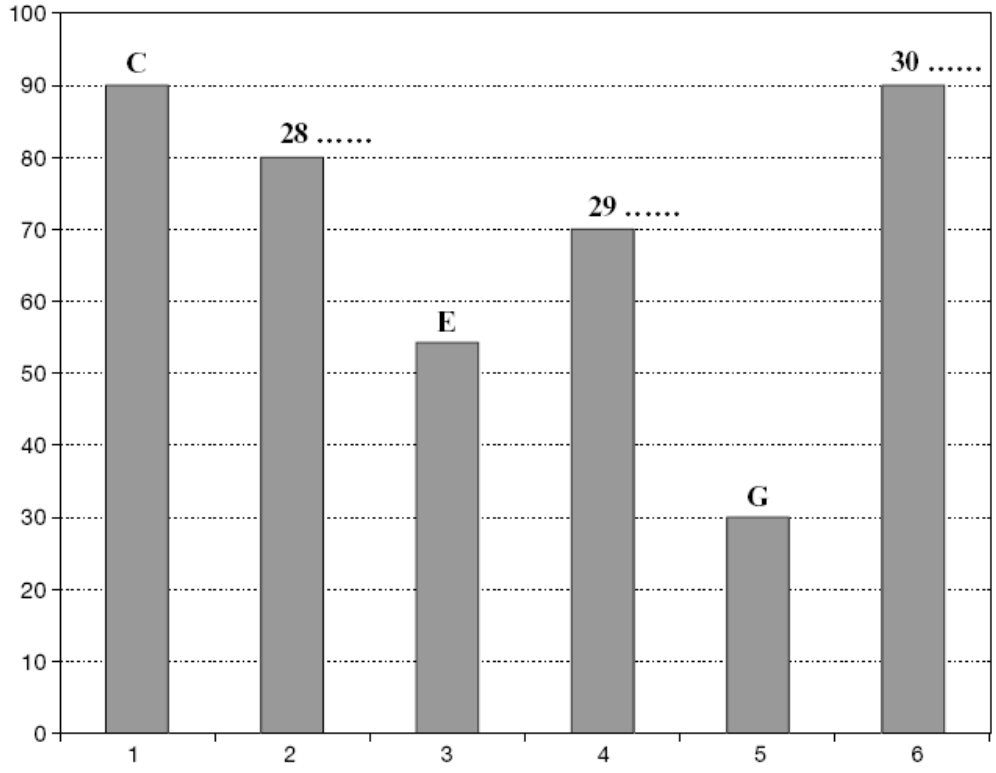
Forster: **27** .....

Questions 28–30

Label the chart below.

*Choose your answers from the box below and write the letters **A–H** next to questions 28–30.*

Population studies
Reasons for changing accommodation



Possible reasons

A uncooperative landlord
B environment
C space
D noisy neighbours
E near city
F work location
G transport
H rent

SECTION 4 *Questions 31–40*

Complete the notes below.

*Write **NO MORE THAN TWO WORDS** for each answer.*

THE URBAN LANDSCAPE

Two areas of focus:
- the effect of vegetation on the urban climate
- ways of planning our 31 ..... better

Large-scale impact of trees:
- they can make cities more or less 32 .....
- in summer they can make cities cooler
- they can make inland cities more 33 .....

Local impact of trees:
- they can make local areas
  - more 34 .....
  - cooler
  - more humid
  - less windy
  - less 35 .....

Comparing trees and buildings

Temperature regulation:
- trees evaporate water through their 36 .....
- building surfaces may reach high temperatures

Wind force:
- tall buildings cause more wind at 37 ..... level
- trees 38 ..... the wind force

Noise:
- trees have a small effect on traffic noise
- 39 ..... frequency noise passes through trees

Important points to consider:
- trees require a lot of sunlight, water and 40 ..... to grow

CHAPTER 8
IELTS – LISTENING (4)

SECTION 1 *Questions 1–10*

Questions 1–6

Complete the notes below.

Write ***NO MORE THAN TWO WORDS AND/OR A NUMBER*** *for each answer.*

Dreamtime travel agency

Tour information

Example	*Answer*
Holiday name	*Whale Watch* Experience

Holiday length	2 days
Type of transportation	1 .....
Maximum group size	2 .....
Next tour date	3 .....
Hotel name	4 The .....

Questions 5 and 6

*Choose **TWO** letters **A–E**.*

*Which **TWO** things are included in the price of the tour?*

A fishing trip
B guided bushwalk
C reptile park entry
D table tennis
E tennis

Questions 7–10

Complete the sentences below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

7 The tour costs $..... .

8 Bookings must be made no later than ..... days in advance.

9 A ..... deposit is required.

10 The customer's reference number is ..... .

SECTION 2 *Questions 11–20*

Questions 11–19

Complete the table below.

*Write **NO MORE THAN THREE WORDS** for each answer.*

Brand of Cot	Good Points	Problems	Verdict
Baby Safe	Easy to **11**	• Did not have any **12** ..... • Babies could trap their **13** ..... in the side bar	**14** .....
Choice Cots	Easy to **15**	• Side did not drop down • Spaces between the bars were **16**	**17** .....
Mother's Choice	Base of cot could be moved	• Did not have any **18** ..... • Pictures could be removed easily	**19** .....

Question 20

Complete the notes below.

*Write **ONE WORD ONLY** for the answer.*

- Metal should not be rusted or bent
- Edges of cot should not be **20** .....

SECTION 3 *Questions 21–30*

Questions 21–23

*Choose the correct letter, **A**, **B** or **C**.*

21 Andrew has worked at the hospital for

- **A** two years.
- **B** three years.
- **C** five years.

22 During the course Andrew's employers will pay

- **A** his fees.
- **B** his living costs.
- **C** his salary.

23 The part-time course lasts for

- **A** one whole year.
- **B** 18 months.
- **C** two years.

Questions 24 and 25

*Choose **TWO** letters **A–E**.*

*What **TWO** types of coursework are required **each month** on the part-time course?*

- **A** a case study
- **B** an essay
- **C** a survey
- **D** a short report
- **E** a study diary

Questions 26–30

Complete the summary below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

Modular Courses

Students study **26** ..... during each module. A module takes **27** ..... and the work is very **28** ..... . To get a Diploma each student has to study **29** ..... and then work on **30** ..... in depth.

SECTION 4 *Questions 31–40*

Questions 31–35

Complete the sentences below.

*Write **NO MORE THAN THREE WORDS** for each answer.*

31 According to George Bernard Shaw, men are supposed to understand ....., economics and finance.

32 However, women are more prepared to ..... about them.

33 Women tend to save for ..... and a house.

34 Men tend to save for ..... and for retirement.

35 Women who are left alone may have to pay for ..... when they are old.

Questions 36–40

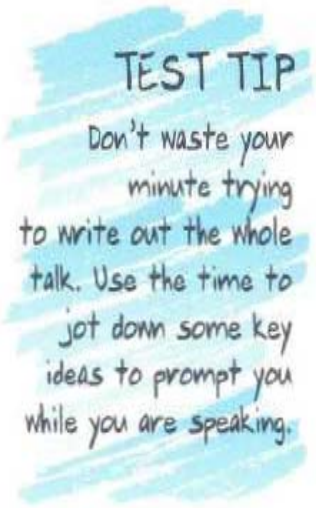
Complete the summary below.

*Write **NO MORE THAN THREE WORDS AND/OR A NUMBER** for each answer.*

Saving for the future

Research indicates that many women only think about their financial future when a **36** ..... occurs. This is the worst time to make decisions. It is best for women to start thinking about pensions when they are in their **37** ..... . A good way for women to develop their **38** ..... in dealing with financial affairs would be to attend classes in **39** ..... . When investing in stocks and shares, it is suggested that women should put a high proportion of their savings in **40** ..... . In such ways, women can have a comfortable, independent retirement.

CHAPTER 9
IELTS – SPEAKING (3)



PREPARING YOUR TALK

1. Below is an example of a topic for Part 2. Look at the topic and the three mini questions which accompany it. The Part 2 topic will always follow this format with one main topic and three sub-topics, and will usually focus on a familiar or personal area

Describe a place you have lived in that you particularly liked.

You should say:

- when you lived there
- who you lived with
- what was most memorable about this place

2. First, read the instruction carefully and decide how you are going to approach the topic. In this case you are asked to describe a place where you have lived. If you have only ever lived in one place, then you should describe that place. If you have lived in a number of different places, then you will need to make a quick decision.
3. Think about the topic for a moment.
4. Underline any key words that strike you as important, e.g. *describe, particularly liked.*
5. Decide which place you are going to describe.
6. Jot down some key ideas drawing on your own experience. Here is an example.

NOTES

- Perth, Australia – student hall of residence
- 2 years
- other overseas students
- very friendly place, beautiful gardens & sporting facilities
- Sometimes homesick

7. Below is a list of possible ways to introduce this topic.
8. Practise using them all so that you have a number of different 'openings' for your talk.

I'd like to talk about .....
I've chosen to talk about .....
I'm going to talk about .....
I've lived in quite a few places, but one place I particularly liked was .....
I've really only ever lived in ....., so I'll talk about that.

SAMPLE OF TOPIC CARD

Describe a job that you would like to do in the future. You should say: • Why you are attracted to this job • How much training, if any, would be necessary • What kind of personal qualities it would require	Describe a person who has had a major influence on you. You should include in your answer: • Who that person is and what he or she looks like • How you first met • His or her special qualities and characteristics • ... And why that person is so important in your life.
Describe your ideal study room. You should say: • Where it would be • What equipment and furniture it would contain • How it would be decorated	Describe a family celebration that you once attended. You should say: • Where it took place • Why it was held • How you felt about it
Describe a children's story that you know well. You should say: • When you first heard or read it • What you particularly liked about it • Why you think it became popular	Describe an interesting historic place. You should say: • What it is • Where it is located • What you can see there now • And explain why this place is interesting.
Describe an interested hobby that you enjoy You should say: • How long you become interested in • How long you have been doing it • Why you enjoy it • And explain what benefit you get from this interest or hobby	Describe a river, lake or sea which you like You should say: • What the river, lake or sea is called • Where it is • What the land near it is like • And explain why you like this river, lake or sea

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The Importance of Documentation

Few individuals who make the decision to go to nursing school get excited when they learn about documentation. Most nursing professionals have a vision of taking such good care of clients that they do not realize the power that effective documentation has in ensuring continuity of care and improved client outcomes.

It is important to know that the nurse's active involvement in documentation can make a significant difference in a client's course of care. Just imagine what could happen if a nurse forgot to document that medications were given or held or if a nurse accidentally charted an intervention on the wrong client's chart. Effective documentation that represents an accurate picture of care reduces the chance of harm coming to a client.

The performance of proper documentation practices is also important for the nursing professional's career. Clear, concise, accurate, and timely documentation helps prevent medical malpractice lawsuits; it also acts as the nurse's best defense in the case of a lawsuit. The only way to demonstrate that the standard of care was met is to document thoroughly, objectively, and appropriately.

This handy pocket manual provides the nursing professional with a ready reference to help ensure that an effective record of the client's progress is kept. By keeping an accurate account of this information, you will be contributing to better client outcomes, interdisciplinary communication, and more effective utilization review. You will also be reflecting, through objective documentation, the fact that you provided care that is expected, both legally and ethically.

Why the Nurse Documents

Nurses document to:

- Reflect subjective and objective data collected.
- Record planning and delivery of care.
- Monitor responses to nursing interventions.
- Facilitate interdisciplinary communication.
- Substantiate utilization reviews.
- Provide information for billing services.

- Demonstrate quality of care provided.
- Comply with the professional responsibility of providing nursing care.

In other words, the nurse records:

- What the client reports.
- What he or she observes as a nurse.
- Care plans instituted.
- Interventions, including procedures, undertaken.
- Client's responses and outcomes.

Some nurses think of documentation as writing a miniature biography of the time that the client is in their care. When you think of documentation in these terms, you are more likely to consider what is truly important and remember to record it.

The Nursing Process

The nursing process is the foundation from which nursing professionals provide care and make decisions to improve client outcomes. The five portions of the nursing process, as defined and described by the American Nurses Association (2008), should be evident in any nurse's documentation. When encapsulating these portions of the nursing process, the nurse should strive to include the following elements in documentation.

Assessment

Assessment is a method of collecting information about a client. It includes:

- **Subjective information:** Subjective information is reported by the client. It is how the client feels or how he or she perceives his or her condition. It is stated by the client, and the nursing professional records what the client explains about his or her symptoms. Examples include:
  - "My chest pain burns." (The nurse could record "client reports burning chest pain.")

- "It feels like I'm going to throw up when I look at food." (The nurse could record "client states, 'it feels like I'm going to throw up when I look at food'.")
- "This is just like the last time I had strep throat." (The nurse could record "client states his symptoms are just as they were the last time he had strep throat.")

- **Objective information:** Information that is gathered through observation, auscultation, palpation, and percussion. Objective information is collected by the nursing professional. Examples include findings such as:
  - Flat affect.
  - Client guards abdomen in the right upper quadrant.
  - Left eye with purulent discharge.
  - Lungs clear to auscultation.
  - Tenderness noted upon palpation.
  - No hepatosplenomegaly upon percussion.
  - Heart–regular rate and rhythm.
  - Full range of motion in each of the extremities.
  - Pedal pulses equal in strength bilaterally.

Nursing theorist Betty Neuman identified five variables that affect humans:

1. **Physiological:** This is the physical nature of the client, including the state of physical wellness or illness.
2. **Psychosocial:** This is the mental and emotional nature of the client, including the state of psychological wellness or illness.
3. **Spiritual:** This is the desire of the client to connect with a higher purpose; for many clients, this is their belief in a higher power.
4. **Developmental:** This is the stage of life in which the client is in based on life occurrences. Developmental age and chronological age do not always appear in parallel. For example, a 15-year-old may present much more mature beyond his years, based on his lived experience, whereas a 30-year-old may be very immature, devoid of meaningful relationships, and unable to provide for himself, although the chronological expectation would place him in Erikson's stage of Intimacy versus Isolation.
5. **Sociocultural:** This includes the socioeconomic and cultural factors that influence a client's life.

These variables serve as an appropriate basis on which the nurse can collect information; they include physical, psychosocial, sociocultural, developmental, and spiritual components. Assessment of all of these dynamics allows the nurse to gain a comprehensive picture of the client's condition and concerns, and serves as a basis upon which the nurse can provide holistic client care.

Nursing Diagnosis

A nursing diagnosis is not a medical diagnosis. It is the identification, based upon nursing judgment, of the client's needs and is the basis for planning nursing care. Nursing diagnoses are formulated as a "clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable" (NANDA-I). The purpose of nursing diagnoses is to provide a uniform, consistent international language for nurses to utilize that represents the comprehensive knowledge that nurses possess when constructing plans of care for their clients.

Nursing diagnoses can reflect actual or potential problems that the individual, family, or community is experiencing. When an actual problem is identified, it is phrased in the present tense of the concern. For example, if a client has had a stroke and cannot use one side of his or her body, the nursing diagnosis would reflect "unilateral neglect related to cerebrovascular accident." This reflects an actual problem that is occurring.

If a client has been placed on bedrest, is a known diabetic, but has no current skin breakdown, the nurse could determine that the client is now "at risk for impaired skin integrity related to bedrest." In other words, the client does not currently have the problem, but the nurse has identified that this concern could indeed develop. By identifying potential problems, the nurse can initiate actions that will better prevent this issue from developing.

The following are examples of nursing diagnoses:

- Altered bowel habits
- Fluid or gas alteration or impairment
- Dysfunctional grieving
- Risk for spiritual distress

5

Outcomes and Planning

Outcomes are the measurable goals that the nurse designs. For the client with a fluid or gas alteration, the outcome might be for the client's SpO_2 to reach 90% when it has been running at 87%. For the client who is at risk for spiritual distress, the outcome may be for the client to verbalize three ways to meet spiritual needs while hospitalized. These are the things that optimally the nurse would like to see the client accomplish in order to more effectively reverse the nursing diagnosis.

When writing outcome statements, think of what you want the client to be able to do as a result of the implementation of your plan of care. You need to be very specific and concise in your construction of these outcomes. The first word should be an action verb, demonstrating the action that you want to the client to be able to accomplish. Then, you need to determine "how much" of the action verb you want the client to be able to accomplish, which "quantifies" what the client's goal is. If numerical quantifiers are not appropriate in your outcome statement, you should state "under what condition" the client is to meet this goal. Finally, you need to devise a reasonable time frame in which the client can meet that specific objective.

Example: Your client has not been eating well and is losing weight, and is at risk for impaired skin integrity due to the weight loss that makes her bony prominences more pronounced. The nursing diagnoses you have identified are "nutritional imbalance, less than body requirements" and "risk for impaired skin integrity." Some appropriate outcome statements might look like this:

- Eat 50% of daily meals in 2 weeks.
- Drink one can of meal supplement daily.
- Identify three sources of lean protein by discharge.
- Consult with wound care specialist within 1 month.
- Experience no skin breakdown within 1 month.

Each of these outcome statements are concise, contain an action, a quantifier or the specific conditions that apply to the situation, and a date of expected achievement. This is the key to writing effective outcome statements.

Implementation of Interventions

Implementation is the portion of the care plan that includes nursing interventions. These are things that the nurse can do to assist the client in meeting the outcomes. They might include:

- **Independent nursing actions:** Those actions performed alone by the nurse, without a medical order.
- **Dependent nursing actions:** Those actions performed in response to a medical order, such as the delivery of a medication.

There are also different type of interventions:

- **Assessment and monitoring interventions,** such as looking for improvement or trends in a condition.
- **Treatment interventions,** such as placing hot or cold packs, changing dressings, or administering medications per orders.
- **Educational interventions,** such as teaching the client about treatments or actions that will help the client to help himself or herself.
- **Referral interventions,** such as when a referral to another care provider is needed; this is usually accomplished in response to a medical order, as occurs when a treating physician orders physical therapy and the nurse assists in setting up that appointment.

Documenting implementation of interventions is similar to constructing outcome statements, in that they both should be concise, start with an action verb, and have a quantifier or a full description of the conditions. **Initial statements** about interventions should reflect exactly what the nurse did, so there is no question, if another nursing professional reads the documentation, what was done. Effective documentation of nursing interventions should **start** like this:

- Provided extra pillow beneath heels to prevent skin breakdown.
- Administered 500 mg acetaminophen orally, per orders, for headache.
- Encouraged client to drink one can of nutritional supplement at lunch today.
- Educated client about lean protein and where this is found in different foods.

Further documentation is needed to qualify the rationale for the intervention and to further discuss the depth of what nursing care was provided.

7

Evaluation

Evaluation is the measurement of whether the nursing interventions, which took place during implementation, were effective. It demonstrates whether the client has met the established outcomes. If the client has not met the outcomes, the plan of care can be altered to increase the chances of success. It is important to remember that the care plan is dynamic and changes in response to the client's condition, abilities, and progress.

Documenting evaluations basically means returning to your outcome statements and determining if they were met, based on the implementation of interventions.

For example, consider our original outcome statements for the client who was not eating, was losing weight, and was at risk for impaired skin integrity due to the weight loss that made her bony prominences more pronounced:

- Eat 50% of daily meals in 2 weeks.
- Drink one can of meal supplement daily.
- Consult with wound care specialist within 1 month.
- Experience no skin breakdown within 1 month.

Within a month of her initial consultation, the client is now following up. The nursing professional now must ask:

- Did the client report eating 50% of daily meals in 2 weeks?
- Does the client drink one can of meal supplement daily?
- Did the client consult with a wound care specialist within 1 month?
- Has the client experienced any skin breakdown within 1 month?

Once the nursing professional has answered these questions, corresponding evaluation documentation 1 month later may read like this:

- Client reports eating 50% of daily meals in 2 weeks.
- Client reports drinking one can of meal supplement daily.
- Client has made appointment for a consultation with a wound care specialist.
- Client has experienced no skin breakdown.

If the evaluation showed that the client had not met the outcomes, a reassessment of the plan of care, with subsequent modifications, would be in order.

The Medical Record

When nursing students look inside a medical record for the first time, the reaction is often the same: "There is so much stuff in there!" or "How will I know what I am supposed to read or write?"

Indeed, there are many pieces of information within the medical record, but they all work together to achieve the same purpose, which is to provide a picture of the whole client and provide the nurse with a wide range of information from which to deliver competent, safe, and compassionate care.

Information that is contained within the medical record is dictated by the need for necessary information, the requirements of billing agencies, Medicare and Medicaid regulations, and accrediting bodies. The order of the information will be dictated by the organization, such as the hospital or clinic. As the nurse reviews the medical record, he or she can generally expect to locate the following information before seeing the history of presenting illness, review of systems, and physical examination and assessment information:

- Basic demographics.
- Reason for visit or chief complaint or concern.
- Medical information.

The specific medical information that will be found in the medical record that will be of use to the nursing professional includes the following. The order in which these are placed into the medical record is dependent upon facility policy.

- Medical history
- Medical examinations
- Laboratory results
- Imaging results
- Other diagnostic testing results
- Physician order sheets
- Physician consultation sheets
- Physician progress notes
- Admission information (completed by the nurse, with the client)
- Nursing progress notes
- Interdisciplinary notes
- Nursing care plan

- Flow charts for intake and output (often kept at the bedside until discharge, and then integrated into the medical record)
- Flow charts for vital signs (often kept at the bedside until discharge, and then integrated into the medical record)
- Medication administration record (often kept in the area where medication is dispensed until discharge, and then integrated into the medical record)
- Discharge summary

The medical record may contain different methods of recording information, depending on the facility policy and the type of establishment that the client is being seen in. A medical record in a hospital will largely be comprised of narrative documentation and template forms, whereas a medical record in a physician's office is usually centered on the POMR format or Problem-Oriented Medical Record. This means that the documentation will be reflective of the reason that the client came in to see the physician on that day, rather than containing a full assessment for each and every visit (unless warranted by medical judgment).

Medical records will also be organized in different ways. Generally, there is always a face sheet, which contains basic demographic information. From that point forward, facility policy generally dictates the organization of the remainder of the information contained within the medical record.

Basic Demographics

Included in the client's basic demographics will be a specific and unique identifier, sometimes called the "medical record number." Each facility will have its own system for identifying clients. Some will utilize formats such as:

- Last name, first name
- "MR" followed by numeric code, with MR signifying "medical record"
- Last name followed by birth date, such as Smith06251930
- Social security number

The use of a client's social security number is becoming rare as a result of the privacy requirements mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Along with the client's identifying number, other basic demographic information on the client's chart will include:

- Name
- Address
- Telephone number
- Alternate telephone number
- Date of birth
- Age

Even if date of birth is indicated, including the client's age on the chart makes it very easy to know exactly how old the client is at a glance.

- Gender

Documenting the client's gender is important, as many names in today's society are gender-neutral.

- Primary-care provider's name
- Billing and payment information
  - Medicare
  - Medicaid
  - Third-party payer, such as Blue Cross and Blue Shield
  - Self-Pay
- Emergency contacts
- Religion of choice, as well as religious leader to be contacted (if client desires)
- Primary language spoken and written
- Occupation and employer
- Presence or absence of advance directives
- Code status
- Presence or absence of allergies

Although allergies may not seem to initially be part of a set of basic demographic information, it is important to provide this information here also. Health-care professionals often inadvertently overlook allergies, so inserting them into all prominent places within the medical record, including the basic demographic section, helps to draw attention to these concerns.

Reason for Visit or Chief Complaint or Concern

It is important to reflect the primary purpose for the visit. In this same section, there may be triage notes if the client is being seen in an environment that must prioritize delivery of client care, such as emergency department or urgent care.

The type of arrival may also be noted in this section, such as whether the client came by car, by ambulance, from an extended-care facility, or from home, among other modes of transport and originating location. This is particularly common if the client is being seen in an environment that must prioritize delivery of client care, such as the emergency department or urgent care.

Medical Information

- Admission note, provided by physician, physician assistant, or nurse practitioner (HPI)
- Review of systems (ROS)
- Past medical history, which may include surgical history

In some facilities, the surgical history is listed separately right below the past medical history (PMH, PSxH, or PMSxH).

- Past social history (PSH)
- Family history (PFH)
- Physical examination/assessment (PE)
- Diagnosis, as provided by physician, physician assistant, or nurse practitioner
- Treatments ordered, as provided by physician, physician assistant, or nurse practitioner
  - Pharmacological prescriptions
  - Diagnostic tests
  - Other therapeutic treatments
  - Consultations from other providers requested
- Plan of nursing care
- Nursing notes, or the chronology of care provided by the nursing professional

- Progress notes, as provided by physician, physician assistant, or nurse practitioner
- Laboratory and diagnostic testing results
- Operative reports, if the client had surgery
- Final diagnosis with discharge summary, as provided by physician, physician assistant, or nurse practitioner
- Autopsy results, if the client died and an autopsy was performed

Types of Documentation

Today's nurses are able to document in many different ways. We have the ability to document on paper, but we also have template systems and electronic charting methods to choose from when considering how to keep a clear, concise, accurate, and objective record of care provided. While paper charting has been most common in decades past, where records are handwritten and maintained in paper files, electronic health records—accomplished via entry of computerized charting—have gained popularity in recent years. This cuts down on the use of paper, as well as provides a comprehensive database of client care that can be referred to for years to come. See "Electronic Records" in this tab for more information.

In most facilities, the methods are chosen for the nursing profession by administrators within the facility where the nurse works, and generally, the documentation systems blend electronic records with handwritten notes. Nurses must be astute and continually adapt their ways to best record information about clients.

Just as there are a number of methods for keeping documented records, there are a number of formats in which to record the information. These formats include narrative charting, SOAP notes (as well as SOAPIE and SOAPIER notes), DART charting, PIE charting, FOCUS charting, charting by exception, FACT charting, core charting, template charting, check-box charting, and electronic charting. Although some nurses may prefer one method of documentation over another, no one format is necessarily superior. The nurse's ability to assess information and record it accurately is much more powerful than any type of documentation format.

Case Study with Documentation Examples

Refer to the following case study of Helena Cortez when reviewing the different types of documentation.

Helena Cortez, a 40-year-old Hispanic American, has a known diagnosis of hypertension. She has been treated in the past with medication. Over the past few weeks, she has not taken her medication because she cannot afford it. Today, she developed a throbbing headache while driving her vehicle and subsequently was involved in a motor vehicle accident when she drove off the road. She has a fractured right femur, multiple rib fractures, and multiple abrasions.

Ms. Cortez speaks some English, but prefers to speak Spanish. There are a limited number of translators in the hospital. She has no one at home other than her 2-year-old son, Hector, and her elderly mother, who is caring for Hector since the accident.

Ms. Cortez's initial assessment in the emergency department revealed that she was mildly confused about the date, but she was oriented to person and place. She states that she had no bowel or bladder control issues at the time of the accident. The emergency physician ordered a complete blood count (Hgb 11.0, Hct 37, WBC 9.0). A computed tomography scan of the head was normal. She had two small lacerations on her left arm that were sutured. Vital signs were T 98.0, R 20, BP 200/100, P 90.

Ms. Cortez has been admitted to your unit for monitoring and care. She is still complaining of a headache (6 out of 10 on a 1 to 10 scale with 1 being no pain and 10 being the most severe pain ever experienced) and rubs her temples. Her pupils are equal, round, and reactive to light and accommodation. Vital signs include temperature 98.2, pulse 88, respirations 18, and blood pressure 180/90. Oxygen saturation is 96% on room air. Her heart has a regular rate and rhythm, and her respirations are unlabored. Capillary refill is 3 seconds. Lung sounds are clear. She has some mild left upper quadrant tenderness but she thinks this "might be where the ribs are broken." Bowel sounds are normoactive in all quadrants. Her strength is equal in all extremities, although there is a positive Homans' sign on the left.

The primary-care provider has stated that Ms. Cortez will be in the hospital at least 3 days while they attempt to control her hypertension and monitor her fractures. Now that there is a positive Homans' sign, Ms. Cortez is worried that she'll be in the hospital even longer. This

concerns her because she is a single parent and is afraid of what will happen to Hector if she's in the hospital for a lengthy amount of time. Her elderly mother is unable to care for the needs of a toddler for very long, as she is not well either.

The orders left for Ms. Cortez by the primary-care provider, Dr. Smith, include a low-sodium diet, which Ms. Cortez does not like, because she salts almost everything; TED hose; BSC; and VS every 2 hours to monitor hypertension. Dr. Smith has written for Tylenol ES, 650 mg by mouth, q 6 hours for headache. As you enter the room to apply the TED hose, Ms. Cortez is praying the rosary and crying softly. When she looks up, she tells you that she needs to smoke a cigarette to calm her nerves.

Narrative Documentation

Narrative documentation is similar to writing a short story. It is the type of documentation that most all health-care providers are familiar with, and a type of documentation that predates today's electronic and template charting methods. The nurse writes in sentence and paragraph form all of the information that is pertinent to the client. This includes subjective and objective data, treatments and procedures, and client responses.

The following example reflects charting that began when Ms. Cortez was admitted to your unit for monitoring and care, as highlighted earlier. Not all elements of the treatment plan are included, as this example serves as an initial encounter between the nurse and client. Be sure to reference the Tools tab to clarify any abbreviations.

11 December 2009, 1100: Admitted for monitoring; still notes headache with severity of 6/10 on 1–10 scale while rubbing temples. T 98.2, R 18, BP 180/90, P 88. SpO_2 96% on room air. Heart RRR. Capillary refill 3 seconds. Lungs CTA. Mild LUQ tenderness reported where she "thinks [her] ribs are broken." Bowel sounds x 4 quadrants. Strength equal in all extremities. Positive Homans' sign LLE. Concerned about length of stay in hospital and who will care for her son and elderly mother; noted to be saying the rosary and crying softly. States she needs to smoke a cigarette to calm her nerves. _____

_____ *G. Nurse, RN*

Charting By Exception (CBE)

CBE involves recording only significant information, or abnormalities, that occur. The previous example regarding Ms. Cortez would be charted very similarly to narrative documentation, but would only focus on the abnormalities or significant incidences that arose during her care.

11 December 2009, 1100: Notes headache with severity of 6/10 on 1–10 scale while rubbing temples. BP 180/90. Mild LUQ tenderness reported where she "thinks [her] ribs are broken." Positive Homans' sign LLE. Concerned about length of stay in hospital and who will care for her son and elderly mother; noted to be saying the rosary and crying softly. States she needs to smoke a cigarette to calm her nerves.

G. Nurse, RN

CORE Charting

CORE charting involves documentation of a client's functional and cognitive status. The initial portion of CORE documentation is to be completed within 8 hours of admission. CORE documentation includes the following:

- **Database:** This provides a framework for the creation of a plan of care. It consists of the admission documentation, which is facility-specific. Nursing diagnoses are assigned based on the admission information collected.
- **Care plan:** The plan of care that is created based on the assessment and nursing diagnoses is included.
- **Flow sheets:** Flow sheets encompass progress notes that reflect the client's status during the entire length of stay. Flow sheets also serve to record diagnostic testing performed, nursing interventions, and education that is provided to the client.
- **Progress notes:** DAE information for each problem the client encounters during the length of stay is included on the progress note. Similar to DART charting, DAE stands for:
  - **Data:** This section will include both subjective and objective data collected.
  - **Action:** What did the nurse do to address the concern noted in the "Data" section? This could include pharmacological treatment given

per orders, nursing interventions, comfort measures instituted, and other actions taken by the nurse.
  - **Evaluation (or response):** How did the client respond to the action that the nurse took? Did the concern noted in the "Data" section improve, or did the concern magnify?
- **Discharge summary:** When the client is discharged, a summary of all nursing care provided, which includes assessment, nursing diagnoses, outcomes, interventions, and evaluations, is created. Recommendations for further care are included in the discharge summary.

DART Charting

DART charting includes a record of the following:

- **Data observed and reported:** This section will include both subjective and objective data collected.
- **Action taken:** What did the nurse do to address the concern noted in the "Data" section? This could include pharmacological treatment given per orders, nursing interventions, comfort measures instituted, and other actions taken by the nurse.
- **Response of the client:** How did the client respond to the action that the nurse took? Did the concern noted in the "Data" section improve or did the concern magnify?
- **Teaching given:** What did the nurse tell the client about the concern? This can include formal teaching, such as discharge instructions, or informal teachings, such as how to use a call light.

The earlier example regarding Ms. Cortez could include several different DART entries by a nursing professional delivering bedside care. The following examples are by all means not comprehensive of all DART notes that could be constructed from this scenario. It is also important for the nursing professional to recognize that each DART note represents a small moment in time and a "snippet" of information. DART charting is generally not used by medical providers of care such as NPs.

11 December 2009, 1100

- **D:** States headache is 6 of 10 on a 1–10 scale; crying softly, rubbing temples; PERRLA.
- **A:** Tylenol ES, 650 mg, given per order.

- **R:** Twenty minutes later, client reports pain is now 3 of 10 on a 1–10 scale.
- **T:** Reminded client to use call light to report any increase in head pain. _____
_____*G. Nurse, RN*

11 December 2009, 1130

- **D:** Worried about who will care for elderly mother and son; noted to be crying softly and praying the rosary.
- **A:** Call placed to social services department to discuss options for care for elderly mother and son.
- **R:** Client stated "thank you" for calling social services.
- **T:** Educated client about function of social services, and that they are an appropriate resource for assisting clients in finding answers to concerns such as hers. _____
_____ *G. Nurse, RN*

11 December 2009, 1215

- **D:** Stated "ouch!" when dorsiflexing left foot; noted facial grimace when dorsiflexing left foot.
- **A:** Apply TED hose per orders; will continue to monitor.
- **R:** Two hours later, client still with discomfort upon dorsiflexion of LLE.
- **T:** Educated client about function of TED hose, and the importance of continuing to wear them while hospitalized. _____
_____ *G. Nurse, RN*

FOCUS Charting

FOCUS charting in very similar to DART charting and includes a record of the following:

- **Focus of the concern:** This is a statement of the immediate focus of the plan of care. Usually this will be the nursing diagnosis.
- **Data:** This section will include both subjective and objective data collected.
- **Action:** What did the nurse do to address the concern noted in the "Data" section? This could include pharmacological treatment given per orders, nursing interventions, comfort measures instituted, and other actions taken by the nurse.

- **Response:** How did the client respond to the action that the nurse took? Did the concern noted in the "Data" section improve, or did the concern magnify?

The earlier example regarding Ms. Cortez could include several different FOCUS entries by a nursing professional delivering bedside care. The following examples are by all means not comprehensive of all FOCUS notes that could be constructed from this scenario. It is also important for the nursing professional to recognize that each FOCUS note represents a small moment in time and a "snippet" of information. FOCUS charting is generally not used by medical providers of care such as NPs.

11 December 2009, 1100

- **Focus:** Head pain related to hypertension.
- **Data:** States headache is 6 of 10 on a 1–10 scale; crying softly, rubbing temples; PERRLA.
- **Action:** Tylenol ES, 650 mg, given per order.
- **Response:** Twenty minutes later, client reports pain is now 3 of 10 on a 1–10 scale._____
_____ *G. Nurse, RN*

11 December 2009, 1130

- **Focus:** Anxiety related to family concerns.
- **Data:** Worried about who will care for elderly mother and son; noted to be crying softly and praying the rosary.
- **Action:** Call placed to social services department to discuss options for care for elderly mother and son.
- **Response:** Client stated "thank you" for calling social services._____
_____ *G. Nurse, RN*

11 December 2009, 1215

- **Focus:** LLE pain related to dorsiflexion.
- **Data:** Stated "ouch!" when dorsiflexing left foot; noted facial grimace when dorsiflexing left foot.
- **Action:** Apply TED hose per orders; will continue to monitor.
- **Response:** Fifteen minutes later, client still with discomfort upon dorsiflexion of LLE. Will continue to monitor. _____
_____*G. Nurse, RN*

PIE Charting

PIE charting includes a record of the following:

- **Problem observed and reported:** This section will include both subjective and objective data collected.
- **Interventions taken:** What did the nurse do to address the concern noted in the "Data" section? This could include pharmacological treatment given per orders, nursing interventions, comfort measures instituted, and other actions taken by the nurse.
- **Evaluation of the client's response:** How did the client respond to the action that the nurse took? Did the concern noted in the "Data" section improve, or did the concern magnify?

The earlier example regarding Ms. Cortez could include several different PIE entries by a nursing professional delivering bedside care. The following examples are by all means not comprehensive of all PIE notes that could be constructed from this scenario. It is also important for the nursing professional to recognize that each PIE note represents a small moment in time and a "snippet" of information. PIE charting is generally not used by medical providers of care such as NPs.

11 December 2009, 1100

- **P:** States headache is 6 of 10 on a 1–10 scale; crying softly, rubbing temples; PERRLA.
- **I:** Tylenol ES, 650 mg, given per order.
- **E:** Twenty minutes later, client reports pain is now 3 of 10 on a 1–10 scale. Reminded client to use call light to report any increase in head pain. _____ _____ *G. Nurse, RN*

11 December 2009, 1130

- **P:** Worried about who will care for elderly mother and son; noted to be crying softly and praying the rosary.
- **I:** Call placed to social services department to discuss options for care for elderly mother and son.
- **E:** Client stated "thank you" for calling social services. _____ _____*G. Nurse, RN*

11 December 2009, 1215

- **P:** Stated "ouch!" when dorsiflexing left foot; noted facial grimace when dorsiflexing left foot.
- **I:** Apply TED hose per orders; will continue to monitor.
- **E:** Fifteen minutes later, client still with slight discomfort. Will continue to monitor. _____

_____ *G. Nurse, RN*

SBAR Charting

SBAR charting includes a record of the following:

- **Situation observed or reported:** This section will include both subjective and objective data collected.
- **Background information:**
  - What brought the client in for care?
  - What was happening right before the situation occurred? For example, was the client eating, walking, lying in bed, watching television, or doing some other activity?
  - Contributory medical history should be listed here.
  - What treatments has the client received to date for this situation?
- **Assessment**
  - The pertinent portions of the physical assessment will be recorded here. See Tab 6: Physical Assessment for specific information.
  - It is of particular importance that the nursing professional documents any changes in the client's assessment from previous observations. What is different about this assessment than the last time the nurse observed the client?
- **Recomendation**
  - What nursing interventions can be implemented to address the situation?
  - For NPs: What treatment plan is needed at this time?
  - Diagnostic orders
  - Medication orders
  - Treatment orders

The earlier example regarding Ms. Cortez could include several different SBAR entries by a nursing professional delivering bedside care. The

following examples are by all means not comprehensive of all SBAR notes that could be constructed from this scenario.

11 June 2009, 1215

- **S:** States headache is 6 of 10 on a 1-10 scale.
- **B:** Admitted for monitoring and hypertension following car accident; T 98.2, R 18, BP 180/90, P 88. SpO_2 is 96% on room air upon admission to unit.
- **A:** Crying softly, rubbing temples; PERRLA. (Other assessment information would be noted here, such as repeat vital signs.)
- **R:** Called Dr. Smith for orders: Tylenol ES 650 mg given per order. ___ _____ *G. Nurse, RN*

11 June 2009, 1300

- **S:** Worried about who will care for elderly mother and son.
- **B:** Admitted for monitoring and hypertension following car accident.
- **A:** Crying softly and praying the rosary. (Other assessment information would be noted here, such as repeat vital signs.)
- **R:** Call placed to social services department to discuss options for care for elderly mother and son. _____ _____ *G. Nurse, RN*

11 June 2009, 1330

- **S:** Stated "ouch!" when dorsiflexing left foot; noted facial grimace when dorsiflexing left foot.
- **B:** Admitted for monitoring and hypertension following car accident; T 98.2, R 18, BP 180/90, P 88. SpO_2 is 96% on room air upon admission to unit.
- **A:** Pain elicited upon dorsiflexion of left foot. Facial grimace noted. (Other assessment information would be noted here, such as repeat vital signs.)
- **R:** Applied TED hose per order; will reassess for comfort in 15 minutes. _____ _____ *G. Nurse, RN*

SOAP Charting

SOAP documentation involves writing in a block format and recording the following:

- **Subjective findings:** What the client reports to the nurse; it is the client's description of his or her perception of the concern.
- **Objective findings:** The nurse's observations and findings based upon assessment of the client. It can include data gathered via observation, auscultation, palpation, and percussion.
- **Assessment data:** The nurse's assessment of the concern. If a bedside nurse is providing an assessment, it may include a nursing diagnosis. If a nurse practitioner is making the assessment, it will include a medical diagnosis.
- **Planning:** The plan to address the concern. The bedside nurse may record interventions, treatments delivered, and the client's response to such. The nurse practitioner (NP) will use this section to write pharmacological interventions, diagnostic testing, and other orders, such as the type of diet the client should have and the activity level the client is allowed to observe.

With the SOAP format, information is generally brief and targeted at singular problems if written by a nurse at the bedside. If it is written by an NP, the SOAP note is much more comprehensive.

The earlier example regarding Ms. Cortez could include several different SOAP entries by a nursing professional delivering bedside care. The following examples are by all means not comprehensive of all SOAP notes that could be constructed from this scenario. It is also important for the nursing professional to recognize that each SOAP note represents a small moment in time and a "snippet" of information. If the nursing professional's facility uses SOAP charting as its standard, it is entirely possible that there could be 10, 20, or more SOAP entries from a shift depending on the severity of the client and the concerns noted. See basic examples that follow:

11 December 2009, 1100

- **S:** States headache is 6 of 10 on a 1–10 scale.
- **O:** Crying softly, rubbing temples; PERRLA.
- **A:** Head pain r/t hypertension.

- **P:** Tylenol ES, 650 mg, given per order. Twenty minutes later, client reports pain is now 3 of 10 on a 1–10 scale. _____ _____ *G. Nurse, RN*

11 December 2009, 1130

- **S:** Worried about who will care for elderly mother and son.
- **O:** Noted to be crying softly and praying the rosary.
- **A:** Need for social service intervention.
- **P:** Call placed to social services department to discuss options for care for elderly mother and son. _____ _____ *G. Nurse, RN*

11 December 2009, 1215

- **S:** Stated "ouch!" when dorsiflexing left foot.
- **O:** Noted facial grimace when dorsiflexing left foot.
- **A:** Positive Homans' sign, LLE.
- **P:** Apply TED hose per orders; will continue to monitor. _____ _____ *G. Nurse, RN*

*REMINDER: In nursing documentation, the SOAP notes may be very short and directed at specific incidences in time during which the nursing professional delivers bedside care. When NPs document, the SOAP note will be much more comprehensive and reflect a full picture of the visit between the client and the NP.

SOAPIE Charting

SOAPIE documentation involves taking the original SOAP note and expanding it via:

- **Implementation of interventions:** This involves documenting what the nurse did in the plan of care to address the client's concern(s).
- **Evaluation of outcomes:** This involves documentation of the evaluation of whether the interventions assisted in addressing the client's concern(s).

11 December 2009, 1100

- **S:** States headache is 6 of 10 on a 1–10 scale.
- **O:** Crying softly, rubbing temples; PERRLA.

- **A:** Head pain r/t hypertension.
- **P:** Tylenol ES, 650 mg, ordered by Dr. Smith.
- **I:** Tylenol ES, 650 mg, given per order.
- **E:** Twenty minutes later, client reports pain is now 3 of 10 on a 1–10 scale.

_____
_____ *G. Nurse, RN*

11 December 2009, 1130

- **S:** Worried about who will care for elderly mother and son.
- **O:** Noted to be crying softly and praying the rosary.
- **A:** Need for social service intervention.
- **P:** Social services to be called.
- **I:** Call placed to social services department to discuss options for care for elderly mother and son.
- **E:** Client notified that social services will be coming in for a consult; client states, "thank you—that helps ease my mind." _____
_____ *G. Nurse, RN*

11 December 2009, 1215

- **S:** Stated "ouch!" when dorsiflexing left foot.
- **O:** Noted facial grimace when dorsiflexing left foot.
- **A:** Positive Homans' sign, LLE.
- **P:** TED hose ordered by Dr. Smith.
- **I:** Applied TED hose per orders; will continue to monitor.
- **E:** Tolerated application of hose without discomfort; states that hose feel comfortable. _____
_____ *G. Nurse, RN*

SOAPIER Charting

SOAPIER documentation involves taking the SOAPIE note and expanding it via:

- **Revision:** This involves any changes that need to be made to the plan of care, if evaluation demonstrates that interventions were not successful.

11 December 2009, 1100

- **S:** States headache is 6 of 10 on a 1-10 scale.
- **O:** Crying softly, rubbing temples; PERRLA.

- **A:** Head pain r/t hypertension.
- **P:** Tylenol ES, 650 mg, ordered by Dr. Smith.
- **I:** Tylenol ES, 650 mg, given per order.
- **E:** Twenty minutes later, client reports pain is now 7 of 10 on a 1–10 scale.
- **R:** Dr. Smith paged for further orders, as client's pain is increasing.

_____
_____*G. Nurse, RN*

11 December 2009, 1130

- **S:** Worried about who will care for elderly mother and son.
- **O:** Noted to be crying softly and praying the rosary.
- **A:** Need for social service intervention.
- **P:** Social services to be called.
- **I:** Call placed to social services department to discuss options for care for elderly mother and son.
- **E:** Client still crying; states she "feels as though God is punishing" her.
- **R:** Chaplain services offered; client agreed to talk with chaplain. Chaplain services contact. _____
_____ *G. Nurse, RN*

11 December 2009, 1215

- **S:** Stated "ouch!" when dorsiflexing left foot.
- **O:** Noted facial grimace when dorsiflexing left foot.
- **A:** Positive Homans' sign, LLE.
- **P:** TED hose ordered by Dr. Smith.
- **I:** Applied TED hose per orders; will continue to monitor.
- **E:** States TED hose are very tight and uncomfortable.
- **R:** Remeasured for TED hose; one size larger ordered from Central Supply. _____
_____ *G. Nurse, RN*

Extra Examples

Let's consider another client situation. Then, we will document it in all four formats. For purposes of this example, we will focus only on the information contained in the following paragraph, assuming that regular and complete documentation has preceded this situation.

INTRO

Mr. Kirby is a 50-year old businessman who was admitted to the hospital with pneumonia. His vital signs have been stable this morning. Mr. Kirby says he feels very "washed out" today. This morning, he ate all of his breakfast and walked to the bathroom with the help of a nursing assistant. Mr. Kirby currently has a headache, which he rates as a 7 on a 1–10 scale. He thinks it started after he read too much without his glasses. Upon physical examination, the nurse notes nothing unusual. The nurse has administered Tylenol, 650 mg, which is on his "prn" medication orders. Thirty minutes later, Mr. Kirby says his headache is better and is now a 2 on a 1–10 scale. The nurse lets him know to use the call light if the headache returns or he has any concerns or needs.

Narrative

11 June 2009, 1109: Vital signs stable (see flow sheet). Physical examination (assessment) unremarkable. States he feels "washed out." 100% of breakfast consumed; ambulated to bathroom with assist. States has headache of 7 on 1–10 scale due to not using glasses when reading. Tylenol, 650 mg, administered as ordered. _____
_____*G. Nurse, RN*

11 June 2009, 1140: States headache is now 2 on 1–10 scale. Instructed to use call light if headache returns or develops other concerns. _____
_____ *G. Nurse, RN*

SOAP

11 June 2009, 1215

- **S:** Reports headache of 7 on 1–10 scale.
- **O:** Physical examination (assessment) unremarkable.
- **A:** Pain (head) is r/t not using glasses when reading.
- **P:** Tylenol, 650 mg, administered as ordered _____
_____ *G. Nurse, RN*

**Note: The SOAP note does not have a field for recording the client's response to treatment. Therefore, another SOAP note would be needed to follow up.*

11 June 2009, 1300

- S: States headache is now a 2 on 1–10 scale.
- O: Physical examination (assessment) unremarkable.
- A: Pain (head) r/t not using glasses when reading resolved.
- P: Continue to monitor; client to use call light if headache returns ____
_____*G. Nurse, RN*

DART

11 June 2009, 1215

- **D:** Reports headache of 7 on 1–10 scale. Physical examination (assessment) unremarkable.
- **A:** Tylenol, 650 mg, administered as ordered.
- **R:** States headache is now a 2 on 1–10 scale.
- **T:** Instructed to use call light if headache returns or develops other concerns. _____

_____ *G. Nurse, RN*

*Note: The "D" in the DART includes both subjective and objective information collected by the nurse. Because components of the DART note may occur at varying times, the nurse can select only the components exercised at one time. For example, the previous note would likely read like this with correct times inserted:

11 June 2009, 1215

- **D:** States headache of 7 on 1–10 scale. Physical examination (assessment) unremarkable.
- **A:** Tylenol, 650 mg, administered as ordered. _____

_____ *G.Nurse, RN*

11 June 2009, 1245

- **R:** States headache is now a 2 on 1–10 scale.
- **T:** Instructed to use call light if headache returns or develops other concerns. _____

_____*G. Nurse, RN*

SBAR

11 June 2009, 1215

- **S:** Reports headache of 7 on 1–10 scale.
- **B:** Has been admitted to hospital with diagnosis of pneumonia. Has been reading without his glasses while hospitalized.
- **A:** Physical assessment unremarkable.
- **R:** Tylenol, 650 mg, administered as ordered. _____

_____*G. Nurse, RN*

SOAP Notes by Nurse Practitioners

Review the following three examples of SOAP notes documentation to see how nurse practitioners utilize the SOAP format.

Example 1

Examined by Jane Brown, FNP, RN

Client: John Doe
DOB: 6-11-68

Subjective:

CC: New diagnosis of diabetes; here to establish.
HPI: Went to ED 7-21-05 for kidney stone treatment. During stay, an Accu-check revealed a blood sugar of 368. Sent to Dr. Snider to establish for diabetes care. Client was unaware of diabetes; reports no symptoms whatsoever leading to this diagnosis. States he has always been "very healthy," that he "works out regularly," and has a "pretty good" diet.
PMH: Other than ED visit as above, client states he has been in "exceptional" health all his life. Other than normal colds and viruses, he has no remarkable past medical history.
FH: Mother is 68, still living and in good health. Father is 70, still living and in good health with only hypertension (since age 62) managed with medication.
SH: Nonsmoker, non-user of recreational drugs. Drinks 1–2 beers weekly if watching football (states he has changed to the "low carb" version since learning of his diabetes). Works as a banker. Lives with wife and two young children. Enjoys watching football. Monogamous.

ROS:

- **Constitutional:** Fever, chills.
- **Psych:** Denies anxiety and depression.
- **Eyes:** Denies eye pain, tearing, redness, swelling, discharge, changes in vision.
- **GI:** Denies abdominal pain, changes in bowel habits.
- **GU:** Denies urinary frequency and urgency, denies pain on urination, denies changes in urinary habits; + for kidney stone in July 21 but all symptoms have resolved.

- **Card/Vasc:** Denies palpitations (SVT controlled with Cardizem), changes in temperature of extremities, swelling and edema.
- **ENMT:** Denies ear pain, congestion, sore throat, mouth lesions or sores.
- **Hem/Lymph:** Denies blood in stool, denies knowledge of swollen glands.
- **Neuro:** Denies changes in neurological status, denies changes in strength and coordination of extremities.
- **MS:** Denies muscle or bony pain.
- **Resp:** Denies shortness of breath and coughing.
- **Allergy/Immuno:** For seasonal allergies, denies history of risk factors for HIV.
- **Endo:** Denies knowledge of enlarged thyroid (has been tested for hypothyroidism periodically due to family history), denies excessive thirst.
- **Integumentary:** Denies skin rashes or sores.

Objective:

- **Constitutional:** WDWNBM. T 98.2, BP 124/80, P 68, R 18. Accu-check by nurse reads 220.
- **Psych:** Appears relaxed and at ease.
- **Head:** NCAT. No sinus tenderness.
- **Eyes:** PERRLA, no discharge or tearing bilaterally. Discs sharp. Vessels within normal limits.
- **ENMT:** TM's WNL. Can hear whispers accurately through each ear. No pain in either ear. Nasal mucosa pinkish—no current drainage. Occlusion of each nare reveals no congestion of opposite side. Client has no difficulty smelling various odors with accuracy. Mucous membranes moist, throat pink with no streaking or exudates.
- **Hem/Lymph:** No nodes in cervical or axillary areas.
- **Card/Vasc:** Heart RRR.
- **Resp:** Lungs clear to auscultation bilaterally. No wheezes, rales or rhonchi noted.
- **GI:** Abdomen obese; soft, nontender on palpation.
- **Endo:** No splenomegaly detected.
- **MS:** Feet without lesions or ulcers; no breakage in skin. Nails are trimmed well.

Assessment:
New diagnosis, type II diabetes

Plan:

- Refer to diabetic educator.
- Refer to dietician.
- Education (basic) for need to monitor home blood sugars, oral hypoglycemics, foot and eye care.
- Glucophage 500 mg tablets, take one tablet twice daily with meals.
- Labs: HbA1C, fasting glucose, CMP.
- F/U 1 month _____

_____ *J. Brown, FNP, RN, 11 June 2009*

Example 2

Examined by Jane Brown, FNP, RN

Client: Jane Doe
DOB: 7-2-72

Subjective:

CC: Migraine headaches almost daily for 3 months.
HPI: Has had a migraine almost every day for the past 3 months. States has had migraines in the past, but not this often. Has taken Tylenol without relief; sometimes Excedrin helps. Generally she just goes to bed and turns out all the lights, but this is starting to interfere with her part-time job schedule as a librarian. Headaches always associated with nausea; occasionally she has vomited as well. Describes "rainbow" aura in vision field during migraines.
PMH: Migraines in the past since age 22 (only 1–2 annually). G1P0A1. Follows yearly for PAPs with Dr. Little, OB/GYN. Td last received in 2004 after stepping on nail. NKDA. Otherwise unremarkable.
FH: Mother and father both alive and in good health. One brother, 35, in good health. Paternal grandfather died from NIDDM complications at age 74.
SH: Nonsmoker. Drinks 1–2 alcoholic beverages weekly. Works part time as a librarian. Enjoys camping with her boyfriend. Sexually active since age 19—total of 3 partners. States she was tested for HIV in 2001 after boyfriend #2 was unfaithful—test was negative. No unprotected sex since that time.

ROS:

- **Constitutional:** Fever, chills.
- **Psych:** Denies anxiety and depression.
- **Eyes:** Denies eye pain, tearing, redness, swelling, discharge; describes changes in vision only with migraine attacks—"rainbow" aura bilaterally.
- **GI:** Denies abdominal pain, changes in bowel habits; + for nausea and occasional vomiting only with migraine episodes.
- **GU:** Denies urinary frequency and urgency, denies pain on urination, denies changes in urinary habits.
- **Card/Vasc:** Denies palpitations, changes in temperature of extremities, swelling and edema.
- **ENMT:** Denies ear pain, nasal congestion, sore throat, mouth lesions or sores.
- **Hem/Lymph:** Denies blood in stool, denies knowledge of swollen glands.
- **Neuro:** Denies changes in neurological status during or between attacks, denies changes in strength and coordination of extremities; positive for "excruciating," throbbing pain during migraine attacks.
- **MS:** Denies muscle or bony pain.
- **Resp:** Cough, wheezing.
- **Allergy/Immuno:** For seasonal allergies, denies history of risk factors for HIV (other than 2001 when she was tested and shown to be negative).
- **Endo:** Denies knowledge of enlarged thyroid, denies excessive thirst.
- **Integumentary:** Denies skin rashes or sores.

Objective:

- **Constitutional:** WDWNWF. T 98.0, BP 118/80, P 82, R 18.
- **Psych:** Appears anxious and concerned about physical symptoms.
- **Head:** NCAT. Short, shiny, well-groomed hair with no baldness noted. Scalp normal—no overt dryness or flaking. No sinus tenderness, scalp tenderness on palpation.
- **MS:** No trapezoid or sternocleidomastoid tenderness noted. Neck with full ROM.
- **Eyes:** PERRLA, no discharge or tearing bilaterally.
- **ENMT:** TMs WNL. Can hear whispers accurately through each ear. No pain in either ear. Nasal mucosa pink—no current drainage. Occlusion

of each nare reveals no remarkable congestion of opposite side. Client has no difficulty smelling various odors with accuracy. Mucous membranes moist, throat pink with no streaking or exudates.
- **Hem/Lymph:** No nodes in cervical or axillary areas.
- **Card/Vasc:** Heart RRR.
- **Resp:** Lungs clear to auscultation bilaterally. No wheezes, rales or rhonchi noted.
- **GI:** Abdomen obese; soft, nontender on palpation.
- **Endo:** No splenomegaly detected. _____

_____*J. Brown, FNP, RN, 11 June 2009*

Example 3

Examined by Jane Brown, FNP, RN

Client: Jane Doe
DOB: 7-2-72

Neuro-Specific Examination:

- Awake, alert, and oriented x 3. Can state date, time, and location.
- CN1: Can distinguish ammonia from perfume without difficulty.
- CN2:
  - Can read at 20/20 without difficulty (with glasses).
  - Visual fields—no difficulty distinguishing objects within appropriate range in 8 fields.
  - Funduscopic examination—red reflex visualized; vessels intact, discs sharp.
- CN3: As above—PERRLA.
- CN4: No nystagmus noted.
- CN5: Equal strength when biting down. Sensation intact via touch test with filament.
- CN6: (No nystagmus noted.)
- CN7: Facial nerve intact—equal response when raising brows, smiling, showing teeth, and puffing cheeks; strength equal with eyes closed; bone and air conduction equal.
- CN8: Can easily hear whispered voices.
- CN9: No strange tastes noted or reported.
- CN10: Normal visualization as client says "ah."
- CN11: Client easily resists with shoulders when pushed down; can easily place stress on examiner's hands with head.

- CN12: As previously—Normal visualization as client says "ah."
- Motor coordination: No involuntary movements noted; gait steady without limping. Easily sits and stands. Can walk on heels and toes, can hop on either feet. No difficulty with deep knee bends. Romberg test negative for drift.
- Sensory: Responds to all touches to medial and lateral extremities; can identify sharp and dull sensations, vibratory sense intact bilaterally.
- Reflexes intact and responsive, and otherwise unremarkable.

Assessment:
Likely migraine headaches

Plan:

- CT scan of head to rule out any other further concerns.
- Zomig tablets, 5 mg, #10—1 po within 20 min of headache onset.
- Follow up 1 week after CT scan for test results.
- Referral to neurologist if any CT scan abnormalities. _____
_____ *J. Brown, FNP, RN, 11 June 2009*

Electronic Records

Much like the benefit of template charting, utilization of electronic records or computerized charting allows the nurse to quickly record information about the client. Numerous types of computerized charting software are available. Some are tailored to physician or primary care provider use, some are geared toward nursing care, whereas others target various additional members of the ancillary health-care team. Additional software packages serve facilities in which multiple disciplines document on the same client, such as when physicians, nurses, therapists, and social workers use the same documentation system in hospital settings.

Not only does electronic documentation speed up the documentation process, it also helps to unify documentation by providing fields that must be filled in each time the nurse inputs data.

Entry for electronic records can be accomplished in a variety of ways. Some programs use keyboards, where the nursing professional types in information, much as one would type a letter on a computer. Other electronic systems use voice recognition, where the nursing professional is able to dictate into a microphone, and the program translates

that dictation into a generated record, such as a progress update or a documentation of treatment or procedure.

Continuity of documentation is as important as continuity of care, and electronic record-keeping allows the nurse to demonstrate reliable, consistent documentation in this venue.

Important guidelines exclusive to electronic record-keeping include:

- Do not give your user name or password to anyone. If an individual is able to log in under your credentials, he or she can document as if that person were you. This is illegal but could be very difficult to prove if you have voluntarily divulged your user name or password to someone else.
- Log on and log off each time you use the computer. Leaving yourself logged on could allow someone to document as you. Logging off is very important, even if you suspect you might be stepping away from the computer for just a moment. Things happen quickly, and if you are unable to return to the computer in short order, it is very easy for someone else to use your user credentials on that system.
- Be cautious about who can see the computer screen when you are inputting documentation. Privacy in computerized charting is just as important as in handwritten documentation. People without a need to know should not have visual access to client names on the computer screen. Therefore, document in a location where people are not looking over your shoulder.
- If you are using software that utilizes voice recognition, be cognizant of HIPAA requirements when speaking. It is important that others who are not authorized to know about the client are not able to hear what you are recording.
- If your system allows you to provide narrative information, be aware of your spelling and grammar. Documentation is a reflection of the professional care you provide and should read as such.

Legal and Ethical Issues

Documenting appropriately, thoroughly, and accurately is a nurse's legal and ethical responsibility. Concerns about care can easily be brought into question if a nurse's documentation does not support or represent the comprehensive picture of care that was delivered to the client. When nurses are too brief or casual in their documentation, document subjectively, or omit key portions of care that was delivered, it leaves them open to legal action for claims of negligence or malpractice.

These words serve as a powerful reminder that everything you do in the line of duty, from assessing and planning care, to delivering the care, to documenting it, is critical. In 2004, the median payment made for malpractice litigation involving registered nurses was $100,000, with a mean payment of $302,737 (Irving, 2006). These numbers should act as a powerful motivator for you to make sure that your documentation is as complete and thorough as possible.

In this tab, you will find examples of common legal documents that the nurse may need to complete or witness. It is very important that accurate documentation about any of these documents occurs and that the nurse understands these types of legal situations. If you have questions about what should or should not be included in the client's record, it is important to check with your nurse manager or facility attorney.

Also, ethical issues are often tied to legal concerns and often call for additional critical thinking in both your decision-making process and your documentation. In this tab, there is a framework to assist the nursing professional in considering implications of ethical issues, making decisions, and then documenting.

Legal Terminology

As the nursing professional documents, it is helpful to have an understanding of specific legal terminology. This does not mean that these terms are to be included in the medical record, but rather that the nursing professional is mindful of legal considerations and how appropriate documentation serves to represent comprehensive, individualized, appropriate care that was provided to a client.

Advance Directives are the expressed wishes of clients, created when they are lucid and able to make decisions about their own care. Types of advanced directives include:

- Health Care Proxy
- Living Will
- Do Not Resuscitate (DNR)
- Do Not Resuscitate/Comfort Care (DNR-CC)

Assault, as it pertains to the health-care profession, involves the threat of bringing harm to another. Physical contact (called "battery") is not necessary to file a complaint of assault. Assault can also involve making gestures that are considered threatening, even without actual physical contact.

Battery involves physical contact that is intended to injure another person. Accidental injury is not considered battery, but would fall under the category of "malpractice" or "negligence."

Defamation involves communication, which inflicts injury to a person's reputation, and causes an undesired emotion, such as ridicule, shame, or hatred, to be directed at the object of the communication. Defamation can encompass "libel" and "slander."

Good Samaritan Law was a law created to protect those who attempt to assist another in an emergent situation.

False imprisonment occurs when a client is intentionally confined to either his or her room or with restraints, without legal authority.

Informed consent is the practice of making the client aware of all treatment options, including the benefits and risks associated with these choices, as well as the benefits and risks associated with rejecting the treatment options. The primary care provider must provide information to the client during the course of obtaining informed consent; the nursing professional may witness the document indicating that the client has given informed consent.

Libel involves defamation in the form of writing. If the nursing professional writes or records something about a client that is defamatory, it can be considered libel. This is the reason that objective, clear, concise, and accurate documentation is so important.

Malpractice involves doing something that should not have been done, or not doing something that should have been done, *which resulted in*

injury to the client. As this relates to nursing, malpractice means failure to provide the standard of care that a reasonable, prudent nurse would have provided under the same circumstances, or performing an action that a reasonable, prudent nurse would not have performed under the same circumstances.

Negligence involves not doing something that should have been done. As this relates to nursing, negligence means failure to provide the standard of care that a reasonable, prudent nurse would have provided under the same circumstances. Failing to document appropriately also falls under the category of negligence.

Restraints are means by which clients are contained. There are physical restraints, such as chest-vests, soft or leather wrist or ankle restraints, lap belts, and mitten restraints, and there are chemical restraints such as medications that cause clients to become more compliant. Restraints can be medically ordered, with the order being carried out by the nursing professional; however, as a nurse, you must observe the many legal requirements for monitoring and documentation of the restrained client. If restraints are used inappropriately, or in the absence of a medical order, the client could be considered *falsely imprisoned*. The following table, from the Joint Commission (2008), demonstrates a framework for application and monitoring of restraints. It is important to continually document during each of these phases as they pertain to the individual client. The nursing professional should also consult facility policy.

Seclusion involves placing a client, against his or her wishes, in a room or location in which the client cannot leave. If seclusion is used to promote client safety, the same standards applying to restraints (see above) are to be observed. The nursing professional should also consult facility policy.

Slander involves defamation in the form of speech. If the nursing professional says something about a client that is defamatory, it can be considered slander.

Time Frames for Restraint Usage in Adults

The following are the time frames for reevaluating and reordering of restraint or seclusion for an adult.

- **Adult placed in restraint or seclusion:** Order obtained from licensed independent provider (LIP) within 1 hour of initiation of restraints or seclusion.
- **Adult evaluated in person by LIP:**
  - If the hospital uses accreditation for Medicare deemed purposes, the LIP must complete an evaluation on the client within 1 hour of initiation of restraint or seclusion.
  - If the hospital does not use accreditation for Medicare deemed status purposes, the LIP must complete an evaluation on the client within 4 hours of initiation of restraint or seclusion.
  - If an adult client is released prior to expiration of an original order, the LIP must conduct an in-person evaluation within 24 hours of the initiation of restraints.
- **LIP orders restraint, with evaluation by qualified staff:** Occurs every 4 hours until adult released from restraint or seclusion.
- **In-person evaluation by LIP:** Occurs every 8 hours until adult is released from restraint or seclusion.

Time Frames for Restraint Usage in Children

- **Child placed in restraint or seclusion:** Order obtained from LIP within 1 hour of initiation of restraints or seclusion.
- **Child evaluated in person by LIP:**
  - Within the first 2 hours for children 17 years of age and younger, LIP conducts an in-person evaluation.
  - If child released prior to expiration of original order (2 hour or 1 hour), LIP in-person evaluation conducted within 24 hours of initiation of restraints.
- **LIP orders restraint, and evaluation is conducted by qualified staff:** Every 2 hours for children ages 9 to 17 years until the child is released. Every hour for children younger than age 9 years until the child is released.
- **In-person evaluation by LIP:** Every 4 hours for children 17 years of age and younger until the child is released.

Joint Commission Guidelines for Restraints

The Joint Commission (2008) recommends that the nursing professional evaluate the restrained (or secluded) client every 15 minutes for the following:

- Signs of injury associated with the application or maintenance of the restraint or of the seclusion
- Nutrition and hydration needs
- Circulation and range of motion in the extremities; particularly those restrained
- Vital signs
- Hygiene and elimination needs
- Physical and psychological status, and comfort
- Readiness for discontinuation of restraints or seclusion

Ethical Terminology

As the nursing professional documents, it is helpful to have an understanding of specific ethical terminology. This does not mean that these terms are to be included in the medical record, but rather that the nursing professional is mindful of ethical considerations and how appropriate documentation serves to represent comprehensive, individualized, appropriate care that was provided to a client.

Autonomy involves the individual's right to choose for himself or herself; this is a type of respect that is shown for individual liberty. The client has the right to decide if he or she desires to take part in certain healthcare practices, or to refuse them.

Beneficence is the duty to do good to others. As a nursing professional, you are ethically bound to promote good for your clients. When practicing beneficence, it is important to remember to avoid *paternalism.*

Fidelity involves doing what one has promised. As a nursing professional, you are ethically bound to keep your word and commitments to your clients. If you say you will do something, you are to do it. Fidelity is the basis of the nurse-client relationship, and reinforces the nurse's obligation to act as a client advocate. For example, if the nursing professional tells the client that he or she will contact the physician about

a possible change in treatment, the nurse is obligated to follow through and contact the physician.

Justice reflects equitable distributions. This can be interpreted as providing equity in the way that a nursing professional cares for a client, as well as equally distributing potential benefits and risks when explaining health-care options. Justice represents the fact that discrimination, exploitation, and unfair treatment to clients is not appropriate. For example, if the client states that he or she is uncomfortable having the nurse perform a task, such as the insertion of a nasogastric tube, the nurse can utilize the ethical principle of justice to explain the benefits of the procedure versus the risks. Then, the client must make a choice that the nurse respects, which reflects an understanding of the client's autonomy.

Nonmaleficence is the obligation to do or cause no harm to another individual. This can be interpreted as physiological, psychological, social, cultural, or spiritual harm. A guiding question for the nursing professional is, "Will this care modality cause more harm or more good to the client?"

Paternalism involves allowing someone to make a decision for another person that is of age and ability. This does not include parents or guardians who make choices for their minor children, but rather addresses adults who make choices for other adults who are otherwise able to make their own decisions. For example, if a client decides he does not want to take chemotherapy, but his wife decides that he is going to take the treatment (and the primary care provider permits the chemotherapy to be ordered), paternalism has been exercised. Paternalism can also take place if the nursing professional attempts to influence a client's decision about care or treatment plans; this is not appropriate.

Respect involves showing others that their rights and decisions are acknowledged.

Veracity is the obligation to tell the truth.

Ethical Decision Making and Documentation

The following table represents a decision-making tree concerning ethical issues. Again, this information does not need to be specifically documented in the medical record, but the objective documentation of the situation should represent appropriate ethical decision making according to this or another ethical decision-making framework.

Recognize an Ethical Issue
1. Is there something wrong personally, interpersonally, or socially? Could the conflict, situation, or decision be damaging to people or to the community?
2. Does the issue go beyond legal or institutional concerns? What does it do to people, who have dignity, rights, and hopes for a better life together?
Get the Facts
3. What are the relevant facts of the case? What facts are known?
4. What individuals and groups have an important stake in the outcome? Do some have a greater stake because they have a special need or because we have special obligations to them?
5. What are the options for acting? Have all the relevant persons and groups been consulted? If you showed your list of options to someone you respect, what would that person say?
Evaluate Alternative Actions From Various Ethical Perspectives
6. Which option will produce the most good and do the least harm?
Utilitarian Approach: The ethical action is the one that will produce the greatest balance of benefits over harms.
7. Even if not everyone gets what they want, will everyone's rights and dignity be respected?
Rights Approach: The ethical action is the one that most dutifully respects the rights of all affected.
8. What options are fair to all stakeholders?
Fairness or Justice Approach: The ethical action is the one that treats people equally, or if unequally, that treats people proportionately and fairly.

Continued

Evaluate Alternative Actions From Various Ethical Perspectives—*cont'd*
9. Which options would help all participate more fully in the life we share as a family, community, society?
Common Good Approach: The ethical action is the one that contributes most to the achievement of a quality, common life together.
10. Would you want to become the sort of person who acts this way (e.g., a person of courage or compassion)?
Virtue Approach: The ethical action is the one that embodies the habits and values of humans at their best.
Make a Decision and Test It
11. Considering all these perspectives, which of the options is the right or best thing to do?
12. If you told someone you respect why you chose this option, what would that person say? If you had to explain your decision on television, would you be comfortable doing so?
Act, Then Reflect on the Decision Later
13. Implement your decision. How did it turn out for all concerned? If you had to do it over again, what would you do differently?

Santa Clara University. (2006). A framework for ethical decision making. Retrieved July 1, 2008 from http://www.scu.edu/ethics/practicing/decision/framework.html

The key when documenting an ethical situation is to simply report the facts in an objective manner. The nursing professional does not have to identify the situation as an ethical one; the objective documentation is evidence enough to demonstrate what is being recorded. It is important for the nursing professional to remember that it is not the nurse's responsibility to rectify every ethical issue that he or she confronts; there are ethical committees or panels in many facilities that specialize in addressing these concerns professionally and fairly.

Advance Directives

Clients have the right to determine what happens to their bodies and are to be allowed to participate in decisions regarding their health care. Advance directives are the pieces of written documentation that confirm the client's wishes about their health care. The client creates them, usually with an attorney, when the client is of sound mind and judgment to

declare what he or she wishes to happen in the future if he or she is impaired and cannot verbalized those choices. The client has the autonomy to change his or her advance directives at any time the client is competent and able to make decisions for him or herself. For example, a client may want to change the person who is designated to make health-care decisions for them, called a *Durable Power of Attorney* or Health Care Proxy. As long as the client is of sound mind and ability, he or she can make this change at any time. The client does not have to state a reason for wanting to make changes to his or her advance directives. Revocation can be done verbally or in writing, but is it recommended that all changes be confirmed in writing so there is no question about the client's wishes. Advance directives come in several formats. Some clients may have all forms of advance directives; others may only have one or two. The most common components of advance directives include:

- **Living Will:** This is a document that details the treatment (or lack of treatment) that a client desires during end-of-life care. Clients may desire one type of care, but not others; they may request all of the care available (often called *heroic measures*) or specify that no such measures should be instituted. A living will often addresses whether a client desires to have, or to decline, the following examples of interventions:
  - Administration of oxygen for comfort care.
  - Placement on a ventilator for oxygenation.
  - Cardiopulmonary resuscitation (CPR) if the heart stops beating.
  - Artificial feeding, e.g., by a PEG tube inserted into the stomach.
  - Prolonged hydration, other than for comfort care.
- **Durable Power of Attorney (Health Care Proxy):** This is an individual who is appointed by the client, when of sound mind and ability, to serve as the decision-maker for health-care decisions, if the client is incapacitated. This is not to be confused with a *General Power of Attorney,* which gives another individual power to sign for general purposes, such as banking and real estate.
- **Do Not Resuscitate (DNR) orders:** These orders state that the client does not wish to be revived. Often, a client will receive designation as a "DNR-CC," which means that the client is not to be revived, but that comfort care measures can be instituted when the client is actively dying, such as the administration of oxygen or hydration for comfort purposes, but that would not extend longevity.

Although you, as a nursing professional, are not involved in the actual design and implementation of a client's advance directives, information about these documents must be recorded in the client's chart. Sometimes another department has completed this before the client reaches the unit, but you should still confirm that it has been documented. Information to document includes:

- Type of advance directive.
- When the advance directive was received.
- Where the advance directive was collected, such as in registration, preadmission testing, or on the floor.
- If no advance directive exists, that information about advanced directives was provided, as well as an avenue for completing them if desired, such as the hospital legal representative.
- That the physician has been informed about the presence, absence, or current creation of advance directive.

If a health-care provider chooses to not follow an advance directive, various legal implications, such as assault, battery, negligence, or malpractice can ensue. For example, consider that a client has an advance directive stating he is to be DNR. When the client codes, a health-care provider decides to willfully ignore the DNR status and starts providing advanced cardiac life-saving techniques. This is in direct violation of the client's wishes. The health-care provider who participates in treatment that is specifically against the client's declared wishes can be held in legal violation with charges encompassing assault, battery, and malpractice.

Incident Report

An incident report is a document that is completed when an incident occurs that has an adverse outcome, such as an injury incurred while hospitalized, such as from a fall. Instead of being filed in a client's chart, an incident report is circulated to an appropriate committee that reviews the report and attempts to enact positive change so that similar episodes do not happen again. This type of committee is often called something like "Performance Improvement," "Clinical Quality Improvement," or "Quality Assurance and Improvement."

Most facilities use an incident report form that is exclusive to their setting. However, information contained on incident reports of different facilities

will be very similar. You will use the incident report to record information such as:

- Name and room number (bed number) of client.
- Date and time of incident.
- Location of incident.
- Individual(s) involved in incident.
- Situation of incident (how it occurred).
- Adverse effect of incident, such as injuries sustained.
- Individuals notified, including supervisor, treating physician, family member.
- Care provided as a result of incident.
- Outcome after care was provided.
- Name and signature of person completing the incident report.

It is important for you to document the incident in the client's record, but the incident report itself should not be included. This documentation should provide an objective overview of the situation, a record of any care given, the individuals notifed, and reflect the client's current disposition. *It is also very important that you not document that you have completed an incident report.* The charting should remain very objective and address only the facts of the situation.

Informed Consent

Informed consent is a "process of communication between a client and physician that results in the client's authorization or agreement to undergo a specific medical intervention" (American Medical Association, 2007, ¶ 1). The physician must discuss the following information in the process of this communication (American Medical Association, ¶ 2):

- The client's diagnosis, if known.
- The nature and purpose of a proposed treatment or procedure.
- The risks and benefits of a proposed treatment or procedure.
- Alternatives, regardless of their cost or the extent to which the treatment options are covered by health insurance.
- The risks and benefits of the alternative treatment or procedure.
- The risks and benefits of not receiving or undergoing a treatment or procedure.

LEGAL/
ETHICS

The nurse's role in the informed consent process is to witness the signature of the client or the power of attorney who can make health-care decisions. Although the burden of disclosure is on the treating physician, the nurse can assist in the informed consent process in the following ways:

- Ascertain the alertness of the client. If a client is not alert and oriented, obtaining informed consent at that time is not appropriate.
- Clarify with the client whether he has any further questions or concerns prior to signing.
- Explain that the client can change his mind about giving informed consent, even if he has already signed the forms.

If all of the appropriate conditions for informed consent have been met, the nurse should document the following:

- Name of physician providing information to the client.
- The client's response to the discussion, including level of understanding voiced.
- Any questions asked and answered.
- That the informed consent form was signed by the client.

The nursing professional is not witnessing whether the client understood the information (this burden is placed on the physician), but rather that the actual client is the one who has signed the informed consent form.

Informed Refusal

Informed consent is a "process of communication between a client and physician that results in the client's authorization or agreement to undergo a specific medical intervention" (American Medical Association, 2007, ¶ 1). It is always possible that the client will refuse to sign the informed consent form, even after thorough dialogue with the physician.

If all of the appropriate conditions for informed consent have been met (see earlier), the nurse should document the following:

- Name of physician providing information to the client.
- The client's response to the discussion, including level of understanding voiced.
- Any questions asked and answered.

- That the informed consent form was *not* signed by the client with notation of the client's verbalization for why he or she has declined to provide informed consent.

The nursing professional is not witnessing whether the client understood the information (this burden is placed on the physician), but rather that the actual client is the one who declined to sign the informed consent form.

Withdrawal of Treatment

Withdrawal of treatment is agreed upon when two physicians have determined that there is no hope for recovery and that further medical intervention is futile. Family members are consulted in this process, and decisions are made regarding termination of treatment. The nursing professional is often called upon to record information that indicates that treatment is being withdrawn. The following form is an adaptation from The Liverpool Care Pathway and The West Yorkshire Critical Care End of Life Care Bundle, and provides a reflective example of the documentation necessary when withdrawal of treatment occurs. It is important that the nurse also document the decision to discontinue treatment and the content of the accompanying conversations of such in the medical record.

End-of-Life/Withdrawal of Treatment	
Name:	Date:
MR Number:	Consultant:

1.	**Multidisciplinary Meeting Date:** Aim to establish an agreement within the meeting among the members of the team to withdraw life-prolonging treatment.			
1.1.	Members of the multidisciplinary team present during the meeting.			
	Names	**Position**		
1.2.	Is there an agreement on the need to withdraw treatment?		**YES**	**NO**

2.	**Consider Organ Donation**	**YES**	**NO**
2.1.	If 'Yes' contact Transplant Coordinator.		

3.	**Plan Family Meeting** The goal is to ensure that all information and personnel are gathered prior to the meeting.		
3.1.	Is there a room where the family can be left alone?	**YES**	**NO**
3.2.	Have the religious/cultural/spiritual needs been identified and met?	**YES**	**NO**
3.3.	Is an interpreter required?	**YES**	**NO**
	If 'Yes' give name and contact number:		
3.4	Is a Social Services referral required?	**YES**	**NO**
	If 'Yes' give name and contact number:		

4.	**Family Care Meeting Date:** The goal is to ensure that the family fully understands the need and process of withdrawal of treatment.			
4.1.	**Names of people present**	**Dr/Nurse/Relative/Friend**		
4.2	Discussion over telephone with NOK if meeting not possible.			
	Comments:			
4.3.	Full explanation of futility of treatment explained?		**YES**	**NO**
4.4.	Clinical plan shared with family members?		**YES**	**NO**
4.5.	Decision to withdraw treatment agreed by family members?		**YES**	**NO**
4.6.	Does the family require time?		**YES**	**NO**
4.7.	Explanation of the process of events following withdrawal of treatment is explained without time scales.		**YES**	**NO**

5.	**Organ/Tissue Donation** The goal is to discuss the possibilities of organ donation/tissue donation if the client is a candidate.		
5.1.	Has organ/tissue donation been considered by the family?	**YES**	**NO**
	If 'Yes' contact Transplant Coordinator.		

6.	**Withdrawal of Treatment** The goal is to ensure that everything is ready for withdrawal of treatment.		
6.1.	Is the decision to withdraw fully documented in the client's medical notes?	**YES**	**NO**
6.2.	When and where is treatment to be withdrawn?		

Orders for Withdrawal of Treatment

Therapy		Action (completed by physician)	Date	Time	Sign
Airway	ETT				
	Tracheostomy				
	Other				
Breathing	Ventilation mode and support				
	FiO_2				
	Saturations				
Circulation	Inotropes				
	B/P monitoring				
	ECG monitoring				
Fluids	Maintenance				
	Resuscitation				
GI	Enteral Feeding				
	Insulin regime				
	BMS				
Kidney	Catheter				
	Renal replacement				

Continued

Orders for Withdrawal of Treatment—*cont'd*

Therapy		Action (completed by physician)	Date	Time	Sign
Lines	Arterial line				
	Central line				
	Peripheral canula				
Dressings	Burn dressings				
Medication	Infusions				
	Oral medication				
	See prescription chart				

Withdrawal of Treatment Care Pathway

On going Assessment (A = Achieved, Not Achieved)

Time				
Respiratory tract secretions Aim: Secretions are not a problem				
Pain Aim: Client is pain free				
Agitation Goal: Client is not agitated				
Nausea/vomiting Goal: Clients does not feel nauseous or vomitous				
Mouth care Goal: Mouth is moist and clean • Follow mouth care policy • Assess mouth 4 hourly				
Elimination Goal: Client is comfortable and clean				

Continued

Withdrawal of Treatment Care Pathway—*cont'd*

On going Assessment (A = Achieved, Not Achieved)				
Mobility/pressure area care Goal: Client is comfortable and safe, with regular positional changes				
Psychological support Goal: Client is informed of all care, family are aware of imminent death				
Religious/cultural/spiritual support Goal: Appropriate religious/cultural/ spiritual support has been given				

Withdrawal of Treatment: Verification of Death

Date of death:	Time of death:
Persons present:	
Notes:	
Signature of nurse:	

Care after death		
• Primary nurse informed	**YES**	**NO**
• Coroner notified	**YES**	**NO**
• Primary care provider contacted re client's death (message left if out of hours)	**YES**	**NO**
• Police informed if involved in case	**YES**	**NO**
• Procedures for care of body followed according to facility policy	**YES**	**NO**
• Family given information on facility procedures following death	**YES**	**NO**
• Facility policy followed for client's valuables and belongings	**YES**	**NO**
• Bereavement leaflet given	**YES**	**NO**

Basic Documentation Tips

Now that you recognize the need for documentation, as well as the formats available to keep records of your client's progress, it is time to review what needs to be included. One of the key principles to remember is that you should include information that is concise, descriptive, and informative.

There are some cardinal rules to follow as you document. Although they may sound basic, they are of critical importance as you put pen to paper or fingers to keyboard. Your documentation reflects your professionalism and is a true representation of the care you provide as a nurse. These rules include:

- **Obtaining the correct client's record:** Double check to make certain that the paperwork within the chart belongs to the same client; it is not unusual for papers to get shuffled between charts if people are not careful.
- **Pacing yourself to document in a timely format:** It is impractical and inappropriate to try to backload your documentation at the end of the shift. Be certain to document in a timely fashion after care is provided so that you stay on top of this important task. It is also important to timely document so that any other health-care provider who needs to reference the medical record can read an up-to-date account of the assessment of the client and the care that has been provided to that point in time.
- **Being certain that your documentation is legible so that subsequent providers of care can follow it:** When documenting in a paper-based chart, it is critical to write legibly. Other caregivers need to see exactly what you did, when you did it, and how the client responded. In rare and unfortunate instances that documentation may be called into question during legal pursuits; it is of the utmost importance that you are able to read your own writing and explain what you did.
- **Using permanent ink in only black or blue (or as your facility mandates) if documenting on paper:** Multiple ink colors make documentation difficult to follow and do not look professional. Some institutions require only one color, such as black. Be sure to follow your facility's guidelines; otherwise, choose black or blue, and avoid erasable ink or markers that bleed through paper.

- **Proofing your spelling and grammar:** Again, it is of critical importance to represent accurately the care that was provided. As a nurse, you want people to reflect the professionalism of the services and care that you provide. Inaccurate spelling and grammar detracts from that professionalism. If necessary, keep a pocket dictionary handy. When using computerized documentation, run a spell-check before submitting the records.
- **Lining through blank spaces and not skipping lines when documenting on paper:** Leaving blank lines and spaces at the end of lines allows other people to chart after you and makes it appear that you were responsible for that portion of the charting. To protect yourself, use all lines available without skipping, and line through any unused portions.
- **Using quotation marks when documenting exact words spoken by the client:** Sometimes, clients explain symptoms in words that are very descriptive. It is important to reflect exactly what the client said by the use of quotation marks. This can also be helpful when documenting comments by the client that are indicative of state of mind or emotion. For example, if the client tells the nurse to leave him alone, the nurse would include in the documentation a phrase such as this: Client states, "Leave me alone."
- **Being objective:** Subjective charting about a client, such as documenting about a client's demeanor or culture, is not appropriate. The nurse should never pass judgment on a client or put this type of thought into documentation. If a client is uncooperative, document the client's words or actions; never say that a client is being cranky, mean, uncooperative, or nasty. That type of language is never appropriate in the nurse's documentation. The nurse must strive to record only objective findings, and it is important to note that objective documentation of behaviors, cultural practices, spiritual beliefs, and other pieces of individual assessment information can greatly contribute to the plan of care. The key is maintaining that objectivity and recording only what is observed and what is communicated to the nurse. Personal feelings or judgments of the nurse do not belong anywhere in professional documentation.
- **Using abbreviations appropriately:** We discussed the issues associated with abbreviations in Tab 1. The nurse must decide, in conjunction with his or her institution, whether the use of abbreviations is appropriate

and acceptable. *DocuNotes* does not recommend or decry the use of abbreviations, but rather suggests that the nurse comply with the institution's guidelines. *DocuNotes* does, however, support following the Joint Commission's "Do Not Use" list and highly recommends that the nurse document very legibly if using abbreviations, so that discrepancies in interpretation are avoided.

- **Making corrections proactively and accurately:** Improper documentation will occur. Sometimes, a nurse will inadvertently document in the wrong chart; other times, the nurse will inaccurately record data. When this occurs, the nurse must amend the incorrect documentation. When making a correction, place a simple line through the inaccurate documentation and initial it. Do not use white-out or attempt to black out the wrong documentation. Once finished with your correction, continue to record appropriately.
- **Include late entries:** What happens when your best intentions go awry and you are not able to document in a timely fashion? This is not uncommon, as sometimes client needs require your full attention and you are unable to document at the time you had anticipated, such as when a code is called. When this occurs, the best practice is to simply annotate that the entry is late, describe the reason that charting was delayed, and proceed with the objective documentation. For example:
  - 7-1-08, 1215 – Late entry: (Chart was unavailable 7-1-08 at 2330; physician was documenting) *Proceed to document the pertinent information here.*

Synthesizing the Information Documentation Example

Three examples of documentation performed for the same client are presented here. Which one would you identify as best reflecting the assessment completed by the nurse? Which is the most descriptive and allows other caregivers to interpret exactly what the nurse observed during the assessment? Which documentation would you rather have recorded in case something ended up in the hands of an attorney? Undoubtedly, the answer to all three of those questions is Documentation Example 3.

Documentation Example 1 (Poor Documentation)

11 December 2009, 1100: Vitals done. Physical assessment done. No problems noted. Skin clear. Eyes and nose OK. Mouth moist. Hears. Heart regular. Lungs clear. Bowel sounds present. Pulses +2. Capillary refill present. _____ *G. Nurse, RN*

WHY IS THIS DOCUMENTATION POOR? This documentation is missing key details that would provide continuity of care. It is also missing information, which means that it is not representing the accurate portrayal of the full assessment performed by the nurse. Many general statements are included, but the next nurse reading this documentation is left to ask:

- "What were the vital signs?"
- "How well did the client hear?"
- "How long did capillary refill take?"
- "Which pulses were palpated?"

The nurse has not documented the exact vital signs or the specifics of what was found during the assessment. Even if findings are normal, it is important to record what was specifically inspected, auscultated, palpated, and percussed.

Documentation Example 2 (Fair Documentation)

11 December 2009, 1100: Vital signs taken. T 99.0, P 82, R 16, BP 134/84. Skin without lesions or breakdown. PERRLA. Nose patent. Mucous membranes moist. Can hear. No JVD, no carotid bruits. Heart: regular rate and rhythm. Lungs clear to auscultation. Bowel sounds normoactive in 4 quadrants. Radial and pedal pulses present. Strength equal. Capillary refill x 2 seconds. _____ *G. Nurse, RN*

WHY IS THIS DOCUMENTATION FAIR? This documentation is clearly better than the documentation found in Example 1, as it includes more detail. The specific vital signs are listed, and the nurse has not identified findings ambiguously by saying they are "OK." The nurse has also clarified the location of the bowel sounds, describing them as normoactive, and has completed the timing of capillary refill.

Documentation Example 3 (Good Documentation)

11 December 2009, 1100: T 99.0, P 82, R 16, BP ~~130/80~~GR 134/84. Alert and oriented x 3. Smiling and conversant. Skin warm and dry with pink undertones and without lesions or breakdown. PERRLA; wearing glasses. Nose patent. Mucous membranes moist; wearing clean dentures. Can hear whispers. No JVD, no carotid bruits. Heart: 82 and regular, no murmurs noted. Lungs clear to auscultation; breathing easy and symmetrical. Abdomen soft and round, nondistended, nontender. Bowel sounds normoactive in 4 quadrants. Last bowel movement yesterday; states "it was normal." No breast or vaginal discharge noted. Radial and pedal pulses + 2 and equal. Strength equal in upper and lower extremities. Capillary refill x 2 seconds. No edema noted. Bed in low position, 2 side rails up, call light in reach. _____ *G. Nurse, RN*

WHY IS THIS DOCUMENTATION GOOD? In comparison with examples 1 and 2, the nurse has clearly identified pertinent findings about the client, and has included very specific clarifying phrases, such as complete descriptions of heart rate and ease of breathing, as well as notation of the pulses, commentary on extremity strength, and a description of how the client was left. When the next shift's nurse comes on, he or she will be able to read this documentation and know exactly what the nurse observed. This provides the best basis for continuity of monitoring and care planning.

Documenting Situations

When it comes to documenting situations, we're discussing extraordinary incidents that need to be included in your documentation. There are numerous situations that will arise during the nursing professional's career, and it is helpful to know how to document these objectively and comprehensively in the chart. There are two types of situations:

1. Client situations, which include searching, equipment tampering or handling, hostile advances or harassment, information to be passed to media, and photographing.
2. Situations involving other individuals, which include discussions with other health-care individuals and discussions with a client's family members.

It is important for the nursing professional to remember that legal considerations must be adhered to, as a health-care professional has no authority to search someone against his or her will. Health-care providers should always act in strict accordance with state law, as well as facility policy.

Searching

To search a client for items that are of concern, such as illegal substances, alcohol, firearms, or other weaponry, it is important to recognize that there must be a clear rationale and need for doing so. Hospitals and clinics do not routinely search clients, so there must be an indication present that the client possesses one or more of these items to justify a search. It is unwise to proceed with a search without the knowledge of another individual. *DocuNotes* recommends notifying security so that the nursing professional will not have to search the client alone.

The first step in searching is to simply ask the client if he or she has the suspected item in immediate possession. Sometimes, clients are very forthcoming, and the process is not difficult. In this case, documentation is quite easy:

> 11 June 2009, 1423: Client smells strongly of alcohol, carrying brown paper bag with item resembling a bottle inside. Asked client if he was carrying alcohol; client responded, "yes, want some?" and handed this nurse the bottle, which was noted to be empty. Disposed of bottle.
> *G. Nurse, RN*

Unfortunately, not all situations are this easy. Sometimes clients refuse to allow a search. In cases such as this, it is imperative to notify a supervisor, such as a nurse manager, and security. Facilities may also have policies in place that are specific to their institution, so the nursing professional should contact those individuals listed by the facility. It is important to not engage the client any further in an effort to secure the substance until reinforcement has arrived.

In cases such as this, a chronological record of events must be documented by the nursing professional. It is imperative to keep this information objective, and not condemn the client for not surrendering the item:

11 June 2009, 1423: Client smells strongly of alcohol, carrying brown paper bag with item resembling a bottle inside. Asked client if he was carrying alcohol; client responded "nope." When asked to see what was in the paper bag, client refused. Nurse asked for client to give her the bag; again, client refused. _____ *G. Nurse, RN*

11 June 2009, 1426: Notified nurse manager Kathy Hughes and security officer John Patrick of client's refusal to surrender paper bag. Hughes and Patrick on their way to emergency department. _____ _____ *G. Nurse, RN*

11 June 2009, 1430: Kathy Hughes, nurse manager, and John Patrick, security officer, arrived at emergency department. After unsuccessful dialogue between Mr. Patrick and client, Mr. Patrick reached for brown bag without client's permission and secured the bag with an empty alcohol bottle inside. Reviewed hospital policy with client regarding alcohol, and the rationale for why Mr. Patrick had to take the bottle. _____ _____ *G. Nurse, RN*

Equipment Tampering or Handling

Clients may purposefully tamper with equipment, or may accidentally hit a switch or button, causing a change in function of the equipment. Education about proper use of the equipment is important in both of these situations, as is documentation that reflects the situation and the teaching provided:

11 June 2009, 1423: Client noted to have removed pulse oximeter from finger and replaced it upside down; client became alarmed when reading showed no saturation on the monitor and an alarm began to sound. Explained proper placement of pulse oximeter to client and reinforced the need to keep the mechanism on his finger in the appropriate position. Encouraged client to call if he had any questions about the equipment prior to removing or manipulating it. Client voiced understanding. Lungs clear bilaterally, pulse oximetry at 99% after correct placement. _____ *G. Nurse, RN*

Hostile Advances and Harassment

Hostile advances may include physical or verbal aggression or sexual harassment. The nursing professional must know how to effectively temper and handle these situations and how to document an accurate representation in the chart about the event.

The nurse's responsibility is to protect the client and himself or herself. If the client becomes aggressive, there are multiple possibilities for this behavior, such as fever-induced delirium, medication reactions, or a psychiatric crisis. The nurse must quickly assess the possible causative agent and then take action to protect both client and self.

Just as there are numerous potential causes for this behavior, there are multiple potential interventions. The documentation must accurately reflect what took place, beginning with the first assessment of the noted behavior, to the interventions put in place, to the outcome:

11 June 2009, 1423: Client began pulling at nurse's arm, telling him that she wanted to get out of the hospital. Discussed rationale for hospitalization. Client continued to pull at nurse, and began attempting to climb upon him. Nurse called for assistance; John Smith, RN, responded and assisted to place client in bed in soft restraints. Explained rationale for restraints. Client crying softly in bed, no further attempts to get out or pull on nurse. _____ *G. Nurse, RN*

Intent to Sue

In the course of a nursing professional's career, there will undoubtedly come a time when a client or family member states that he or she is going to sue. When documenting a statement that someone makes about a lawsuit, it is important to remain objective, recording only the facts surrounding the situation and the statement made by the client or family member. It is also good practice to notify the facility's risk management department about a verbalized intent to sue.

11 June 2009, 1423: Client lying in bed reading book. When asked if there was anything he needed, client stated "There is nothing I need now, but as soon as I leave, I am suing this hospital. I've been here 2 weeks with the same infection and am no better, so it's obvious that someone is not doing their job." Offered to contact physician to discuss treatment plan, and offered to discuss nursing plan of care with client. Client declined, stating "I don't want to talk about it now. I'll just tell my lawyer when I'm out of here." Client denies any needs at this time, and resumed reading book without further dialogue. _____ *G. Nurse, RN*

Intent to Commit Suicide

Intent to commit suicide may come in the form of a verbal statement by the client, behavioral implications that the nursing professional observes, or an act that the client has attempted. If the nursing professional

becomes aware of a client's intention to commit suicide, it is important to immediately provide for safety according to facility policy, notify the primary care provider, and document interventions appropriately.

11 June 2009, 1423: Client stated to nurse, "I am going to kill myself before this shift is over." Client denies having a plan to do so, but states "I will do it no matter what you think." Client attempted suicide six years prior by ingesting overdose of acetaminophen. Suicide precautions immediately initiated. Dr. Michaels notified. Nursing manager, S. Green, RN, notified; Security notified. Client's room searched; no items that could be used harmfully found. 1-on-1 observation initiated; E. Hammas, RN, supervising client. Client notified that he will be supervised at all times; client verbalized understanding. Unable to contract for safety at this time; will reassess in ten minutes. _____ *G. Nurse, RN*

Nonconforming Behaviors

In any health-care environment, there is the possibility that a client will engage in nonconforming behaviors. This includes exhibition of violent behavior, and may be noted verbally or in physical manifestation. Although this is likely experienced more frequently in mental health units and in the emergency department, it is possible that this can occur in any facility at any time. Nursing professionals must be prepared to take immediate action to promote safety of the client and others in the vicinity, and document interventions accordingly. It is important to attempt to communicate with the client calmly and objectively to avoid contributing to escalation of the behavior.

11 June 2009, 1423: Client noted to be pacing up and down hallway. When asked if he needed help, client began screaming "Leave me alone—if I wanted something, I would ask you!" Client used hand to knock items on nurses' station desk to the floor. Informed client that I understood he was frustrated but that he was not permitted to behave in this capacity and would need to return to him room. I stated I would join him and we could discuss what was troubling him. Client stated, "I am not going back in there" and proceeded to knock another set of newspapers to the floor. Security paged. Client began pacing hall again. Other items on desk removed; no other clients in immediate vicinity. _____ *G. Nurse, RN*

11 June 2009, 1426: Security arrived, escorted client to room. Security is with client at this time. Dr. Griffin paged; orders received. _____ G. *Nurse, RN*

Leaving Against Medical Advice

Autonomy allows individuals to make choices for themselves, as long as they are of sound mind and ability. Occasionally, clients will make a choice to leave against medical advice (AMA). This means that the primary care provider has not provided clearance for the client to be discharged, and that it is recommended that the client stay for further medical evaluation or treatment; however, despite the primary care provider's recommendation, the client has chosen to leave of his or her own free will.

If a client chooses to leave AMA, the nursing professional must provide:

- Accurate documentation to reflect the reason the client has chosen to leave.
- Documentation that the client has been counseled about the implications of leaving in this fashion.

It is important that the client is made aware of the risks of leaving. Documentation should reflect that the nurse has provided this information and that the client has acknowledged understanding of this information.

Many facilities have their own form that clients must sign when choosing to leave AMA. This form should be filled out completely and included in the client's medical record. Narrative documentation should include the information provided earlier, as well as pertinent teaching given to the client before his or her departure. It is also important to reflect an accurate description of the client's mental status at the time he or she chooses to leave AMA, as this can easily be brought into question if the client experiences complications after leaving.

11 June 2009, 1423: Client has chosen to leave against medical advice. Is alert and oriented to person, place, and time, and is mentally clear. Dr. Jeffries notified; states client should not leave at this time due to the need for further testing, and must sign out against medical advice if she chooses to go. Client notified of Dr. Jeffries' instructions regarding the need for further testing. Client still states, "I am leaving, I just don't want to stay." Educated client about risks of leaving before further testing and evaluation are completed; client verbalized understanding and says "I will see my own doctor." AMA form completed and client signed. No medications ordered by Dr. Jeffries. Leaving with spouse, states "I am going home but will call my doctor if I need him."
_____ *G. Nurse, RN*

Note: If client refuses to sign AMA form, simply reflect that in the narrative charting and document the client's statement regarding why he or she is refusing to sign the form.

11 June 2009, 1423: Client has chosen to leave against medical advice. Is alert and oriented to person, place, and time, and is mentally clear. Dr. Jeffries notified; states client should not leave at this time due to the need for further testing, and must sign out against medical advice if she chooses to go. Client notified of Dr. Jeffries' instructions regarding the need for further testing. Client still states, "I am leaving, I just don't want to stay." Educated client about risks of leaving before further testing and evaluation are completed; client verbalized understanding and says "I will see my own doctor." Client refused to sign AMA form; states, "This makes no difference—I'm leaving whether I sign or not, and I don't need to sign it to leave anyway." No medications ordered by Dr. Jeffries. Leaving with spouse, states "I am going home but will call my doctor if I need him."
G. Nurse, RN

Photographing

At some point in your career, you may need to obtain written consent from a client to photograph him or her. There are situations in which the facility's media liaison will arrange consent, such as if pictures are being taken for marketing purposes. Other reasons for photography, however, are related to the care of the client and require the intervention of the nurse to secure consent. Some of the reasons to photograph a client in relation to care provided include:

- To record wound changes, such as pressure ulcer development or resolution of a surgical scar that is healing.
- To record abrasions, contusions, and lacerations of a rape, domestic abuse, or accident victim.
- To record evidence of suspected or actual child abuse.

In cases such as these, you will generally have to ask the client to sign a specific form that is facility-specific. These types of forms are often called "Consent to Photograph," or "Permission to Photograph." The form will provide the date, the name of individual to be photographed, the specific places on the body that will be photographed, and the purpose of the photography. In the case of a client who is a minor, the parent or legal guardian will be asked to sign. This form will also need to be witnessed by the nursing professional.

If the facility does not have a standard form, the nursing professional should reflect this same information in the record:

11 June 2009, 1423: Client notified of the need to photograph progression of healing of decubitus ulcer on her right heel. Verbal permission given to photograph. _____ *G Nurse, RN*

If your facility does not have a specific form for permission to photograph, *DocuNotes* recommends that you bring this issue to the attention of management. Written permission or consent to photograph signed by the client (or parent or legal guardian) is preferable to recording verbal permission in the chart.

Situations Involving Other Individuals

Other Health-Care Professionals

In every nursing professional's career, there will come a time when a difference of opinion about a situation needs to be documented. Often, these differences are experienced between physicians and nurses, although the possibility for these encounters to take place between any two or more members of the health-care team is possible.

In this situation, objectivity in documentation is key. You will need to accurately and appropriately reflect the discussion without letting your subjective view of the situation reflect itself in the documentation. See the following example, which reflects a heated conversation between a physician and nurse about getting paged and not giving orders for medication to relieve a client's headache.

11 June 2009, 1600: Paged Dr. Smith regarding client's headache _____ *G. Nurse, RN*

11 June 2009, 1615: Re-paged Dr. Smith regarding client's headache _____ *G. Nurse, RN*

11 June 2009, 1630: Re-paged Dr. Smith regarding client's headache _____ *G. Nurse, RN*

11 June 2009, 1635: Client still with headache. Dr. Smith has not returned pages. Nurse manager Jennifer Sammons notified, who re-paged Dr. Smith with a "STAT" page message. _____ *G. Nurse, RN*

11 June 2009, 1640: Dr. Smith returned page. Stated that he never received pages. Did not wish to give orders for medication for headache.

Referred to Nurse manager Jennifer Sammons who discussed client's condition with Dr. Smith. Orders received for Tylenol ES, 650 mg, po q 6 hours prn. _____ *G. Nurse, RN*

Notice that when you read the sample documentation, it does not allude to undue stress between the physician and nurse, although it does accurately reflect that the physician was paged and no calls back were received until the nurse manager paged him. It also demonstrates that a conversation took place during which the physician did not want to give any orders for medication, yet decided to do so after speaking with the nurse manager. Any nurse reading the documentation could likely surmise that there was a heated discussion in this event; however, the documentation is appropriate, objective, and professional. It does not point fingers at the physician for not calling back; it simply reflects that the pages went unanswered. It does not employ subjective opinions when the physician did not give an order for the medication, but rather addressed how that situation was handled.

Each nurse must be responsible for the objectivity and professionalism of his or her own documentation. It is imperative that we interact as professionals, even when colleagues present challenges that we must overcome. Your documentation is a representative example of you as a professional and should read as such.

Family of the Client

When documenting situations with a client's family, follow the same principles as you would when documenting situations with another health-care provider—objectivity and professionalism remain your guiding principles. See the following example in which a client's mother became insistent about giving medication to her son:

11 June 2009, 1816: Client's mother requested pain medication for client. Client is unable to have more pain medication for one more hour. Explained rationale for timing of pain medications to mother. Client states pain is 4 of 10 on 1–10 scale; no grimacing or guarding is noted. Repositioned client in bed, provided teaching on deep breathing exercises when experiencing pain. Client verbalized understanding. Mother insistent that client needs pain medication; reassured mother that medication will be given in 1 hour after assessment and dialogue with client. _____ *G. Nurse, RN*

The above documentation accurately and objectively records the events without subjectively berating the mother. Appropriate information is given about the assessment the nursing professional performed on the client, as well as the interventions given to make the client as comfortable as possible. Education given to the mother is recorded, demonstrating the nurse's attentiveness to the potential need for pain medication in another hour if the client assessment warrants it.

History of Presenting Illness

In order for the nursing professional to effectively plan care, gathering a thorough history of presenting illness (HPI) is essential. Understanding what brought the client to be seen is the basis for formulating all nursing interventions.

There are several venues for gathering an HPI. The most obvious, and often the most productive, involves getting this information directly from the client. It is important for the nurse, however, to assess whether the client is able to accurately give a history. Factors that can influence the accuracy of a client's HPI include dementia, delirium, confusion, immediate sense of pain, and differences in culture. If it is determined that the client cannot provide an accurate history, other potential sources include family members; extended care facility staff, if the client is a resident at a skilled nursing facility; and witnesses to an accident, if the client is brought in for such.

HPIs can be global in nature, covering several concerns that the client has, or can be focused—related on one chief complaint. For example, if a client comes in with multiple, generalized concerns such as flu-like symptoms, the nurse is going to explore many different aspects of how the client feels, how long he or she has been feeling this way, what has made the symptoms better or worse, and what associated concerns the client might have. These types of questions may be asked about all of the symptoms the client is experiencing. If the client states that he or she has a headache, nausea and vomiting, and a sore throat, the nurse may ask the same types of questions related to each problem.

If the client comes in with one primary concern, such as a sprained ankle, the nurse is going to focus on that particular area and perform a focused history. The questions that the nurse asks will be related strictly to the ankle itself, what the client was doing when the sprain occurred, and the symptoms experienced in that generalized area of the body.

Nurses also perform other types of assessments during the HPI. Spiritual, cultural, psychosocial, and educational assessments can provide important pieces of information for the nurse to use when planning care.

Spiritual assessments comprise learning what is important to the client and what gives his or her life meaning. Often, the response a client will give regarding spirituality will also include references to a preferred religion. It is

important for the nurse to recognize that clients can indeed be spiritual, and seek life's meaning, without following a religion.

Cultural assessments entail seeking information about how to support the client's culturally specific beliefs and practices. Sometimes, these will also include religious practices, but there are many different types of cultural implications beyond religious ones.

Psychosocial assessments include assessing how clients care for themselves, their living arrangements, family systems, important activities, and self-esteem.

Educational assessments include observing and questioning how a client learns best, and if there are specific learning barriers that need to be taken into consideration when the nurse teaches. Often, the most important information regarding a client's educational assessment will be based on the observation of the nurse rather than the questions asked of the client.

Special note for nurse practitioners: HPI, ROS, and past histories can be considered "unobtainable" if the client is unable to provide them and there are no family members or other reliable sources available to share information. Documentation can state "history unobtainable." This waives these criteria for billing purposes.

When collecting an HPI, the nurse should attempt to gain a thorough understanding of the client's chief complaint and presenting illness or injury by asking a series of questions about the following criteria:

- Timing
- Context
- Duration
- Status of chronic illness
- Location
- Severity
- Modifying factors
- Quality
- Associated signs and symptoms

Special note for nurse practitioners: The practitioner must document at least 4 elements in the HPI to bill for any of the following levels:

- 99204, 99214
- 99205, 99215

Examples of Questions to Ask

It is important to remember that all questions do not have to be asked if you are confident that a reasonable picture of that criterion has been achieved. For example, if the client tells you that his symptoms "come and go" (under the criterion of *timing*), it is not necessary to then ask if the symptoms are continuous.

Timing

- How often is this symptom occurring?
- Does it come and go?
- Does it seem continuous?
- Do you notice that it occurs at one time of day more often than another? Does it occur in the morning more so than in the evening, or visa versa? Does it only happen after a particular meal? Does it happen when you lie down to go to sleep?

Context

- Where were you when this happened?
- What were you doing when it started?
- How did this happen?

Note: There is a distinct difference between what the client was doing when it started and how something happened. The client might have been playing baseball, which reflects what he was doing when it started, but the problem happened when he slid into base and turned his ankle, which reflects how it happened.

Duration

- How long has this concern been going on? Has it been happening for hours, days, weeks, or months?
- When did this concern start?

Status of Chronic Illness

- Do you have any chronic problems or conditions? If the client answers "yes," ask how (or if) the problem is being managed. Example questions to determine how the problem is being managed include:
  - Is the chronic problem or condition well managed?
  - Are you seeing any other practitioners for management of this chronic illness or condition? **Note: Questions like these are**

particularly important when learning how many medications the client is on and who prescribed them.

- Have there been any developments in this illness or condition since the last visit? Has the condition become better or has it worsened? Have you undergone any procedures or surgeries for this condition?
- Are you on any new medications for this condition or concern?
- What current medications are you taking for this condition?
  - It is vitally important to take an accurate medication history in order to complete a medication reconciliation upon admission and discharge to the hospital.
  - Are you participating as a subject in a clinical trial for this condition or concern?

Special note for nurse practitioners: Each status of a chronic illness reviewed is considered an element reviewed for billing purposes.

Location

- Where specifically on or in the body is the pain/injury/concern? (If the client has an injury, have him or her point to the exact location of the condition. If the client is being seen for a general condition, such as flu-like symptoms, have him or her describe each part of the body that is affected by the generalized issue.)
- Does the problem radiate anywhere else? **Note: This is an important question to ask if the client has an injury; the affected area may be localized to one specific area, but pain or swelling may radiate to surrounding locations.**

Severity

- How bad is the pain or sensation on a 1 to 10 scale? **Note: Describe to the client that 1 should be the least amount of pain or sensation and 10 should be the worst amount of pain or sensation.**
- Is this the worst pain or sensation you have ever experienced? **Note: This is an important question, because the nurse can be alerted to potential life-threatening situations. If the client describes a headache as "the worst ever," the nurse should be alert for a possible aneurysm; the "worst chest pain ever" could indicate a myocardial infarction; the "worst back pain ever" could indicate a dissecting aortic aneurysm.**
- Is this the same or different from previous occurrences with this presenting symptom?
- Consider using the Wong scale for pediatrics (see Tools tab).

Modifying Factors

- What makes the presenting symptom better or worse?

Quality

- What does this symptom feel like? Is it sharp, dull, pulsating, piercing, prickling, or itchy? **Note: Include any descriptive word or phrase given by the client, such as "I just don't feel right."**

Associated Signs and Symptoms

- Do you have any other concerns at this time?
  - If a client has nausea, he or she may also have vomiting or diarrhea.
  - If a client has pain in an affected extremity, he or she may also have swelling.

Special note for nurse practitioners: Each status reviewed is considered an element reviewed for billing purposes.

Review of Systems

A review of systems (ROS) allows the nurse to learn if there are any concerns other than what has brought the client to seek medical care. This also allows the client time to reflect on any other issues that he or she needs to discuss with the nurse or provider.

The ROS can be collected in the same way as the HPI. When obtaining an ROS, the nurse should attempt to gain a thorough understanding of the client's health condition by asking a series of questions about the following organ systems:

- Constitutional.
- Eyes.
- Ears, nose, mouth, throat (ENMT).
- Cardiovascular.
- Respiratory.
- Gastrointestinal.
- Genitourinary.
- Allergic/Immunological.
- Hematological/Lymphatic.
- Integumentary.
- Musculoskeletal.

- Endocrine.
- Psychiatric.
- Neurological.

Special note for nurse practitioners: The practitioner must document at least 10 elements in the ROS to bill for any of the following levels:

- 99205, 99215

Note: The phrase "all other systems negative" can be used after reviewing and documenting on two organ systems. This serves to summarize the fact that the practitioner has indeed reviewed all 14 systems with the client and found that any systems not specifically mentioned in documentation are negative.

Examples of Questions to Ask

It is important to use appropriate judgment in asking the following questions. If the client has answered a question during the HPI questioning, it does not need to be asked again. Therefore, the list of questions included in this section is to serve as a guide.

Constitutional

- Have you had any fevers?
- Have you had any chills?

Eyes

- Are you experiencing eye drainage?
- Are you experiencing eye itching?
- Are you experiencing eye redness?
- Have you had recent changes in vision?
- Have you recently begun or stopped wearing contacts or eyeglasses?
- Have you had any changes in contact or eyeglass prescriptions lately?

ENMT

- Have you had changes in taste?
- Have you had changes in smell?
- Have you had changes in hearing?
- Have you had any dental changes, such as tooth pain or removal?
- Do you have a sore throat?

- Do you have nasal congestion?
- Do you have ear pain?
- Do you have ear drainage?

Cardiovascular

- Do you have any chest pain?
- Do you have any sensations of burning in your chest?
- Do you have any fluttering sensations in your chest, or a sense of palpitations?
- Have you experienced edema in the extremities?

Respiratory

- Are you experiencing shortness of breath?
- Are you experiencing difficulty breathing?
- Do you have congestion in your chest?

Gastrointestinal

- Have you had any change in stool habits?
- Do you have abdominal pain?
- Do you have abdominal swelling or bloating?
- Have you experienced an unusual amount of gas?

Genitourinary

- Have you had any change in urinary habits?
- Do you experience pain or discomfort upon urination?
- Have you had any changes in your libido or performance?
- If the client is male: Have you experienced penile discharge? If the client is female: Have you experienced vaginal discharge?
- If the client is female: When was your last menstrual period?

Allergic/Immunological

- Have you experienced an allergic response to food, pollen, or chemicals?
- Are you aware of anything that would make you immunocompromised, including corticosteroid usage, positive HIV status, or recent cancer treatment?

Hematological/Lymphatic

- Have you noticed blood in your stool, urine, gums, or elsewhere?
- Do you bruise very easily?
- Do you experience swollen glands?

Integumentary

- Have you had recent skin changes?
- Is your skin excessively dry or moist?
- Have you experienced any type of rash recently?
- Have you noticed new moles or changes in moles recently?
- Are you experiencing unusual itching?

Musculoskeletal

- Have you had changes in your ability to move or walk?
- Are you experiencing pain in any of your joints or muscles?
- Are you able to move as freely as you'd like? Is your range of motion compromised?
- Do any of your joints make noise when you move them? Do your joints pop, squeak, or grate?
- Do you feel weakness in your muscles?

Endocrine

- Have you experienced excessive thirst?
- Have you experienced excessive urination?
- Do you find that you cannot tolerate excessive heat or cold?

Psychiatric

- Have you felt depressed recently?
- Have you felt anxious or nervous recently?
- Have you experienced feelings of paranoia or disturbing thoughts recently?
- Do you have difficulty sleeping or find yourself sleeping all of the time?
- Do you have difficulty managing food, such as binging and purging or not eating?

Neurological

- Do you ever have difficulty remembering where you are or why you are there?
- Have you lost consciousness or passed out recently?
- Do you experience dizziness or lightheadedness?
- Have you had weakness in your arms or legs?
- Have you had numbness or tingling in your arms or legs?

Spiritual Assessment

It is often helpful to preface this conversation by stating that you are interested in learning more about the client's spiritual or religious belief system as it relates to health-care needs.

- What types of things do you enjoy doing?
- What gives your life meaning?
- Who do you talk to when you seek guidance in your life?
- What helps you stay focused during difficult times?
- What do you hope for in life?
- Is there a spiritual practice that is important to you?
- Is there a religious practice that is important to you?
- As we plan your care, how does your faith have an impact on your health-care decisions?
- As we plan your care, is there something I can do to assist you in observing your spiritual or religious beliefs?

Cultural Assessment

It is often helpful to preface this conversation by stating that you are interested in learning more about the client's cultural background as it relates to health-care needs.

- What is your definition of health?
- What do you do to stay healthy?
- What kinds of foods do you like to eat?
- How are these foods prepared?
- When do you prefer to eat your meals?
- Do you celebrate special days of the year?
- If you celebrate special days of the year, do you celebrate with certain kinds of foods?
- Who cares for others in the family who are ill?
- When someone in the family is ill, who is sought for help?
- How does a person decide that he or she needs a doctor?
- How do you prefer to express emotion?
- What does the word *care* mean to you?
- How can I most effectively care for you?
- How do you prefer to communicate?
- How do you perceive the aging process?
- Are there cultural practices I can help you observe?

Psychosocial Assessment

It is often helpful to preface this conversation by stating that you are interested in learning more about the client's psychosocial background as it relates to health-care needs.

The "SELF" acronym can be helpful in conducting a basic psychosocial assessment.

- **S**elf-esteem: This includes observations on grooming, hygiene, how the client makes eye contact with the nurse, statements the client makes about himself or herself, and any other pertinent information that indicates the client's level of self-esteem.
- **E**nergy:
  - What activities are you interested in?
  - Do you find that you have enough time to devote to your favorite activities?
  - Do you have the enthusiasm about your favorite activities that you used to have?
- **L**ifestyle:
  - What type of place do you live in? Do you live in a house, condominium, or apartment?
  - Who lives with you?
  - Who are your most significant relationships with?
  - What do you do for a living?
  - What types of hobbies do you have?
  - What is your educational background?
- **F**amily System:
  - Who would you consider to be part of your support system?
  - What kinds of stress do you face as a family?
  - Have you had any crises recently?
  - How do you usually cope with stress?

Synthesizing the Information

In this section, examples have been included to demonstrate how to effectively document HPIs and ROSs. There is a short case study demonstrating a verbal exchange between the nurse and the client, and example documentation follows, showing how the nurse would appropriately reflect the information gathered during that conversation. This particular case study focuses on **physiological**, **psychosocial**, and **spiritual** concerns.

Case Study

Client: Jane Evans
Nurse: S. Cortez, RN

Jane Evans has just been brought to the emergency department at her local hospital via squad. She was walking in her neighborhood when she began experiencing chest pain and shortness of breath. A neighbor called 911 when he saw Jane slowly sit down in his yard and grip her chest. The emergency medical technicians brought Jane to the hospital. She has been admitted to the telemetry unit at the hospital, and the nurse has just informed Jane that they will be talking together for the next few moments regarding admission questions. Jane tells the nurse that this is a good time to talk, and she will be happy to answer the nurse's questions.

Nurse: "Good morning, Mrs. Evans. I understand from the emergency medical technicians that you were having chest pain today."
Client: "Yes, I was."
Nurse: "Can you tell me what you were doing when it started?"
Client: "Well, I went out for my morning walk at around 7 a.m., like I always do. I got about halfway around my neighborhood and my chest just started hurting something fierce. I had to sit down for a minute to try to catch my breath, because it was hard to breathe. I thought it was my asthma acting up."
Nurse: "Do you have a history of asthma?"
Client: "Yes, I have had it 3 years. I always carry an inhaler, so I pulled it out of my pocket when I sat down in the neighbor's yard, and took a couple of puffs thinking it would help."
Nurse: "Did it seem to help any?"
Client: "A little, but not as much as I thought it would. I am surprised it didn't help more. It's been fairly easy to control for the past 3 years."
Nurse: "Have you been taking anything besides your inhaler for the asthma?"
Client: "Yes, I take Singulair once a day. It's the pink one—10 milligrams."
Nurse: "Are you still feeling short of breath at this time?"
Client: "Yes, a little bit."

Nurse: "And how is your chest pain? On a scale of 1 to 10, with 10 being the worst, how would you rate your pain at this time?"
Client: "Well, it was a 10 when I was out this morning. Now, it's about a 6."
Nurse: "Can you tell me where specifically that you are experiencing the pain?"
Client: "Well, it's been coming and going since this morning, about every 30 minutes, so it's kind of hard to pinpoint. But most of the time, it seems like it's right in the middle of my chest."
Nurse: "How would you describe the chest pain? Is it sharp, dull, stabbing, or constant?"
Client: "Oh, it's sharp—no doubt about it. When it hits, it almost takes my breath away again."
Nurse: "I see. Do you feel nauseated, or have you vomited, when this happens?"
Client: "No vomiting, but I do feel quite nauseated."
Nurse: "Have you had any fever or chills today?"
Client: "No."
Nurse: "How about any weakness?"
Client: "Definitely. My arms and legs are just like jelly. In fact, I feel pretty weak all over."
Nurse: "Have you had any changes in vision during the episodes of chest pain, or recently?"
Client: "No."
Nurse: Have you recently experienced any ear pain, sore throat, or congestion today?"
Client: "No."
Nurse: "Have you had any recent changes in your bowel or bladder habits?"
Client: "No."
Nurse: "Do you have any food allergies, or have you been exposed to anything that you know you are allergic to?"
Client: "No."
Nurse: "Have you noticed any skin changes, such as excessive dryness or sweating or rashes recently?"
Client: "No."
Nurse: "Have you had any type of intolerance to heat or cold recently?"
Client: "No."

Nurse: "Have you had any difficulty remembering things lately, like where you are or what time it is?"
Client: "No."
Nurse: "Have you had any weakness or numbness in your arms or legs lately?"
Client: "Only the weakness I feel today. Nothing before that."
Nurse: "Have you had any type of anxiety or depression recently?"
Client: "Only because I'm nervous about what this chest pain means today. I've never been too anxious before that."
Nurse: "I understand. You mentioned earlier that you are on Singulair and your inhaler. Do you take any other medications?"
Client: "No—that's it. I'm fairly healthy, other than the fact that I don't feel right today."
Nurse: "That's good to hear. Do you feel that you are able to cook for yourself and eat a variety of foods at home?"
Client: "Oh yes, I love to cook. I make three good meals a day, and often cook for my children and grandchildren."
Nurse: "Does your family live with you?"
Client: "No, it's just me and my husband. My children and grandchildren come to visit quite often, though, because they live in town."
Nurse: "It sounds like you are close to them."
Client: "Oh, I am. They are the center of my world."
Nurse: "It is good to have a support system. What other things sustain you during difficult times?"
Client: "I have a church family that I love dearly. We get together quiet often to go eat. My minister is a close friend, and I know I can turn to him also."
Nurse: "Does your spiritual belief system influence the way you look at your health?"
Client: "Most definitely. I really believe that what is meant to happen will happen, and I'm okay with that."
Nurse: "Is there anything I can do to provide care for you that will help you observe your spiritual beliefs?"
Client: "Not that I can think of, other than if you'd like to ask the hospital chaplain to stop by."
Nurse: "I'd be happy to do that."

HPI Documentation Example

11 June 2009, 1330: Client states that she has had chest pain and shortness of breath that started this morning around 7 AM and persisted until now. She was taking a walk in her neighborhood when it began. She tried using her asthma inhaler, which helped somewhat with the shortness of breath, but she still "doesn't feel right" and is "anxious about what this chest pain means." She also states that she has now developed some sharp pains in her central chest that "come and go" every 30 minutes or so. Additionally, she is now feeling nauseated. She says her chest pain is a 6 on a 1–10 scale now, although it was a 10 when she first experienced it this morning. Her asthma has been stable over the past 3 years while she has used her inhaler and Singulair. States she lives with her husband and enjoys cooking. Children and grandchildren live nearby. Attends church regularly and enjoys outings with church friends. Requests visits from hospital chaplain _____ *S. Cortez, RN*

ROS Documentation Example

11 June 2009, 1330: Client admits to chest pain, shortness of breath, and nausea. She has no fever or chills but says her arms and legs feel weak all over. All other systems negative. _____ *S. Cortez, RN*

Templates for Specific Conditions

The following templates can be very helpful in assisting the nursing professional to document specific physiological conditions more thoroughly. They are not a substitute for a documentation of a complete history of presenting illness, but rather should be used to remind the nursing professional of components that would likely need to be documented for these specific conditions.

The nurse will need to complete the information highlighted in blue (within the templates) with specific information from the client that is being assessed.

Abdominal Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (mild, severe, crushing, pressure-like, burning, sharp, shooting . . . **describe pain**) (abdominal, right, left, upper, epigastric, flank) pain for approximately (number of . . . minutes, hours, days) prior to arrival. The pain (radiates, does not radiate) to (location). There has been (no, mild, some) nausea, (no, some, number of episodes) vomiting, (no, mild, moderate) diarrhea, (no, low-grade) fever, and (no, mild, severe) loss of appetite. There (is, is not) evidence of GI bleed. _____ *S. Cortez, RN*

Allergic Reaction

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (rash, pain, difficulty breathing, itching) to (right, left, arm, chest, leg) after suspected exposure to (unknown allergen, insect, foot item, beverage, cosmetic preparation, seafood) approximately (number of . . . minutes, hours, days) prior to arrival. There (is, is not) difficulty swallowing. There (is, is not) difficulty breathing. _____ *S. Cortez, RN*

Back Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complains of (lower, upper, middle, lumbar, thoracic) back pain approximately (number of . . . minutes, hours, days) prior to arrival. The pain (radiates, does not radiate) to (location). There has been (no, right, left, arms, legs, toes . . . .) tingling, (no, right, left, leg, fingers, toes . . .) numbness, (no, right, left, leg, arm) weakness. There (is, is not) evidence of a gastrointestinal bleed. _____ *S. Cortez, RN*

Blood Pressure, Elevated

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of high blood pressure approximately (number of . . . minutes, hours, days, months). A blood pressure test (was, was not) taken prior to arrival. The reading was (note done, number/number, elevated). There has been

(no, some, left-sided, left arm) weakness and (no, some) dizziness. There has been (no, low-grade, mild) fever and (no, mild, severe) shortness of breath. There has been (no, some) palpitations associated with (pain, high blood pressure, chest pain, shortness of breath). There has been (no, mild, severe, pleuritic) chest pain. The client has (no history of, history of) hypertension and is currently taking (no, list medications) hypertensive medications. _____ *S. Cortez, RN*

Chest Congestion

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of symptoms of URI for approximately (number of . . . minutes, hours, days) prior to arrival. There has been (no, low-grade) fever, (some, no) nasal discharge, (nonproductive, productive, no) cough, (no , some, mild) congestion, (no, mild) earache, (no, mild, moderate) sore throat, and (no, some, mild) malaise._____ *S. Cortez, RN*

Chest Wall Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (mild, severe, sharp, shooting, crushing, pressure-like, pleuritic . . . **describe pain**) (chest wall, right-sided, substernal) pain. The client (DOES, DOES NOT) have the pain now. There has been (a single, multiple, number of, mild, several) episode(s) over the past (minutes, days, hours, weeks, months) with only last episode beginning (minutes, hours, days) ago. The episodes lasted for (number of . . . minutes, hours). The onset was (sudden, gradual). There has been (no, some) radiation to (location). There has been (no, some, mild, severe) dyspnea and (no, mild, some, moderate) diaphoresis. There has been (no, some) palpitations associated with (pain, high blood pressure, shortness of breath). _____ *S. Cortez, RN*

Cough

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of a (describe type: productive, nonproductive, dry, moist) cough for (number of . . . minutes, hours, days). There has been (no, low-grade) fever, (no, some) nasal discharge, (no, some, number of episodes)

vomiting. There has been (no, some, severe) shortness of breath. _____ *S. Cortez, RN*

Diarrhea

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (mild, some, number of episodes) of (diarrhea, vomiting) for approximately (number of . . . hours, days) prior to arrival. There has been (some, no) nausea. There has been (no, steady, persistent, crampy, diffuse, mild, moderate . . . **kind of pain**) (abdominal, right, lower, flank, quadrant) pain and (no, low-grade) fever. _____ *S. Cortez, RN*

Ear Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (bilateral, right, left) ear pain for approximately (number of . . . minutes, hours, days) prior to arrival. There has been (no, low-grade) fever, (no, moderate) ear discharge, (no, mild, severe) sore throat, (no, mild, moderate) cough, (no, some, number of episodes) vomiting. _____ *S. Cortez, RN*

Esophageal Burning or Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (burning, mild, severe, crushing, pressure-like, sharp, shooting . . . **describe pain**) (location . . . epigastric, abdominal, right, lower, quadrant) pain for approximately (number of . . . minutes, hours, days) prior to arrival. There has been (no, some) radiation to (location). There has been (no, mild, some) nausea, (no, some, number of episodes) vomiting, (no, mild, moderate) diarrhea, (no, mild, low-grade) fever, and (no, mild, severe) loss of appetite. _____ *S. Cortez, RN*

Eye Discharge

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (mild, no, moderate) pain/burning, (mild, no, some) redness and (mild, no, some) discharge in (both, right, left) eye(s) for approximately (number of . . . minutes, hours, days) prior to arrival. There has been

(no, some, mild) tearing, (no, some, mild) photophobia and (no, low-grade) fever. There has been (no, sudden, gradual) loss of vision associated with (no, some, number of episodes) vomiting, and (no, mild, severe) headache. There (is, is not) injury to eyes or foreign body in the eyes. _____ *S. Cortez, RN*

Gynecological Concern

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (specific gynecological concern, e.g., spotting, bleeding profusely, amenorrhea) approximately (number of hours, days, weeks). Client (denies, claims) she has experienced the same symptoms in the past. There has been (no, mild, severe) nausea, (no, some, number of episodes) vomiting, and (no, low-grade) fever. Client (is, is not) sexually active and states there (is, is not) a chance she might be pregnant. Last menstrual period was (date) and lasted (how many) days. _____ *S. Cortez, RN*

Headache

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (throbbing, mild, crushing, dull, pressure-like . . . **describe pain**) (frontal, parietal, occipital, and/or temporal) headache for approximately (number of . . . minutes, hours) prior to arrival. Client (denies, claims) it is the worst headache he has ever had. There has been (no, mild, severe) nausea, (no, some, number of episodes) vomiting, (no, some) blurred vision, (no, mild) photophobia, (no, some) numbness/tingling, and (no, low-grade) fever. Client (has, does not have) migraine history _____ *S. Cortez, RN*

Hives

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (red, pruritic, urticarial, erythematous, severe) rash on the (location) onset approximately (number of . . . minutes, hours, days) prior to arrival. There (is, is not) difficulty swallowing. There (is, is not) difficulty breathing. There (is, is not) a history of this. The client (denies, admits)

exposure. The client was exposed to (unknown, poison ivy, sumac, cosmetics). _____ *S. Cortez, RN*

Joint Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex). Client complains of (sharp, mild, severe, crushing, dull, pressure-like . . . **describe pain**) (right, left, shoulder, knee, hip) pain for approximately (number of . . . minutes, hours, days) prior to arrival. There has been (no, work-related, sporting, blunt, crushing, flexion) injury to (location). _____ *S. Cortez, RN*

Kidney Pain

11 June 2009, 1330: Client is a (age) year old (race) (sex) with complaint of (mild, right, left . . . **describe pain**) (location . . . flank, testicle, groin, abdominal, right, lower) pain for (number of . . . hours, days) prior to arrival. There has (no, mild, moderate) hematuria, (no, mild, severe) dysuria, (no, mild, moderate) nausea, (no, some, number of episodes) vomiting, (no, some) frequency, (no, mild) urgency, and (no, mild, low-grade) fever. There has been (no, severe, right, upper, crampy, epigastric, quadrant) abdominal pain and (no, mild) diarrhea. _____ *S. Cortez, RN*

Nasal Drainage and Congestion

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of a (clear, yellow, mucous) nasal discharge for approximately (number of . . . minutes, hours, days). There has been (no, low-grade) fever, (no, mild) sore throat, (no, mild) earache, (no, mild) cough, and (no, some, number of episodes) vomiting. _____ *S. Cortez, RN*

Nausea and Vomiting

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (no, mild, moderate) nausea and (no, some, number of episodes) vomiting for approximately (number of . . . hours, days) prior to arrival. There has been (some, no, number of episodes) diarrhea. There has

been (no, crampy, diffuse, mild) (abdominal, right, left, lower, flank, quadrant) pain and (no, low-grade) fever. There (is, is not) evidence of GI bleed. _____ *S. Cortez, RN*

Neck Pain, Post Accident

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (injury, falling, twisting) to the neck approximately (number of . . . hours, days) prior to arrival. There (has, has not) been (injury, direct blow, blunt trauma, twisting) to the head. There (was, was not) loss of consciousness. There has been (no, some) dizziness, (no, some) nausea, (no, some) vomiting, and (no, some, severe) blurred vision. There has also been (no, some, severe) confusion and (no, mild, severe) seizure activity after the accident. _____ *S. Cortez, RN*

Penile Discharge

11 June 2009, 1330: Client is a (age) year-old (race) male with complaint of (some, mild, green, yellow) penile discharge for approximately (number of . . . hours, days, weeks) prior to arrival. There has been (no, mild, severe) dysuria. There has been (no, mild, severe) hematuria, (no, some) frequency, (no, mild, severe) urgency, and (no, mild, low-grade) fever. There (has been, has not been) flank pain. _____ *S. Cortez, RN*

Rash

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of (red, vesicular, pink, itching, scaly, mild, linear, macular) rash on the (location). Onset approximately (number of . . . minutes, hours, days) prior to arrival. There has been (no, low-grade) fever. The client has (no, some) difficulty breathing. The client has (no, some) difficulty swallowing. The client (denies, admits) exposure. The client was exposed to: (bee sting, beverage, food, chemicals, poison ivy, soap, cosmetic preparation). _____ *S. Cortez, RN*

Sinus Pressure

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of sinus pressure and nasal discharge for (number of . . . minutes, hours, days). There has been (no, low-grade) fever, (no, mild) sore throat, (no, mild) earache, (no, mild) cough, and (some, number of episodes) vomiting. _____ *S. Cortez, RN*

Sore Throat

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of a sore throat for (number of . . . minutes hours, days). There has been (no, low-grade) fever, (no, mild, left, right) earache, (some, no) nasal discharge, (no, mild) cough, and (no, some, number of episodes) vomiting. There has been (no, some, mild, moderate) difficulty swallowing and (no, some, mild, moderate) difficulty breathing. There (is, is not) a rash. There (is, is not) arthralgia. Client (denies, admits) exposure to strep throat. _____ *S. Cortez, RN*

Twisted Ankle

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of falling off a curb (number of . . . minutes, hours, days) ago and hurting his (left or right) ankle. There has been (no, low-grade) fever. (No, mild, left right) swelling, (some, no) pain. There (is, is not) any redness. Client (has, has not) been able to weight-bear since the injury. _____ _____ *S. Cortez, RN*

Urinary Pain

11 June 2009, 1330: Client is a (age) year-old (race) (sex) with complaint of dysuria for (number of . . . hours, days) prior to arrival. There has been (no, some, mild, severe) hematuria, (no, some) frequency, (no, mild) urgency, (no, mild, low-grade) fever. There has been (no, some) flank pain. There has been (no, severe, right, upper quadrant) abdominal pain, (no, mild, severe) nausea, (no, some, number of episodes) vomiting, and (no, mild) diarrhea. _____ *S. Cortez, RN*

Past History Overview

Taking a past history can be just as important as gathering information about the history of presenting illness (HPI) and the review of systems (ROS). The results can lend insight into:

- Conditions the client has had in the past.
- Pertinent medication allergies or adverse effects.
- Client's social practices.
- Family history of interest.

Components of the past history section include past medical history (PMH), past surgical history (PSxH), social history (SH), and family history (FH). You will often see this noted as PMSFH, with the past medical history section encompassing both medical and surgical data.

Just as with the HPI and ROS, the questions posed here are to be used at the discretion of the nurse, based on information that has been gathered in other sections.

Special note for nurse practitioners: HPI, ROS, and past histories can be considered UNOBTAINABLE if the client is unable to provide them and there are no family members or other reliable sources available to share information. Documentation can state "history unobtainable." This waives these criteria for billing purposes.

The nurse practitioner must address at least two of three main pertinent histories (past medical/surgical, past social, past family) in order to bill for any of the following levels:

- 99204, 99214
- 99205, 99215

Past Medical History

A past medical history (PMH) comprises illnesses, surgeries, and medical concerns that the client has experienced in the past. Some clients will have extensive past medical histories, while others will be virtually nonexistent. This is largely dependent on the client's age, state of health, and willingness to seek out health care. When gathering this information, the nurse will be assessing whether the information provided could be

connected to the HPI, whether it is of significance for follow-up, or if it could be indicative of health concerns that are currently developing.

Examples of very common past medical histories include:

- Hypertension.
- High cholesterol.
- Myocardial infarction.
- Stroke.
- Thyroid concerns.
- Diabetes.
- Hospitalizations (other than surgery).

Examples of Questions to Ask

- Have you had any recent health concerns? If so:
  - What kind of health concern?
  - When did this occur?
  - Did you seek medical care?
  - What type of treatment did you receive?
- Have you had any recent injuries? If so:
  - What kind of injury?
  - When did this occur?
  - Did you seek medical care?
  - What type of treatment did you receive?
- Have you had any types of surgeries? If so:
  - What kind of surgery?
  - When did this occur?
  - How would you describe your recovery?
- What types of illnesses have you had in the past, excluding normal viruses and common colds? When did you have these?
- What types of medications are you currently taking? (Record as much of the following about each medication as possible.)
  - Name of medication.
  - Dosage of medication.
  - Frequency of dose of medication.
  - When medication was prescribed.
  - Name of prescribing provider.

- What types of supplements are you taking? For example, are you taking vitamins, minerals, or herbal supplements? (Record as much of the following about each medication as possible.)
  - Name of supplement.
  - Dosage of supplement.
  - Frequency that the client takes the supplement.
  - Reason for taking the supplement, if known.
- Do you have any allergies to medications? If so:
  - What type of medication are you allergic to?
  - What type of reaction do you experience when you take this medication?
- Do you have any allergies to foods? If so:
  - What type of foods are you allergic to?
  - What type of reaction do you experience when you eat this food?
- Do you have any allergies to inhalants such as pollens? If so:
  - What type of inhalant are you allergic to?
  - What type of reaction do you experience when you are exposed to this inhalant?
- Do you have any allergies to chemicals? If so:
  - What type of chemical are you allergic to?
  - What type of reaction do you experience when you are exposed to this chemical?
- Are your immunizations up to date? If not:
  - Which immunization(s) have you had?
  - Which immunization(s) have you not had?
  - What dates did you have your last immunizations?

Note: For the most updated information regarding pediatric and adult immunizations, visit http://www.cdc.gov/vaccines/recs/schedules/default.htm

Examples of Past Medical History Documentation

In this section, examples have been included to demonstrate how to effectively document PMHs in addition to the chief complaint (CC) and HPI. There is a short case study demonstrating a verbal exchange between the nurse and the client, and example documentation follows, showing how the nurse would appropriately reflect the information gathered during that conversation.

Case Study 1

Client: Kelly Brown, 19 years old
Nurse: J. Scully, RN
Kelly Brown has come to the physician's office to be seen.
Nurse: "Good afternoon—what brings you in today, Kelly?"
Client: "I feel awful. I'm all stuffed up, my ear hurts, and I'm burning up. I took my temperature last night and it says 101. I missed school today."
Nurse: "I'm sorry to hear that. Which ear is hurting?"
Client: "The right one."
Nurse: "On a scale of 1 to 10, with 10 being the worst, how bad is it hurting?"
Client: "About 7. Last night it wasn't this bad. I took some Tylenol this morning but it hasn't seemed to help."
Nurse: "I understand. Have you been around anyone else who is sick, or who has strep throat?"
Client: "Not that I know of."
Nurse: "Have you had any kind of past illnesses, other than normal colds or viruses, that we should know about before you are treated?"
Client: "No, I've always been healthy."

11 June 2009, 1715:

CC: Nasal congestion, R ear pain, fever.
HPI: Nasal congestion x 3 days, consistent sharp pain in R ear (pain scale 7 on 1–10 scale with 10 being worst) and fever of 101 since last night, Tylenol not helping. Missed college classes today. Denies exposure to anyone with strep throat or other known illness.
PMH: Denies any past history other than normal colds and viruses.
_____ *J. Scully, RN*

Case Study 2

Client: Jessica Carmen, 40 years old
Nurse: J. Scully, RN
Jessica Carmen has come to the emergency room with migraine headaches that are occurring regularly over the past few months.

Nurse: "Good morning, Miss Carmen. I understand you are having migraine headaches."

Client: "Every day for the past few months, it seems I keep getting these headaches."

Nurse: "I'm sorry to hear that. Have you had headaches before the past few months?"

Client: "Oh yes, I've had tension headaches since I was a teenager, but I've never had them this badly or this often."

Nurse: "On a scale of 1 to 10, with 10 being the worst, how bad is it hurting?"

Client: "About 8. Last night, it wasn't this bad. I took some Tylenol this morning, but it hasn't seemed to help. Usually I take Excedrin and it works, but it didn't work after I took it this afternoon."

Nurse: "I understand. Have you ever tried anything else that made the headache better?"

Client: "Usually I just go to bed and turn out the lights. But I can't do that during the day, because I have to work. I had to leave work in the library this afternoon because it got so bad, and my boss is getting tired of me having to go home so often due to these headaches."

Nurse: "Are you having any other symptoms other than the head pain?"

Client: "They make me nauseated and then I throw up. I keep seeing a rainbow out of my eyes, too."

Nurse: "You said you've had the migraines since you were a teenager. Have you had any additional kinds of past illnesses, other than normal colds or viruses, that we should know about before you are treated?"

Client: "I fell down the stairs and broke my ankle in 2000, but after the cast came off, it hasn't given me any more trouble. Other than that, I can't think of anything else other than normal colds."

11 June 2009, 1715:

CC: Migraine headaches almost daily for 3 months.

HPI: Has had a migraine almost every day for the past 3 months. States has had migraines in the past, but not this often or this intensely. Has taken Tylenol without relief; sometimes Excedrin helps. Generally she just goes to bed and turns out all the lights, but this is starting to interfere with her part-time job schedule as a librarian. Headaches always associated with nausea; occasionally she has vomited as well.

Describes "rainbow" aura in vision field during migraines. Current headache is an 8 on a 1–10 scale.

PMH: Has history of "tension headaches" since she was a teenager. Had a broken ankle in 2000 that was casted and healed; client states no further complications _____ *J. Scully, RN*

Case Study 3

Client: Joseph Michaels, 60 years old

Nurse: J. Scully, RN

Joseph Michaels has come to the emergency room with shortness of breath.

Nurse: "Good afternoon, Mr. Michaels. I understand you are somewhat short of breath."

Client: "Yes, and my chest is tight, too. I feel like I can't take a breath."

Nurse: "I'm sorry to hear that. Were you doing anything when the shortness of breath began?"

Client: "No. I've had this happen once before when I was working out in the gym, but over the past 3 weeks, I've started to feel it more and more, no matter where I am or what I'm doing."

Nurse: "Do you notice a pattern to when this shortness of breath occurs?"

Client: "Seems like I get it once a week for about an hour each time. It's always during the day. Never when I sleep."

Nurse: "Has this interfered with your daily activities?"

Client: "Well, of course. I just don't want to do anything before I'm afraid it will be hard to take a breath."

Nurse: "I understand. Have you had any kinds of past illnesses, other than normal colds or viruses, that we should know about before you are treated?"

Client: "Yes. My doctor said I had something called 'pre-hypertension' back in 1999. I'm also a type II diabetic."

Nurse: "Were you diagnosed with diabetes?"

Client: "In 2005, but I don't take any medication for it. I just eat right and try to exercise and it seems like my blood sugars are good."

Nurse: "That's good to hear. Do you take anything for the pre-hypertension?"

Client: "Yes, one pill a day of something called hydrochlorothiazide. It's 25 milligrams, and I take it in the morning."

11 June 2009, 1715:

CC: Shortness of breath.
HPI: Hard time taking a breath—"tight" chest. States that it feels as if "I can't take a deep breath." Felt this before when working out in the gym, but now feels it "more" over the last 3 weeks, even if not in gym. Reports one episode (of approx. 1 hour) per week over the past 3 weeks but hasn't noticed anything at night. States "I just don't want to do anything" because he is afraid it will be "hard to take a breath."
PMH: Has history of pre-hypertension since 1999; controlled with hydrochlorothiazide, 25 mg daily in the morning. Has type II diabetes, diagnosed in 2005, controlled with diet and exercise. _____ *J. Scully, RN*

Past Surgical History

The past surgical history (PSxH) is a natural progression from the PMH. This section allows the nurse to gather pertinent data about a client's surgical experiences. Common past surgical procedures include:

- Knee replacement.
- Hip replacement.
- Appendectomy.
- Cesarean section (C-section).
- Hysterectomy.
- Vasectomy.

Examples of Questions to Ask

- What kinds of surgeries have you undergone? For each surgery:
  - What kind of health concern prompted this surgery?
  - When did this occur?
  - Who performed your surgery?
  - Did you have any surgical complications?
  - What type of recovery did you have?
  - Did you need to take pain medication during your recovery? If so:
    - What kind of pain medication?
    - What dosage?
    - How long did you have to take it?

Examples of Past Surgical History Documentation*

***Refer to Case Study 1 for sample dialogue. Include the following:**

Nurse: "Have you undergone any surgeries in the past?"
Client: "No, thank goodness."

11 June 2009, 1715:

CC: Nasal congestion, R ear pain, fever.
HPI: Nasal congestion x 3 days, consistent sharp pain in R ear (pain scale 7 on 1–10 scale with 10 being worst) and fever of 101 since last night, Tylenol not helping. Missed college classes today. Denies exposure to anyone with strep throat or other known illness.
PMH: Denies any past history other than normal colds and viruses.
PSxH: Client denies having had any surgeries. _____ *J. Scully, RN*

***Refer to Case Study 2 for sample dialogue. Include the following:**

Nurse: "Have you undergone any surgeries in the past?"
Client: "I had a C-section in 2000, but that's it."
Nurse: "Did you have any complications from this surgery?"
Client: "No, everything went fine."

11 June 2009, 1715:

CC: Migraine headaches almost daily for 3 months.
HPI: Has had a migraine almost every day for the past 3 months. States has had migraines in the past, but not this often or this intensely. Has taken Tylenol without relief; sometimes Excedrin helps. Generally she just goes to bed and turns out all the lights, but this is starting to interfere with her part-time job schedule as a librarian. Headaches always associated with nausea; occasionally she has vomited as well. Describes "rainbow" aura in vision field during migraines. Current headache is an 8 on a 1–10 scale.
PMH: Has history of "tension headaches" since she was a teenager. Had a broken ankle in 2000 that was casted and healed; client states no further complications.
PSxH: Had C-Section performed in 2000; client denies having experienced any complications. _____ *J. Scully, RN*

***Refer to Case Study 3 for sample dialogue. Include the following:**

Nurse: "Have you undergone any surgeries in the past?"
Client: "Oh yes. I had a bunion fixed in 1989, my carotid fixed in 1993, an abdominal aneurysm repaired in 2004, and then my stitches blew apart and they had to go back in and sew me up again."
Nurse: "Other than the stitches needing to be repaired, did you have any complications from your other surgeries?"
Client: "No, everything was okay other than that."

11 June 2009, 1715:

CC: Shortness of breath.
HPI: Hard time taking a breath—"tight" chest. States that it feels as if "I can't take a deep breath." Felt this before when working out in the gym, but now feels it "more" over the last 3 weeks, even if not in gym. Reports one episode (of approx. 1 hour) per week over the past 3 weeks but hasn't noticed anything at night. States "I just don't want to do anything" because he is afraid it will be "hard to take a breath."
PMH: Has history of pre-hypertension since 1999; controlled with hydrochlorothiazide, 25 mg daily in the morning. Has type II diabetes, diagnosed in 2005, controlled with diet and exercise.
PSxH: Right bunionectomy 1989; left endarterectomy June 1993; abdominal aortic aneurysm repair 2004; suture line dehiscence repair from abdominal aortic aneurysm repair 2004. _____ *J. Scully, RN*

Past Social History

A past social history (PSH) gives the nurse an opportunity to assess the client's living arrangements, social practices, sexual history, use of recreational substances, educational level, and work environment. This information can be useful in assisting the nurse to identify potential sources of stress, and in planning care most effectively.

Examples of Questions to Ask

Because many of these questions are very personal, it is often helpful for the nurse to preface this conversation by explaining why these questions are asked and how they can be helpful in planning effective care.

- What is your marital status? Are you single, married, divorced, or widowed?
- Where do you attend school (if student)?
- Where do you work (if employed)?
- What type of work have you done in the past?
- Who do you live with?
- What type of home do you live in?
- How much schooling have you completed?
- Are you sexually active? If so:
  - How many partners have you had?
  - When was your last sexual encounter?
  - Have you had a partner who was HIV or hepatitis positive?
  - Have you had a partner who used intravenous drugs?
  - Have you had a partner who engaged in sexual activity with multiple other partners?
- Do you use tobacco? If so:
  - What type of tobacco do you use? Smoked? Chewed?
  - How much tobacco do you use daily? How many packs do you smoke or tins do you chew?
  - When did you begin using tobacco?
  - If you are a former user, when did you quit using tobacco?
- Do you use alcohol? If so:
  - Do you drink socially or regularly?
  - How many drinks per day/week/month do you consume? (This question will be phrased according to whether the client is a social drinker or a regular drinker.)
  - What type of alcohol do you consume?
  - Have you ever felt like you should cut down on your drinking?
  - Have people annoyed you by criticizing your drinking?
  - Have you ever felt guilty about drinking?
  - Have you ever had a drink as soon as you've woken up to steady your nerves or get rid of a hangover?
- Do you use other drugs? If so:
  - What type of drugs do you use?
  - How often do you use this drug?
- Have you experienced domestic violence or abuse?
  - Are you afraid to go home or when you are at home with a loved one?
  - Are you in a relationship where you have been hurt or threatened?

- Has a significant other ever kicked, punched, bit, or hurt you?
- (If bruises are noticed) I notice you have some bruises. Did someone do this to you?

Examples of Past Social History Documentation*

***Refer to Case Study 1 for sample dialogue. Include the following:**

Nurse: "Do you drink alcohol, use tobacco, or use any kind of drugs?"
Client: "No, not at all. I never have."
Nurse: "Are you sexually active?"
Client: "Oh, no. I live at home with my parents while I'm going to community college, and I have never even had a boyfriend."

11 June 2009, 1715:

CC: Nasal congestion, R ear pain, fever.
HPI: Nasal congestion x 3 days, consistent sharp pain in R ear (pain scale 7 on 1–10 scale with 10 being worst) and fever of 101 since last night, Tylenol not helping. Missed college classes today. Denies exposure to anyone with strep throat or other known illness.
PMH: Denies any past history other than normal colds and viruses.
PSxH: Client denies having had any surgeries.
PSH: Nonsmoker, nondrinker of alcohol. Lives with parents and attends local community college. Denies any sexual activity or history. _____ *J. Scully, RN*

***Refer to Case Study 2 for sample dialogue. Include the following:**

Nurse: "Do you use alcohol, tobacco, or drugs?
Client: "I smoke about a pack a day, but don't drink or use drugs."
Nurse: "Who do you live with at home?"
Client: "My husband. We've been married since 1995. He's a mechanic and I'm a grocery clerk."
Nurse: "Have you had any sexual relationships outside of your marriage?"
Client: "No, and my husband better not have, either."

11 June 2009, 1715:

CC: Migraine headaches almost daily for 3 months.
HPI: Has had a migraine almost every day for the past 3 months. States has had migraines in the past, but not this often or this intensely. Has taken Tylenol without relief; sometimes Excedrin helps. Generally she just goes to bed and turns out all the lights, but this is starting to interfere with her part-time job schedule as a librarian. Headaches always associated with nausea; occasionally she has vomited as well. Describes "rainbow" aura in vision field during migraines. Current headache is an 8 on a 1–10 scale.
PMH: Has history of "tension headaches" since she was a teenager. Had a broken ankle in 2000 that was casted and healed; client states no further complications.
PSxH: Had C-Section performed in 2000; client denies having experienced any complications.
PSH: Smokes cigarettes (1 pack per day), states she is a nondrinker of alcohol and does not use drugs. Lives with husband (married in 1995) and states he is monogamous. Works as a grocery clerk.

J. Scully, RN

***Refer to Case Study 3 for sample dialogue. Include the following:**

Nurse: "Have you been sexually active recently?
Client: "Oh, yes. I have a girlfriend. She's a good one. I had a scare in 2001 when an old girlfriend told me she'd been seeing other men. I went out and had an HIV test. Thank goodness it was negative. I learned my lesson and haven't had unprotected sex since then."
Nurse: "Do you smoke or drink alcohol?"
Client: "I don't smoke. I have a beer or two a week with friends."

11 June 2009, 1715:

CC: Shortness of breath.
HPI: Hard time taking a breath—"tight" chest. States that it feels as if "I can't take a deep breath." Felt this before when working out in the gym, but now feels it "more" over the last 3 weeks, even if not in gym. Reports one episode (of approx. 1 hour) per week over the past 3 weeks but hasn't noticed anything at night. States "I just don't want to do anything" because he is afraid it will be "hard to take a breath."

PMH: Has history of pre-hypertension since 1999; controlled with hydrochlorothiazide, 25 mg daily in the morning. Has type II diabetes, diagnosed in 2005, controlled with diet and exercise.
PSxH: Right bunionectomy 1989; left endarterectomy June 1993; abdominal aortic aneurysm repair 2004; suture line dehiscence repair from abdominal aortic aneurysm repair 2004.
PSH: States he is a nonsmoker. Drinks 1–2 alcoholic beverages weekly. Has girlfriend. States he was tested for HIV in 2001 after a former girlfriend was unfaithful—reports that test was negative. Denies having unprotected sex since that time. _____ *J. Scully, RN*

Past Family History

The past family history (PFH) gives the nurse the opportunity to collect information that will be useful in assessing whether the client has a family history that could contribute to his or her current health concerns. This entails a comprehensive review of relevant family history, particularly of conditions that could be hereditary or have an impact on the client's health and condition.

Examples of Questions to Ask

- Are your parents still living?
- If parents are deceased, what was the cause of death and when did they die?
- Do (or did) your parents have any health concerns?
- Do you have siblings?
- Are your siblings still living?
- If siblings are deceased, what was the cause of death, and when did they die?
- Do (or did) your siblings have any health concerns?
- Have any of your immediate relatives, such as parents, siblings, or a first-degree aunt or uncle died an early death, such as before the age of 60? If so:
  - What age did they die?
  - What was the cause of death?

Examples of Past Family History Documentation

***Refer to Case Study 1 for sample dialogue. Include the following:**

Nurse: "Are your parents still living?"
Client: "My mom is. She's always been healthy, and she's 68. My dad died when he was 72. He had lung cancer."

11 June 2009, 1715:

CC: Nasal congestion, R ear pain, fever.
HPI: Nasal congestion x 3 days, consistent sharp pain in R ear (pain scale 7 on 1–10 scale with 10 being worst) and fever of 101 since last night, Tylenol not helping. Missed college classes today. Denies exposure to anyone with strep throat or other known illness.
PMH: Denies any past history other than normal colds and viruses.
PSxH: Client denies having had any surgeries.
PSH: Nonsmoker, nondrinker of alcohol. Lives with parents and attends local community college. Denies any sexual activity or history.
PFH: Mother still living and in good health; father passed away at age 72 from lung cancer. _____ *J. Scully, RN*

***Refer to Case Study 2 for sample dialogue. Include the following:**

Nurse: "Do you have parents and sibling who are still living?
Client: "My folks are alive, and I have a 35-year-old brother."
Nurse: "Are your parents in good health?"
Client: "Yes."
Nurse: "Have you had any relatives die at an early age?"
Client: "Yes, my grandfather on my dad's side died when he was 54. He had type 2 diabetes."

11 June 2009, 1715:

CC: Migraine headaches almost daily for three months.
HPI: Has had a migraine almost every day for the past 3 months. States has had migraines in the past, but not this often or this intensely. Has taken Tylenol without relief; sometimes Excedrin helps. Generally she just goes to bed and turns out all the lights, but this is starting to interfere with her part-time job schedule as a librarian. Headaches always associated with nausea; occasionally she has vomited as well.

Describes "rainbow" aura in vision field during migraines. Current headache is an 8 on a 1–10 scale.
PMH: Has history of "tension headaches" since she was a teenager. Had a broken ankle in 2000 that was casted and healed; client states no further complications.
PSxH: Had C-Section performed in 2000; client denies having experienced any complications.
PSH: Smokes cigarettes (1 pack per day), states she is a nondrinker of alcohol and does not use drugs. Lives with husband (married in 1995) and states he is monogamous. Works as a grocery clerk.
PFH: Mother and father both alive and in good health. One brother, 35, in good health. Paternal grandfather died from complications of type 2 diabetes at age 54. _____ *J. Scully, RN*

Synthesizing the Information

The following documentation examples are based on this case scenario:

Mrs. Miller is a 60-year-old, African American female who has come to the physician's office for a follow-up visit. She has a known history of high cholesterol since 1998 and developed hypertension in 2007. The doctor placed her on Caduet 5/10, 1 po qd. Upon further questioning, the nursing professional learns and documents the following information:

11 June 200, 1215:

CC: Follow-up visit, cholesterol and hypertension.
HPI: (would be documented here)
ROS: (would be documented here)
PMH: High cholesterol since 1998; hypertension since 2007; presently treated with Caduet 5/10, once daily. Allergy to penicillin (causes breathing difficulty). Reports she is current on her immunizations.
PSxH: Left knee replacement in 2003. Client denies any complications from this surgery.
SH: Widowed in 1999; states that she has been celibate since her husband passed away. Lives in apartment on first floor of building. Volunteers part time at the art museum—welcomes visitors and directs them to ticket sales. Has never smoked. Drinks one 4-oz glass

of red wine every evening "for her heart." Denies consuming any other alcohol.

PFH: Father passed away at age 88 from renal failure as a complication of type 2 diabetes (developed at age 65); mother passed away at age 84 from stroke. Has one brother, age 49—history unremarkable. Has one child, age 28—history unremarkable. _____ *J. Scully, RN*

The following documentation example is based on this case scenario:

Sandra Daily is a 46-year-old, white female who got up this morning at 3 AM after waking up and feeling "dizzy." She has some nausea, but no vomiting. She said she got out of bed to go to bathroom, felt room was spinning around her. She did not lose balance while going to bathroom but felt "unsteady" in gait. After she returned to bed, she awoke again at 6 AM with the same sensation. She was able to return to sleep, and then got up at 10:30 AM—her dizziness subsided, but then she noticed a "dull" head pain (2 on scale of 1–10). She had some slight ear ringing during episodes, but none now. There was no confusion, speech slurring, unilateral or systemic weakness, or vision changes noted during the episodes. She has had no recent illnesses, no exposure to anyone ill that she is aware of. She says she had "exact same problem" in April 2006 when she was vacationing in Florida, but she didn't seek medical care because she thought she must have had a virus. Upon further questioning, the nursing professional learns and documents the following information:

11 June 2009, 1215:

CC: Dizzy, nauseated, ear ringing.
HPI: (would be documented here)
ROS: (would be documented here)
PMH: Seasonal allergies treated and managed with Allegra prn. Anxiety x 10 years treated with Paxil 20 mg qd.
PSxH: Client denies having any surgery.
PSH: Lives at home with spouse and two teenage sons. Works as an administrative assistant at a local high school.
PFH: Mother and father both deceased from "natural causes"—mother died at 81, father died at 77. Brother and sister living and in good health. Client is not aware of chronic conditions within family.
_____ *J. Scully, RN*

Physical Assessment

The importance of a thorough physical examination cannot be underestimated when planning care. In some facilities, nurses refer to this as a *physical assessment;* in other facilities, it is termed a *physical examination.* Either way, it involves the objective findings of the nurse, collected by examining the client through observation, auscultation, palpation, and percussion.

The physical assessment serves as the basis for structuring a plan of care, discharge teaching and, in the case of nurse practitioners, pharmaceutical and therapy orders. Therefore, the nursing professional should plan adequate time to perform a thorough assessment.

If you are working in a hospital or long-term care environment, planning the best time for physical examination can be challenging. You have to plan around meal times, therapy, rest times, and social visits of family and friends. Therefore, it is important for you to be prepared with all necessary equipment to perform the physical examination; this equipment should include stethoscope, penlight, thermometer, blood pressure cuff (if not in the room), and pen and paper to record immediate information to be transferred to permanent documentation.

As always, use appropriate nursing judgment about components to assess and record based on the client's condition. Examples are given here of criteria that could be assessed and recorded by the nurse.

Physical Assessment and Documentation Criteria

The physical assessment provides the basis for planning care. Because the nursing professional may need to refer back to the assessment from time to time in the process of planning care, it is important that thorough documentation of the following criteria be recorded.

Constitutional

Vital signs

These may be located on a flow chart or included in narrative, SOAP, or DART notes as applicable and should include:

- Temperature (T).
- Pulse (P).

- Respirations (R).
- Blood pressure (B/P).
- SpO_2.

Also known as oxygen saturation or pulse oximetry, SpO_2 is often included in the section with vital signs. This measures the oxygen saturation in the blood. Generally, the facility will set basic parameters for optimal readings for SpO_2 but this will also be very client-specific. For example, a client with chronic obstructive pulmonary disease (COPD) will likely have a very different baseline (acceptable) SpO_2 compared with a client who does not have a history of respiratory compromise.

Function and Nutritional

When assessing a client's functional and nutritional status, make sure to ask the following questions:

- Is the client independent with activities of daily living (ADLs)?
- Does the client need assistance, or is he or she receiving total care?
- Is the client obese, well-nourished, or emaciated?
- Is the client well-hydrated, or does he or she appear "dry"?
- Has the client had a recent gain or loss in weight that is unintentional?

General Appearance

- How does the client look? **This is an optimal location to also record the client's height and weight.**
- Does the client appear to be:
  - Asleep, unconscious, alert, or have a diminished level of consciousness (LOC)?
  - Pale or flushed?
  - Tired or rested?
  - Anxious or calm?
  - Poorly developed or well developed?
  - Distressed (mild, moderate, severe) or in no apparent distress?
- What else do you observe?
  - C-collar.
  - Splinting devices.
  - Blood or drainage.
  - Open wounds notes.

Note: These findings constitute only items that are immediately observed by the nursing professional; further assessment on these findings is included in subsequent systems.

Eyes

- Note which eye is the affected eye or if both eyes are affected.
- Look for periorbital swelling.
- Look for the presence of a periorbital hematoma.
- Assess for drainage from the affected eye or eyes. If present, note the:
  - Color of the drainage.
  - Consistency (water, thick, gummy, etc.) of the drainage.
  - Amount of drainage.
- Ask the client if he or she has noted itching.
- Observe the color of the sclera? Is it red or bloody, yellow, or clear?
- Ask the client if he or she has noted visual changes. If yes, document if a visual acuity examination is performed and the results thereof.
- Observe the color of the conjunctiva? Is it pale, pink, red, or yellow?
- Observe and document the appearance of lids. Are they dry, moist, cracked, or bruised?
- Inspect the pupils:
  - Are they both round? (If one is not round, document which one is not.)
  - Are they both reactive to light and accommodation? (If reactivity is not noted, document which pupil is not reactive.)
- Inspect the appearance of the optic discs and posterior portions of the eye, *if ophthalmoscope examination is performed*, and document:
  - Pallor of optic discs.
  - Swelling of optic discs.
  - Pupillary reaction.

ENMT

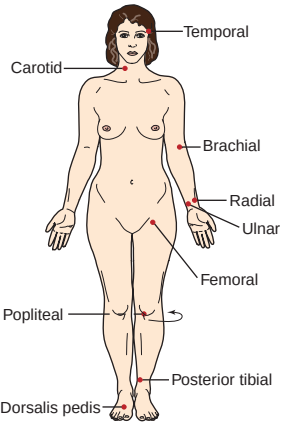
- Note which ear is affected or if both ears are affected.
- Assess the appearance of the tympanic membranes (TM). If otoscopic examination is performed, document whether the TMs are found to

be cloudy, clear, reddened, injected or with mobility, either impaired or unimpaired.

- Perform a basic hearing assessment. Speak normally to the client and then whisper. A tuning fork can also be used, if available. The results should document:
  - If the client can hear audible, regular voices.
  - If the client can hear soft whispers.
  - Any results of testing performed with a tuning fork.
- Note the appearance of lips, and document if they are found to be dry, moist, cracked, or bleeding.
- Note the appearance of teeth or dentures and document:
  - Status of the client's oral hygiene.
  - Whether the client has missing teeth or dentures.
  - Whether the client wears dental appliances.
  - If there is any indication of dental injury.
- Note the appearance of gums and document if they are found to be dry, moist, cracked, reddened, pale, or bleeding.
- Note the appearance of the oropharynx and document:
  - If exudates are noted and the location of such.
  - If the client has adequate airway clearance.
  - Whether the oropharynx is dry or moist.
  - Any abnormalities of the salivary glands.
  - Observation of the palate, and whether it is raised, moist, dry, or compromised in any fashion.
  - Observation of the tongue, and whether it is dry, moist, furrowed, smooth, red, pale, or coated.
  - Observation of the tonsils, and whether they are present (document if tonsils have been removed). Also note their size (+1, +2, +3, +4), if they are covered with any patches of white or yellow exudate, or if they are creviced, swollen, or reddened.
- Inspect the nose. Document the presence of lesions, masses, scabs, and scars.
- Inspect the nasal mucosa, septum, and turbinates. Note if they appear pale, bluish, boggy, or congested.
- Palpate and note tenderness if present.

Cardiovascular

- Auscultate the carotid arteries for bruits. If present, document the side of their location.
- Palpate or auscultate the pulses, making sure to document any abnormalities in equality or strength.



- Note the presence of any pulse deficit.
- Assess the extremities for paleness, cyanosis, and edema. If edema is found, note the side affected and specific location, amount of edema estimated, and whether the edema is pitting or nonpitting. If determined to be pitting edema, make sure to include depth in the documentation.
- Auscultate the client's heart sounds. Document:
  - **S1:** This is the first heart sound and is found in the mitral area at the beginning of ventricular contraction (systole). S1 is often called "lub," when referring to the heart sound cycle of "lub-dub." A normal S1 sound is lower pitched then S2, and has a longer duration than S2.

- **S2:** This is the second heart sound and is found in the aortic area at the closure of the pulmonic and aortic values. S2 is often called "dub," when referring to the heart sound cycle of "lub-dub." A normal S2 sound is higher pitched than S1 and has a shorter duration than S1.
- **S3:** This heart sound is heard after S2 and is best heard at the apex of the heart. S3 can be a normal finding in children and teenage clients, but is usually not normal in adults. It is often called a "gallop," and is usually soft and lower-pitched.
- **S4:** This heart sound is not considered a normal heart sound in adults, except in clients who are athletes. Children will sometimes have a benign S4 sound. It is called "presystolic gallop" and, if heard, occurs at the end of diastole and before S1.

- Also auscultate for the client's apical heart rate, making sure to count for one full minute, and murmurs.

Murmurs

Grade	Description
Grade 1	Very faint; may be hard for the novice to identify.
Grade 2	Easily discernible after placing the stethoscope on the chest.
Grade 3	Moderately loud; novice will easily discern.
Grade 4	Loud; associated with a thrill (palpable vibration due to blood turbulence).
Grade 5	Very loud; associated with thrill; may be heard when stethoscope is partly off the chest.
Grade 6	Very loud; associated with thrill; may be heard with stethoscope entirely off the chest.

Respiratory

- Assess and document any effort expended when breathing, including nasal flaring, presence of intercostal retractions, and the use of accessory muscles.
- Auscultate the client's lung sounds. Document the type of sounds heard, whether they are rales, rhonchi, wheezes, crackles, or stridor. Also document if the client's sounds are clear. If you do auscultate sounds, ensure your documentation is specific as to side and exact location.

Gastrointestinal

- Palpate for masses. If found, document location and approximate size of the mass and its consistency, whether it is hard, soft, or mobile.
- Palpate for tenderness or rigidity. If found, document location and the client's reaction to the palpation, such as whether they exhibited guarding or vocalized pain.
- Assess for hepatosplenomegaly. Document its presence or lack thereof.
- If you perform a rectal examination, make sure to document:
  - Sphincter tone.
  - Presence or absence of hemorrhoids.
  - Hem + or – stool (occult blood test: – "hem" stands for hemoccult, indicating whether there is blood in the stool or not).

Genitourinary

Female*

- Perform a pelvic examination, and document the appearance of the external genitalia, vagina, and cervix. Also note the size, consistency, contour, and position of the uterus, as well as the presence of tenderness or adnexa masses.

***Note: The pelvic examination is usually performed by a nurse practitioner.**

- Palpate the bladder. Document whether it was full or empty and tenderness, if present.

Male*

- Perform a scrotal examination, and document the appearance of the penis.
- Perform a digital rectal examination, and document the size and symmetry of the prostate gland and the presence of nodules or tenderness. Document the scrotal examination.
- Description of the appearance of penis.

***Note: The scrotal examination and the digital rectal examination are generally performed by a nurse practitioner.**

Allergic/Immunological

- Assess the client's body for rashes. If found, provide a description of their appearance and note their location.

Although rashes also relate to the integumentary system, it can be noted here if there is a suspected allergic reaction.

- Document any signs of immunocompromization.

Hematological/Lymphatic/Endocrine

- Assess for nodules. If found, document their size and corresponding location, such as the neck, axillae, or groin.
- Assess the neck for suppleness. Document the presence of masses or nodes found, whether the neck is symmetrical, or if there was tenderness present.
- Assess the thyroid for consistency, enlargement, tenderness, or masses, and document your findings.
- Perform a breast assessment*, making sure to note:
  - Symmetry.
  - Masses found, with notation of the specific location and size.
  - Discharge.
  - Discerned tenderness, with notation of the specific location.
  - Swollen lymph glands, with notation of the specific location.

***Note: Breast assessment is usually performed by a nurse practitioner.**

Integumentary

- Assess the client at risk for pressure sores by using the Braden Scale, which can be found at http://www.bradenscale.com/braden.PDF.
- Inspect the client's skin, making sure to document, with indication of the specific location on the skin any of the following:
  - Dryness
  - Moistness
  - Color changes
  - Rashes
  - Lesions
  - Ulcers
  - Lacerations
  - Abrasions
  - Nodes
  - Nodules
  - Masses

Musculoskeletal

- Inspect the client's digits and nails, making sure to note clubbing, cyanosis, inflammation, and ischemia, if found.
- Document subluxation, luxation, or laxity, with specific location identified.
- Assess and document the client's muscle strength and tone.
- Document any abnormal movements noted, with reference to location.
- Test the client's range of motion, making sure to document limitations.
- Assess the client's spine, and document any curvature.
- Watch the client walk. Document whether the gait is steady, unsteady (ataxic), shuffling, or antalgic. An antalgic gait is a painful gait, as when a client limps or favors one leg over the other.

Psychiatric

- Assess the client's mood and affect and his or her cooperation with the assessment, including the client's perception of anxiety during the assessment. Document your findings.

Neurological

- Assess the client's orientation to person, place, and time. Document your findings.
- Assess the client's pupillary reaction. Does the client demonstrate PERRLA—pupils equal, round and reactive to light and accommodation? Document your findings.
- Note if you have any concerns with the client's recent and distant memory.
- Test the client's deep reflexes. Document their presence or absence, as well as any abnormalities.
- Perform a sensory examination. Document your findings, including the presence or absence of feeling and whether or not the examination was accomplished by filament, touch, or pin.
- Perform a cranial nerve examination; document any abnormalities found.

Cranial Nerve Examination

Following are examples of select methods by which to test cranial nerve (CN) functions. For documentation purposes, all normal responses should be noted, as well as any abnormalities.

- **CN I (Olfactory):** Test smell with various odors to see if client can recognize them. This is not a common test. This is generally done by occluding one nostril while testing the other and then doing the same on the opposite side.
- **CN II (Optic):** Have client look at nurse; wiggle finger 12 inches from client's ear and ask client to identify on which side they recognize movement.
- **CN III, IV, VI (Oculomotor, Trochlear, Abducens):** Check for PERRLA (pupils equal, round and reactive to light and accommodation) with penlight: Have client follow nurse's finger with eyes only (not moving head).
- **CN V (Trigeminal):** Perform sensation test of client's cheek, jaw, and forehead while client's eyes are closed. Ask client to acknowledge when sensation is felt. Have client open mouth and then clench teeth; nurse can palpate jaw at this time.

- **CN VII (Facial):** Note any facial droop or asymmetry. Have client wrinkle forehead, shut eyes tightly, and smile to show his or her teeth. Have client puff cheeks out; check for symmetry.
- **CN VIII (Vestibulocochlear):** Perform Weber's and Rinne tests.
- **CN IX, X (Glossopharyngeal, Vagus):** Note quality of voice. Check palate for uvular movement as client says "ah."
- **CN XI (Accessory):** Stand behind client and have him or her shrug shoulders. Note symmetry.
- **CN XII (Hypoglossal):** Note articulation of words. Inspect client's tongue as it is protruded.

Cranial Nerve Examination Findings

The following table demonstrates key normal and abnormal findings of a cranial nerve examination that can be indicated in documentation if they indeed pertain to the client.

	Normal Finding	Abnormal Finding
CN I (Olfactory)	Can identify certain smells	Cannot identify certain smells
CN II (Optic)	Can recognize movement	Has difficulty or delay in recognizing movement
CN III (Oculomotor)	PERRLA	Absence of PERRLA
CN IV (Trochlear)	PERRLA	Absence of PERRLA
CN V (Abducens)	Can identify sensation	Has difficulty or delay in identifying sensation
CN VI (Trigeminal)	PERRLA	Absence of PERRLA
CN VII (Facial)	No facial droop; symmetry of face; can wrinkle forehead evenly; shut eyes tightly; smile showing teeth with symmetry; puff out both cheeks	One-sided facial droop; face is not symmetrical; cannot wrinkle forehead evenly (one side may raise); both eyes will not shut tightly; smile may be lopsided or may not be able to expose teeth; may only be able to puff one cheek

Continued

	Normal Finding	Abnormal Finding
CN VIII (Vestibulocochlear)	**Rinne:** Vibration tone is longer and louder by the ear as opposed to on the mastoid bone **Weber:** Tones noted are the same in each ear	**Rinne:** Vibration tone is longer and louder on the mastoid bone as opposed to by the ear **Weber:** Tones noted are stronger in one ear versus another
CN IX (Glossopharyngeal)	Normal vocal tone; can say "ah" with noted rise in palate	Vocal tone is compromised; palate may not rise when saying "ah"
CN X (Vagus)	Normal vocal tone; can say "ah" with noted rise in palate	Vocal tone is compromised; palate may not rise when saying "ah"
CN XI (Accessory)	Shoulders shrug symmetrically	One shoulder may not move in symmetry with the other
CN XII (Hypoglossal)	Can articulate words normally; can stick tongue forward	Articulation of words may be compromised; tongue may not come forward easily

Synthesizing the Information—A Case Study

Here is an example of a narrative note based on a physical examination of a client with complaints of sinus pain and congestion, headache, and general flu-like symptoms. Because the nursing professional decides which specific components are relevant for assessment, some of those listed previously may not be addressed.

11 June 2009, 1810:

Exam: BP 140/92, P 88, R 18, T 98.2F. Well-developed, well-nourished female. Sclera clear; conjunctiva mildly injected and reddened bilaterally. PERRLA. Tympanic membranes clear bilaterally. Hears whispers. Nasal mucosa pale and boggy. Right septal deviation. Oral mucosa moist. Heart sounds S1, S2 without murmurs. No carotid bruits. Lung sounds clear bilaterally. No accessory muscle use or retractions noted. Abdomen soft and nontender upon palpation; no masses noted. No

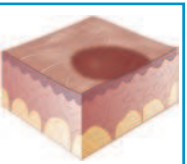
hepatosplenomegaly. GU examination deferred. No nodules in neck or axillae. No cyanosis, clubbing, or edema in extremities. Gait steady. Cooperative with examination. Oriented to person, place, and time. Cranial nerves intact. _____ *B. Snyder, RN*

Tools to Describe Examination Findings

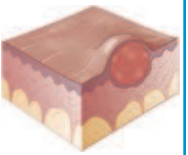
The following tools can be very helpful in assisting you to document specific conditions more thoroughly. They are not a substitute for documentation of a complete physical examination, if necessary, but rather should be used to remind yourself of components that would likely need to be documented for these specific conditions.

Skin Lesions

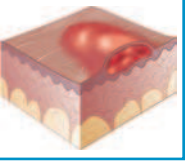
Macule: A localized change in skin color, less than 1 cm in diameter, such as a freckle.



Papule: A solid, elevated lesion, less than 0.5 cm in diameter, such as a mole.



Wheal: A raised, circular-like lesion, such as in hives.



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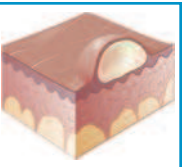
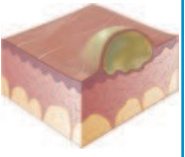
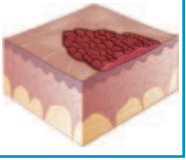
Vesicle: An elevated mass, less than 0.5 cm diameter, containing serous fluid between upper layers of skin, such as in herpes simplex, varicella, and second-degree burns.



Pustule: A pus-filled vesicle or bullae greater than 0.5 cm in diameter, such as in acne, impetigo, and carbuncles.



Crust: Dried serum, blood, or pus on the skin's surface.



Characteristics of Shock States

The following table presents key indicators of certain types of shock that can be indicated in documentation if they indeed pertain to the client.

	Cardiogenic shock	Cardiac Compressive	Hypovolemic or Traumatic Shock			Low-Output Septic Shock	High-Output Septic Shock	Neurogenic Shock
			Mild	Moderate	Severe			
Skin perfusion	Pale	Pale	Pale	Pale	Pale	Pale	Pink	Pink
Urine output	Low	Low	Normal	Low	Low	Low	Low	Low
Pulse rate	High	High	Normal	Normal	High	High	High	Low
Mental status	Anxious	Anxious	Normal	Thirsty	Anxious	Anxious	Anxious	Anxious
Neck veins	Distended	Distended	Flat	Flat	Flat	Flat	Flat	Flat
Oxygen consumption	Low	Low	Low	Low	Low	Low	Low	Low
Cardiac index	Low	Low	Low	Low	Low	Low	High	Low
Cardiac filling pressures	High	High	Low	Low	Low	Low	Low	Low
Systemic vascular resistance	High	High	High	High	High	High	Low	Low

Stages of Hypovolemic Shock

The following list demonstrates key indicators of hypovolemic shock that can be indicated in documentation if they indeed pertain to the client. Hypovolemic shock is the most common type of shock, caused by profuse blood loss. The indicators below are usually found sequentially, meaning that the client first presents with peripheral venous constriction, then poor capillary filling, then pallor, and so on.

Peripheral venous constriction
Poor capillary filling
Pallor
Peripheral cooling
Oliguria
Increased pulse rate
Thirst
Increased respiratory rate
Hypotension
Trunk cooling
Agitation
Decreased pain sensation
Loss of deep tendon reflexes
Acidotic breathing
Deep pallor
Loss of consciousness
Death

Characteristics of Breath Sounds

The following table presents key indicators of certain types of breath sounds that can be indicated in documentation.

Type	Duration of Sounds	Intensity of Expiratory Sound	Pitch of Expiratory Sound	Normal Location
Vesicular	Inspiratory sounds last longer than expiratory sounds	Soft	Relatively low	Over most of both lungs
Bronchovesicular	Inspiratory and expiratory sounds are about equal	Intermediate	Intermediate	Often in the 1st and 2nd interspaces anteriorly and between scapulae
Bronchial	Expiratory sounds last longer than inspiratory ones	Loud	Relatively high	Over the manubrium, if heard at all
Tracheal	Inspiratory and expiratory sounds are about equal	Very loud	Relatively high	Over the trachea in the neck

Characteristics of Percussion Sounds

The following table presents key indicators of certain types of percussion sounds within the body that can be indicated in documentation.

	Relative Intensity	Relative Pitch	Relative Duration	Example Location	Pathologic Examples
Flatness	Soft	High	Short	Thigh	Large pleural effusion
Dullness	Medium	Medium	Medium	Liver	Lobar pneumonia
Resonance bronchitis	Loud	Low	Long	Normal lung	Simple chronic
Hyperresonance pneumothorax	Very loud	Lower	Longer	None normally	Emphysema
Tympany	Loud	High		Gastric air bubble or puffed-out cheek	Large pneumothorax

Documenting Basic Nursing Tasks and Procedures

In this section you will find trigger phrases to help you document effectively the nursing tasks and procedures that you perform. Keep in mind that every nurse has his or her own method for safely performing these tasks and procedures, and documentation should reflect exactly what is done in the order it is accomplished. Also, not every portion of every category is always carried out, based on the situation. The list of trigger words can simply help you remember what content should be documented as it applies to your client's situation; it is left to you, as the nursing professional, to represent that content within the context in which it happened.

Aerosolized Breathing Treatments

- Date and time of procedure.
- Explanation of procedure given to client.
- Assessment of lung sounds, respiratory rate, and respiratory effort.
- Utilization of mask or mouthpiece.
- Length of treatment.
- Number of treatments.
- Re-assessment of lung sounds, respiratory rate, and respiratory effort.
- Pertinent client teaching provided.
- Client response to procedure.

Arterial Blood Gas (ABG) Sampling

- Date and time of procedure.
- Explanation of procedure to client.
- Vital signs prior to procedure.
- Site of arterial puncture.
- Allen's test.
- Circulatory assessment.
- Time spent applying pressure to site of sample.
- Assessment of site after procedure is complete.
- Notation of any oxygenation client is receiving.
- Vital signs after procedure.
- Pertinent client teaching given.
- Client response to procedure.

Bandaging

- Date and time of procedure.
- Explanation of procedure to client.
- Assess skin for any contraindication to wrapping.
- Notation of type of wrap used.
- Notation of method of wrapping, such as figure 8 or spiral wrap.
- Pertinent client teaching given.
- Client response to procedure.

Blood Product Administration

- Physician order.
- Signed consent form, if not for emergent purposes.
- Transfusion history, if client has received blood before.
- Date and time of procedure.
- Explanation of procedure given to client.
- Client teaching given to client regarding potential side effects that must be reported to the nurse:
  - Itching.
  - Dyspnea, shortness of breath.
  - Chills or rigors.
  - Headache.
  - Chest pain.
  - Back pain.
  - Urticaria, hives.
  - Flushing.
- Validation of blood product and client with another registered nurse. **(Note: Make sure to list the name of the nurse.)**
  - Client's name.
  - Client's medical record number.
  - Client's date of birth.
  - Blood donor number on bag.
  - Blood donor number on blood bank form.
  - Client's blood type.
  - Client's Rh type.
  - Crossmatch compatibility.
  - Donor's blood type.

  - Donor's Rh type.
  - Unit and product number.
  - Expiration date and time.
  - Type of blood component versus what is ordered (for example, are you going to hang platelets, and were platelets what was ordered?).
- Vital signs before administration of blood product.
- Catheter type and gauge used.
- Use of normal saline with blood product.
- Warming unit used, if applicable.
- Rate of infusion.
- Vital signs during transfusion, usually every 5 minutes for the first 15 minutes, and then every 15 minutes thereafter.
- Total amount transfused.
- Date and time of transfusion completion.
- Any information about client's condition or response during and following transfusion, including intermittent vital signs.
- Documentation of blood bag form to be returned to blood bank.

Blood Specimen Collection

- Date and time of procedure.
- Explanation of procedure to client, particularly type of collection.
  - Venipuncture.
  - Arterial puncture.
  - Capillary, such as Glucometer testing.
- Note regarding the method of collection.
- Pertinent client teaching provided.
- Client response to procedure.

Cardiac Monitoring

- Date and time of onset of monitoring.
- Explanation of procedure given to client.
- Leads used; if changed later, document changes.
- Initial rhythm strip with interpretations.
- Periodic subsequent rhythm strips with interpretations.
- Client changes during monitoring, if applicable.
- Calls to physician based on client changes, if applicable.

- Disconnect leads when monitoring is complete.
- Pertinent client teaching provided.
- Client response to procedure.

Central Venous Access Device Care and Maintenance

- Date and time of procedure.
- Explanation of procedure to client.
- Removal of soiled dressing, making sure to note drainage color, amount, odor, and other assessment findings.
- Assessment of catheter site.
- Cleansing of surrounding skin.
- Placement of dressing.
- Cleansing around catheter connection.
- Flushing.
- Pertinent client teaching given.
- Client response to procedure.

Chest Tube Care and Maintenance

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of SpO_2, lung sounds, respiratory rate, and respiratory effort.
- Type of device utilized.
- Suction applied, if applicable.
- Activity in the water-seal chamber.
- Notation about drainage, including amount and color.
- Notation about dressings, including draining amount, color, and odor.
- Notation about skin condition surrounding the chest tube insertion site.
- Pertinent client teaching.
- Client response to procedure.

Delivery of Medication

Most facilities have a dedicated medical administration record (MAR) of some kind. The nurse should comply with the institution's policies on

documenting medication administration on this form. Key points to remember that are common to virtually all MARs include:

- The nurse must sign the MAR once he or she has administered the first dose of medication to the client. The MAR should not be signed prior to giving any medication in case there are delays, transfers, or refusals that would preclude the nurse from delivering medication.
- The nurse should indicate that a dose of medication was given only after the client has received it. The nurse should *never* chart ahead in case there is a complication or situation in which the client refuses, or is unable to take, a dose of medication.
- If a medication is not given based on nursing assessment or client refusal, the nurse must circle the time of that dose and document in the narrative record why the medication was not delivered.
- When preparing to deliver medication, the nurse must check the "Five Rights." It is important to consider the same "Five Rights" when documenting to ensure that all information is accurately charted. These include:
  1. **Right client:** Double check to make certain you are documenting on the right client's chart and MAR.
  2. **Right time and frequency:** Make certain you are accurately recording the time you delivered the medication.
  3. **Right drug:** Completely record the name of the medication given, if writing a narrative note. Do not abbreviate names or amounts; for example, write out "milligrams" instead of "mg."
  4. **Right dose:** Be astute to record the right dose given; watch decimal points specifically so that there is no question about what was delivered.
  5. **Right route:** Accurately record the route by which medication was delivered. If given via intramuscular, intradermal, or subcutaneous delivery, record the exact location where the medication was administered.

It is also important to observe all regulations that apply to narcotics administration and documentation. These types of regulations encompass federal, state, and institutional protocols. You are responsible for observing all of these regulations.

Dry Dressing Change

- Date and time of procedure.
- Explanation of procedure to client.
- Removal of soiled dressing, making sure to note drainage color, amount, odor, and other assessment data.
- Assessment of wound.
  - Size, including length, width, and depth.
  - Temperature.
  - Pain noted.
  - Approximation of incision or suture line.
  - Surrounding skin condition.
- Cleansing of wound and surrounding area.
- Application of dressing via sterile technique.
- Emptying of drain or drains, if applicable, noting amount and color.
- Pertinent client teaching given.
- Client response to procedure.

Gastrostomy Button Feeding

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of gastrostomy site with notation of surrounding skin condition.
- Auscultation of bowel sounds.
- If ordered, verification of button placement and residual.
- Administration of formula.
  - Type of formula given.
  - Amount of formula given.
- If ordered, water flush.
- Skin care, if performed.
- Pertinent client teaching provided.
- Client's response to procedure.

Glucose Testing

- Date and time of procedure.
- Explanation of procedure to client.

- Notation of quality controls done in the past 24 hours.
- Site used for sample.
- Results of glucose testing.
- Pertinent client teaching provided.
- Client's response to procedure.

Hygiene

- Date and time of procedure.
- Explanation of procedure to client.
- Type of bath provided.
  - Cleansing.
    - Shower: Bath is taken in a shower by an ambulatory client; some assistance from the nurse may be necessary, although some clients may be able to accomplish this alone.
    - Tub bath: Bath is taken in a tub; some assistance from the nurse may be necessary.
    - Self-help bath (or "bath with assist"): A cleansing bath generally provided for clients confined to bed; the nurse provides bath essentials, such as water, wash towels, and soap, and the client generally will accomplish much of the actual bathing process.
    - Complete bed bath: A bath for clients who are unable to bathe themselves; the nurse provides the entire bath.
    - Partial bath: Involves cleansing only areas of immediate necessity, or areas that would cause odor or discomfort if not cleansed.
  - Therapeutic.
    - Requires the order of a primary care provider, which will designate the bath's temperature, type, area to be treated, and any added solutions that should be included in the bath.
- Changing of linens and whether performed as an occupied or unoccupied change.
- Pertinent client teaching provided.
- Client's response to procedure.

Intake and Output

- Date and time of monitoring.
- Explanation of procedure to client.

- Measurement of all forms of intake.
  - Urine.
  - Intravenous fluid.
  - Intravenous medications, such as piggybacks.
  - Oral intake.
- Measurement of all forms of output.
  - Urine.
  - Vomitus.
  - Draining, such as nasogastric suction, wound drains.
  - Blood loss.
- Pertinent client teaching provided.

Intramuscular Injection

- Date and time of procedure.
- Explanation of procedure to client.
- Notation of injection site.
  - Dorsal gluteal.
  - Vastus lateralis.
  - Ventrogluteal.
  - Deltoid.
- Type of medication given with dosage—record also on MAR.
- Pertinent client teaching given.
- Client response to procedure.

Intravenous Catheter Discontinuation

- Date and time of discontinuation.
- Explanation of procedure to client.
- Location of IV catheter to be discontinued; **be very specific when documenting the location of the catheter.**
- Type and gauge of catheter or needle discontinued.
- Appearance of site upon discontinuation.
- Pressure applied.
- Type of dressing applied over site of discontinuation, such as gauze.
- Pertinent client teaching provided.
- Client's response to procedure.

Intravenous Catheter Insertion

- Date and time of insertion.
- Explanation of procedure to client.
- Location of insertion; **be very specific when documenting the location of the IV.**
- Type and gauge of catheter or needle used.
- Number of attempts to secure access.
- IV solution used and initial flow rate started.
- Pertinent client teaching provided.
- Client's response to procedure.

Intravenous Medication Administration

- Date and time of insertion.
- Explanation of procedure to client.
- Notation of site of administration.
- Compatibility checked against IV fluid, if infusing.
- Type of medication given with dosage—record also on MAR.
- Amount of solution infused, if piggyback.
- Flow rate of current infusion, if piggyback.
- Pertinent client teaching provided.
- Client's response to procedure.

IV Site Change

- Date and time of site change.
- Explanation of procedure to client.
- Location of current IV site and reason for change.
- If infiltrated:
  - Estimate amount infiltrated.
  - Note any swelling, burning, or pain at the site.
  - Note any temperature change at the site.
  - Assess pertinent surrounding area for skin condition and turgor, capillary refill, and peripheral pulses.
  - Note the name of physician called and any orders given as well as carried out, such as elevation, ice packs, warm soaks, and medication.

- Description of current site upon IV catheter removal.
- Type of dressing used to cover current IV site.
- Location of new IV site; **be very specific when documenting the location of the IV.**
- Type and gauge of catheter or needle used.
- Number of attempts to secure access.
- IV solution used and initial flow rate started.
- Pertinent client teaching provided.
- Client's response to procedure.

IV Therapy

Sometimes a nurse simply maintains IV therapy without being responsible for inserting the initial IV line or changing it. To document monitoring of IV therapy, the following trigger words apply:

- Date and time of procedure.
- Assessment of IV site, including such data as color, presence or absence of swelling, temperature, tenderness.
- Provision of continued education about procedure.
- Type of solution.
- Amount of solution infused.
- Flow rate of current infusion.
- Pertinent client teaching provided.
- Client response to procedure.

Nasogastric Tube Discontinuation

- Date and time of removal.
- Explanation of procedure to client.
- Description of residual drainage, including color, consistency, and amount.
- Validation of bowel sounds following removal, as well as other gastrointestinal assessment.
- Pertinent client teaching provided.
- Client response to procedure.

Nasogastric Tube Feeding

- Date and time of procedure.
- Explanation of procedure to client.
- Formula used and dilution factor.
- Notation of gastric residual, if any.
- Amount fed.
- Flush administered.
- Pertinent client teaching given.
- Client response to procedure.

Nasogastric Tube Insertion

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of nares.
- Vital signs and general client condition.
- Date and time of insertion.
- Identification of naris used.
- Size and type of NG tubing.
- Education given during insertion, such as visualization, breathing through mouth, and continued swallowing.
- Validation of placement.
- Type and amount of suction utilized.
- Description of return, including color, consistency, and amount.
- Pertinent client teaching given.
- Client response to procedure.

Nasopharyngeal Suctioning

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of lung sounds, respiratory rate, and respiratory effort.
- Notation of suction pressure.
- Administration of oxygen to client.
- Suctioning action.
- Repeat of oxygenation and suctioning, if applicable.

- Re-assessment of lung sounds, respiratory rate, and respiratory effort.
- Pertinent client teaching given.
- Client response to procedure.

Nutritional Therapy*

***Note: This section covers nutritional therapy that is not tube feedings.**

- Date and time of feeding.
- Explanation of nutritional therapy being given to client.
- Notation of the type of diet.
  - Clear liquid.
  - Full liquid.
  - Soft diet.
  - Low-residue.
  - High-fiber.
  - Low-fat.
  - Sodium-restricted.
  - Calorie diet, such as a 1800 kcal diabetic diet.
- Amount in percentage that client took, such as "ate 25% of tray."
- Pertinent client teaching given.
- Client response to feeding.

Oxygen Administration

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of SpO_2, lung sounds, respiratory rate, and respiratory effort.
- Application of oxygen.
  - Use of mask or cannula.
- Flow rate.
- Re-assessment of SpO_2, lung sounds, respiratory rate, and respiratory effort.
- Pertinent client teaching given.
- Client response to procedure.

Passive Range of Motion Exercises

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of need for appropriate range of motion exercises.
- Notation of exercises performed.
  - Head and neck: Rotation, flexion, extension, lateral rotation.
  - Shoulder: Flexion, extension, abduction, adduction, internal rotation, external rotation, circumduction.
  - Elbow: Flexion, extension, supination, pronation.
  - Wrist: Flexion, extension, hyperextension, abduction, adduction.
  - Hands and fingers: Flexion, extension, hyperextension, abduction, adduction, thumb opposition
  - Hip: Flexion, extension, abduction, adduction, internal rotation, external rotation, circumduction.
  - Knee: Flexion, extension.
  - Ankle: Plantar flexion, dorsiflexion, eversion, inversion.
  - Toes: Flexion, extension, hyperextension, abduction, adduction.
- Pertinent client teaching given.
- Client response to procedure.

Positioning a Client

- Date and time of procedure.
- Explanation of procedure to client.
- Notation of the position client was placed in, with rationale.
  - Fowler's.
  - Semi-Fowler's.
  - Side-lying.
  - Supine.
  - Prone.
- Pertinent client teaching given.
- Client response to procedure.

Note: It is especially important to document when you have positioned and repositioned clients to document the fact that you have attempted to prevent skin breakdown.

Restraint Application

- Date and time of procedure.
- Explanation of procedure to client.
- Rationale for restraint.
- Alternative measures attempted before application of restraints.
- Notation of type of restraint used.
- Pertinent client teaching given.
- Client response to procedure.

Note: Be very attentive to your specific state and facility protocols regarding restraints! It is especially important to monitor clients in restraints continually, per your state and facility protocols. You must routinely document assessment findings after each check of the client while in restraints.

Range of Motion (ROM) Exercises

- Date and time of procedure.
- Explanation of procedure to client.
- Assessment of mobility of client.
- Determination of areas that need attention, with appropriate ROM documented concerning each of the following performed for or with the client:

Head and Neck

- Rotation: Turn side to side.
- Flexion and Extension: Tilt chin toward sternum, then return to anatomical position.

Shoulder

- Flexion and Extension: Move entire arm above head; return to correct anatomical position.
- Abduction and Adduction: Move entire arm away from midline; return to correct anatomical position.
- Internal and External Rotation: Bend elbow at 90-degree angle, keeping upper arm parallel to shoulder; move lower arm upward and downward.
- Circumduction: Move entire arm in circular motion.

Elbow

- Flexion and Extension: Bend elbow, then return to correct anatomical position.
- Supination and Pronation: Turn hand in with palm up, then palm down position.

Wrist

- Flexion and Extension: Bend wrist toward antecubital fossa, then return to correct anatomical position.
- Hyperextension: Exaggerate extension.
- Abduction and Adduction: Move wrist away from midline then toward midline.

Hands and Fingers

- Flexion and Extension: Bend fingers/thumb into palm, then return to correct anatomical position.
- Hyperextension: Exaggerate flexion of fingers.
- Abduction and Adduction: Spread fingers apart, then together.
- Thumb Opposition: Touch each finger with tip of thumb.

Hip

- Flexion and Extension: Move entire leg toward chest, then return to anatomical position. (Keep knee bent slightly for client comfort.)
- Abduction and Adduction: Move extended leg away from body midline and toward body midline.
- Internal and External Rotation: Alternate moving thigh outward and inward very gently.
- Circumduction: Move leg gently in a small circular rotation.

Knee

- Flexion and Extension: Bend knee at 90-degree angle, then return to correct anatomical position.

Ankle

- Plantar flexion: Move foot downward (away from head).
- Dorsiflexion: Move foot toward head.
- Eversion and Inversion: Move entire sole of foot away from midline, then inward toward midline.

Toes

- Flexion and Extension: Bend toes toward sole, then return to anatomical position.
- Hyperextension: Exaggerate flexion.
- Abduction and Adduction: Spread toes apart, then together.

Client Positioned on Side, Holding Onto Rail

- Hyperextension of Head and Neck: Move head back; exaggerate flexion.
- Hyperextension of Shoulder: Move shoulder back; exaggerate flexion.

General Notes

- Pertinent client teaching given.
- Client response to procedure.

Stoma Care

- Date and time of procedure.
- Explanation of procedure to client.
- Emptying of pouch.
  - Contents, including consistency, amount, odor.
- Assessment of stoma.
- Assessment of surrounding skin.
- Cleansing of skin.
- Application of new appliances, making sure to list all used.
- Pertinent client teaching given.
- Client response to procedure.

Tracheostomy Care

- Date and time of procedure.
- Explanation of procedure to client.
- Removal of soiled dressing, making sure to note color, amount, odor on dressing, and other assessment data.
- Assessment of stoma.
- Cleaning of cannula.
- Cleansing of stoma, surrounding skin, and neck plates.
- Ensure placement of cannula when reinserting.
- Application of sterile gauze tracheostomy dressing.
- Application of new tracheostomy ties, if applicable.

- Pertinent client teaching provided.
- Client response to procedure.

Staple or Suture Removal

- Date and time of procedure.
- Explanation of procedure to client.
- Location of site containing staples or sutures.
- Assessment of site and suture line.
  - Size, including length, width, depth.
  - Temperature.
  - Pain noted.
  - Any draining, including color, amount, odor.
  - Approximation of incision or suture line.
  - Surrounding skin condition.
- Removal of staples or sutures, making sure to document number of each removed.
- Pertinent client teaching given.
- Client response to procedure.

Subcutaneous (SC or SubQ) Injection

- Date and time of procedure.
- Explanation of procedure to client.
- Notation of injection site.
  - Upper arm.
  - Thigh.
  - Abdomen.
  - Hip.
  - Upper back.
- Type of medication given with dosage; record also on MAR.
- Pertinent client teaching given.
- Client response to procedure.

Tracheostomy Suctioning

- Date and time of suctioning.
- Explanation of procedure to client.

- Assessment of lung sounds, respiratory rate, and respiratory effort.
- Notation of suction pressure.
- Administration of oxygen to client.
- Suctioning action.
- Repeat of oxygenation and suctioning, if applicable.
- Re-assessment of lung sounds, respiratory rate, and respiratory effort.
- Pertinent client teaching given.
- Client response to procedure.

Tube Feedings

- Date and time of feeding.
- Explanation of procedure to client.
- Abdominal assessment prior to feeding.
  - Gastrointestinal assessment.
  - Validation of tube placement.
  - Assessment of tube site as well as surrounding tissue.
  - Any residual contents noted.
- Type of feeding, including amount and strength, as well as water, if given.
- Pertinent client teaching provided.
- Client response to procedure.

Urinary Catheter Insertion

- Date and time of procedure.
- Explanation of procedure to client.
- Size and type of catheter.
- Provision of hygiene before insertion.
- Ease of insertion.
- Characteristics of urine return upon insertion, including color, cloudiness or clarity, amount, and odor noted, if any.
- Collection of laboratory specimens, if ordered.
- Initiation of intake and output records as ordered.
- Pertinent client teaching provided.
- Client response to procedure.

Urine Sample Collection

- Date and time of procedure.
- Explanation of procedure to client, particularly of type of collection.
  - Regular urinary analysis.
  - 24-hour urine collection.
  - Closed drainage collection.
  - Clean-catch sample.
- Note regarding the method of collection.
- Pertinent client teaching provided.
- Client response to procedure.

Wet-to-Dry Dressing Change

- Date and time of procedure.
- Explanation of procedure to client.
- Removal of soiled dressing, making sure to note drainage color, amount, odor, and other assessment data.
- Assessment of wound
  - Size, including length, width, depth.
  - Temperature.
  - Pain noted.
  - Approximation of incision or suture line.
  - Surrounding skin condition.
- Cleansing of wound and surrounding area.
- Application of wet dressing via sterile technique.
- Emptying of drains, if applicable, making sure to note amount and color.
- Pertinent client teaching given.
- Client response to procedure.

Wound Care

Depending on the type of wound, documentation may vary somewhat. The nurse should be very descriptive about whether the wound is surgical, decubitus, accidental, or another type.

- Date and time of wound care.
- Assessment of wound.
  - Exact location.
  - Size.
  - Shape.
  - Stage.
  - Color.
  - Margins.
  - Tissue type.
  - Odors noted.
  - Assessment of drain, if present.
- Assessment of surrounding tissue.
  - Color.
  - Temperature.
  - Pain or tenderness.
  - Tunneling, making sure to document dimension.
- Removal of current dressing and packing.
  - Color of drainage.
  - Amount of drainage.
  - Any odor noted.
- Care given before redressing, as applicable.
  - Irrigation.
  - Repacking.
  - Application of medication.
- Dressing and packing type used.
- Pertinent client teaching provided.
- Client response to procedure.

Documentation of Specialized Fields

The basic principles of documentation apply to all nursing specialties. However, nuances applicable to specialized fields must also be considered when documenting. These factors, which include the pieces of information differentiating each specialty from general nursing practice, must be documented accordingly.

Not every bullet occurring in these specialty lists may apply to each client. It is the nurse's responsibility to assess and discern which components require documentation to reflect a true and accurate client record.

Note: Information contained within this tab is to be charted in addition to the basic documentation you have recorded, as illustrated in previous tabs.

Pediatrics

Documenting the care of children is not unlike documenting the care of adults. However, as you are aware, there are pieces of assessment information that will include additional characteristics for the pediatric population, and these should be documented in addition to the regular assessment information, as covered in the previous tabs. Below are further pieces of information that are important to cover when documenting care for this population.

Basic Assessment Information

Infancy (age younger than 1 year)

- Prenatal history (any significant concerns).
- Natal history (type of birth and any noted complications).
- Allergies.
- Immunizations.
- Milestones.
- How baby feeds.
  - How much taken.
  - How often.
  - Parental concerns about feeding.

- How baby sleeps.
  - Routine.
  - Self-soothing behaviors.

Early Childhood (ages 1 to 4 years)

- Allergies.
- Immunizations.
- Milestones.
- How well child eats and types of foods consumed.
- Sleeping habits.
- Toileting.

School-Age (ages 5 to 12 years)

- Allergies.
- Immunizations.
- Milestones.
- Diet.
- Sleeping habits.

Adolescence (ages 13 to 18 years)

- Allergies.
- Immunizations.
- Milestones.
- Diet.
- Sleeping habits.

Basic Psychosocial Information

Type of Communication

- Does the infant or child cry? If so, document quality of cry, length of crying episodes, and ability to be comforted when crying.
- Does the school-age child talk?
- Does the adolescent avoid contact with caregivers or authority figures?

Family Support and Interaction

- How does the family interact with the child?
- Is one caregiver more involved with the child than another?
- Is one caregiver more present with the child?

- Does the child become calm, agitated, soothed, or fearful when the primary caregivers are present?
- Does family have an available support system? If so, who is included?

School Performance*

Note: This is based on client's age, as recommended by Bright Futures.

- Expectation for school performance is defined in the Individualized Education Program (IEP): How is the child performing, based on the expectation?
- Homework: Is there too much homework or too little? Is the child able to accomplish the homework without undue stress? Might tutoring be recommended?
- Relationships with teachers: Has the child established a trusting relationship with the teacher? If there are conflicts, how are they managed, and might education about conflict resolution be beneficial?
- Parent-teacher communication.
- Ability of schools to address the needs of children from diverse backgrounds.
- Awareness of aggression, bullying, and victimization.
- Absenteeism.

Social Interaction

- How does the child relate to parents?
- How does the child relate to health-care providers?
- How does the child relate to other authority figures, such as teachers?
- How does the child relate to friends?
- How does the child play, and is this play appropriate to the developmental stage of the child?

Erikson's Stages of Psychosocial Development

Identify the developmental stage and task, and whether the child is developing appropriately based on assessment according Erikson's Stages of Psychosocial Development.

Age	Stage	Implications
Infant	Trust vs. Mistrust	Needs maximum comfort with minimal uncertainty to trust himself/herself, others, and the environment.
Toddler	Autonomy vs. Shame and Doubt	Works to master physical environment while maintaining self-esteem.
Preschooler	Initiative vs. Guilt	Begins to initiate, not imitate, activites; develops conscious and sexual identity.
School-age Child	Industry vs. Inferiority	Tries to develop a sense of self-worth by refining skills.
Adolescent	Identify vs. Role Confusion	Tries integrating many roles (child, sibling, student, athlete, worker) into a self-image under role model and peer pressure.
Young Adult	Intimacy vs. Isolation	Learns to make personal commitment to another as spouse, parent, or partner.
Middle-aged adult	Generativity vs. Stagnation	Seeks satisfaction through productivity in career, family, and civic interests.
Older adult	Integrity vs. Despair	Reviews life accomplishments; deals with loss and preparation for death.

Child Abuse

The nurse is obligated by law to report child abuse. If abuse is suspected, the bedside, community, or office nurse should report it immediately to the primary caregiver so that a prompt and thorough assessment can be made. The nurse practitioner can provide his or her own assessment. Depending on the situation, the nurse should consider all of the following* for documentation on a case-by-case basis:

- Physical signs of abuse or neglect reported by child.
- Repeated emergency department visits or a previous history of abuse.

- Parents blaming siblings for injuries.
- Inappropriate response by the child or caregiver to the injury.
- Inconsistency between physical findings and cause of injury or between injury and child's development.

Obstetrics

Documenting care of the obstetric client is not unlike documenting other types of care of adults. However, as you aware, there are pieces of assessment information that will include additional characteristics for the obstetric population, and these should be documented in addition to the regular assessment information, as covered in the previous tabs. Here are further pieces of information that are important to cover when documenting care for this population.

Basic Assessment Information

Antenatal Assessment*

The antenatal assessment can be utilized when a female client is interested in becoming pregnant or suspects she may be pregnant. It is an important component in a plan to prepare the body for pregnancy, identify women at risk for potential pregnancy complications, and begin care for the woman who is newly pregnant. The following types of histories should be assessed:

Obstetrical History (Taken at Initial Evaluation)

- What types of deliveries has the client had? Vaginal? Cesarean?
- How many deliveries of each type has the client had, and when were these deliveries?
- Were there any complications from past pregnancies, and if so, what were they?
- Have there been any infertility concerns? Documentation should include any treatments sought or provided, with outcomes of each treatment.

*With permission from Holloway, B., et al. (2006). OB Peds Women's Health Notes, 2006. Philadelphia: F.A. Davis.

Pregnancy History

- **Gravida (G):** Number of pregnancies the client has had in her lifetime.
- **Term (T):** Number of deliveries after 37 weeks that the client has experienced in her lifetime.
- **Preterm (P):** Number of deliveries before 20 weeks, either spontaneous or induced, that the client has experienced in her lifetime.
- **Abortion (A):** Number of deliveries before 20 weeks, either spontaneous or induced, that the client has experienced in her lifetime.
- **Living (L):** Number of living children that the client has at this time.

Other Information

- Any concerns noted since the last visit, if this is a subsequent visit during the antenatal period.
- Any client teaching provided by the nursing professional.

Documentation Example 1: The prenatal client states having three children at home. She reports that her son was born on his due date, but her daughters were both born a month early. She states that she lost a baby in her second month.

G: 5 (currently pregnant, 3 children at home, one abortion)
T: 1 (her son was born on his due date)
P: 2 (her daughters were each born a month early)
A: 1 (she lost a pregnancy at approximately 8 weeks)
L: 3 (reports three children at home)
Document as G5-1213

Documentation Example 2: The same prenatal client may also be described as G5 (5 pregnancies) P3 (number of live births); pregnancies ended before 20 weeks are not counted as "P" in this method.

Intranatal Assessment

Intranatal assessment, performed at the time a client presents for medical procedures, triage, and birth, includes the following:*

- Reason for admission, such as labor pains, water breaking, scheduled cesarean section.
- Estimated date of delivery.
- Current gestational age.
- Review of antenatal records, noting any changes.
- Complications in pregnancy.

- Results of laboratory tests and ultrasounds.
- Medications used in pregnancy.
- Presence of vaginal discharge or bleeding.
- Amniotic fluid status.
- Presence of fetal movement.
- Onset and pattern of contractions, including frequency, duration, intensity
- Reason for cesarean section, if applicable.
- Fetal position, based on Leopold's maneuver.
- Fetal heart rate.
- Fundal height.
- Stage and phase of labor.
- Cervical changes.
  - Dilation (0–10 cm).
  - Effacement (0–100%).
  - Station (level of presenting fetal part in relation to the ischial spines of the material pelvis).
- Fetal monitoring type, external versus internal, and results of such.

Upon delivery, the following should be considered for inclusion in documentation:

- Complications of birth.
- Apgar score of infant.
- Nursing interventions accomplished during labor and delivery.
- Maternal response to nursing interventions during labor and delivery.
- Client teaching provided.

Postpartum Assessment*

- Treatments provided.
- Breastfeeding information, such as infant latching.
- Client teaching provided.
- Remember the BUBBLE mnemonic:

Breasts	• Consistency • Tenderness • Nipple characteristics • Breastfeeding education
Uterus	• Level (fingerbreadths above or below the umbilicus) • Tone, height, and location of fundus
Bladder	• First postdelivery void • Distention • Intake and output • Periurethral edema or trauma • Postpartum diuresis • Any necessary catheterization
Bowel	• Bowel sounds • Distention • Hemorrhoids • First postdelivery bowel movement
Lochia	• Amount of lochia (soakage of pad in terms of scant, small, moderate, or large amounts) • Color • Number and size of clots
Episiotomy	• Redness • Swelling • Ecchymosis • Color and consistency of drainage • Approximated edges

*Adapted from Holloway, B., et al. (2006). *OB peds women's health notes.* Philadelphia: F.A. Davis.

Psychiatric Mental Health

Documenting the care of the client with mental health concerns is not unlike documenting other types of care of adults. However, as you are aware, there are pieces of assessment information that will include additional characteristics for the client with mental health concerns, and these should be documented in addition to the regular assessment information, as covered in the previous tabs. Here are further pieces of information that are important to cover when documenting care for this population.

Basic Assessment Information

Psychiatric documentation should include objective information detailing the client's ongoing interactions, behaviors, and responses to interventions. Because each client has varying conditions, schedules, and responses, the nurse can document applicable information related to:

- Chief concern.
- Risk assessment.
- Suicidal ideation or suicide attempt.
- Combative or destructive behavior that has been noted.
- One-on-one supervision that is necessary, such as if only the nursing professional must provide direct care for this client to maintain safety.
- Direct observation.
- Pain assessment.
- Detoxification regimen.
- Administration of stat medication.
- Medication compliance and response.
- Interventions and education.
- Medical conditions, complications, or injuries.
- Team meetings.
- Families.
- Test results.
- Client response to interventions.
- Outings, including if the client is allowed to leave the facility, for how long, where the client will be going, and under whose care.
- Passes, such as if the client is allowed to go home from the facility, for how long, and under whose care.
- Request for release.
- Letter of retraction.
- Client education.
- Any other significant occurrence.

Acute Care Environments

Documenting in the acute care environment requires streamlined charting that is focused on the immediate issue at hand. Many times, facilities such as these will have their own template form that the nursing professional

uses to document. These are often one-page sheets that comprehensively show documented triage notes, nursing intake notes, and provider documentation.

In addition, documentation in the acute care environment will usually include providing written client instructions upon discharge. These are often template items that the nursing professional provides to the client to take home for reference. On the one-page sheet detailing the client's visit, it is important for the nursing professional to document that this instruction sheet has been reviewed with the client and any understanding that the client verbalized. It should also be documented that the client was given that information to take home.

Long-Term Care Environments

Documenting in the long-term care environment is not unlike documenting about care of adults. However, as you are aware, there are pieces of information that will include additional characteristics for this population, and these should be documented in addition to the regular assessment information, as covered in the previous tabs. Here are further pieces of information that are important to cover when documenting care for this population.

- Nutritional intake at every meal, expressed as a percentage of solids and liquids; for example, "took 50% of solids, 100% of liquids."
- Hygiene that has been instituted, such as baths given by staff or taken by client and safety measures employed.
- Basic safety measure employed in the living quarters.
- Visits from friends or family.
- Visits from physicians or mid-level providers.
- Any falls that occurred, including details of the circumstance, physician that was called with order received, and subsequent care given.

Home Health Care Environments

Documenting in the home health-care environment is not unlike documenting about care in a hospital setting. Many times, home health-care agencies will have their own template forms that the nursing professional

uses to document. These often include forms for assessment, skills nursing services provided, and clinical progress notes. Regular principles of documentation, as covered in *DocuNotes,* should be followed when completing these forms.

Ambulatory Care Environments

Documenting in the ambulatory care environment, such as the physician's office, requires streamlined charting that is focused on the immediate issue at hand. Often, physician's offices will have their own template form that the nursing professional uses to document. Regular principles of documentation, as covered in *DocuNotes,* should be followed when completing these forms.

Abbreviations

Terminology used in health care is virtually a language unto itself. Just as attorneys learn to talk about legal issues, nurses must learn to converse and document about health-care issues. In order to ensure accurate transfer of information between people and continuity of care, it is important to understand the language of health-care providers.

A large part of communication in health care is documented by using abbreviations. However, this is not the ideal method of charting, because the use of abbreviations can contribute to errors by opening the door to the possibility of misinterpretation and charting errors. When a nurse makes a conscientious effort to write out all portions of his or her documentation, this potential for error is greatly diminished. However, because abbreviations are used within health-care systems, nurses must be able to interpret them and be astute to any potential for error.

Commonly Abbreviated Words

The following is a list of commonly abbreviated words. This is by no means inclusive of all abbreviations used in practice, but it does represent those most frequently used.

Items in green indicate abbreviations with more than one potential interpretation that should be viewed closely to be interpreted in the correct context.

- ā . . . . . .Ante (before)
- A&O . . . . . .Alert and oriented
- AA . . . . . .African American
- AA . . . . . .Aplastic anemia
- AA . . . . . .Asian American
- AAA . . . . . .Abdominal aortic aneurysm
- AAO or A&O . . . . . .(Awake) Alert and oriented
- ab . . . . . .Abortion
- AB . . . . . .Antibody
- ABG . . . . . .Arterial blood gas
- ac . . . . . .Ante cibum (before meals)
- ACLS . . . . . .Advanced cardiac life support
- ADH . . . . . .Antidiuretic hormone
- ADLs . . . . . .Activities of daily living
- Ad lib . . . . . .At liberty; as desired

- AED . . . . . .Automated external defibrillator
- AF . . . . . .Atrial fibrillation
- A-fib . . . . . .Atrial fibrillation
- A-flutter . . . . . .Atrial flutter
- AI . . . . . .Aortic insufficiency
- AKA . . . . . .Above-the-knee amputation
- ALL . . . . . .Acute lymphocytic leukemia
- ALS . . . . . .Amyotrophic lateral sclerosis
- AMA . . . . . .Against medical advice
- AMA . . . . . .American Medical Association
- AMB . . . . . .Ambulate
- AMI . . . . . .Acute myocardial infarction
- AMI . . . . . .Acute mitral insufficiency
- AML . . . . . .Acute myelogenous (myelocytic) leukemia
- AMS . . . . . .Altered mental status
- ARC . . . . . .AIDS-related complex
- ARDS . . . . . .Adult respiratory distress syndrome
- ARF . . . . . .Acute renal failure
- ARF . . . . . .Acute rheumatic fever
- AS . . . . . .Aortic stenosis
- ASA . . . . . .Aspirin
- ASAP . . . . . .As soon as possible
- ASCVD . . . . . .Atherosclerotic cardiovascular disease
- ATNC . . . . . .Atraumatic, normocephalic
- au . . . . . .Both ears
- BBB . . . . . .Bundle branch block
- BC . . . . . .Blood cultures
- BCG . . . . . .Bacille Calmette-Guérin (tuberculosis vaccine)
- BCP . . . . . .Birth control pills
- BE . . . . . .Bacterial endocarditis
- BE . . . . . .Barium enema
- BID . . . . . .Twice daily
- BKA . . . . . .Below-the-knee amputation
- BLE . . . . . .Bilateral lower extremities
- BLS . . . . . .Basic life support
- BM . . . . . .Black male
- BM . . . . . .Bowel movement
- BMP . . . . . .Basic metabolic profile
- BP . . . . . .Blood pressure
- BPH . . . . . .Benign prostatic hypertrophy (hyperplasia)
- BRB . . . . . .Bright red blood

- BRBPR . . . . . .Bright red blood per rectum
- BRP . . . . . .Bathroom privileges
- BS . . . . . .Blood smear
- BS . . . . . .Blood sugar
- BS . . . . . .Bowel sounds
- BS . . . . . .Breath sounds
- BSA . . . . . .Body surface area
- BSO . . . . . .Bilateral salpingo-oophorectomy
- BUE . . . . . .Bilateral upper extremities
- BUN . . . . . .Blood urea nitrogen
- BW . . . . . .Black woman
- Bx . . . . . .Biopsy
- c̄ . . . . . .With
- C&S . . . . . .Culture and sensitivity
- Ca . . . . . .Calcium
- CA . . . . . .Cancer/carcinoma
- CABG . . . . . .Coronary artery bypass graft
- CAD . . . . . .Coronary artery disease
- CAH . . . . . .Chronic active hepatitis
- CBC . . . . . .Complete blood count
- CBD . . . . . .Common bile duct
- CC . . . . . .Chief complaint
- cc . . . . . .Cubic centimeter
- CCE . . . . . .Cyanosis, clubbing, edema
- CCU . . . . . .Coronary care unit
- CEA . . . . . .Carcinoembryonic antigen
- CF . . . . . .Caucasian female
- CF . . . . . .Cystic fibrosis
- CHD . . . . . .Congenital heart disease
- CHF . . . . . .Congestive heart failure
- CK . . . . . .Creatinine kinase
- CLL . . . . . .Chronic lymphocytic (lymphoblastic) leukemia
- CML . . . . . .Chronic myelocytic (myelogenous) leukemia
- CMP . . . . . .Complete metabolic profile
- CMT . . . . . .Cervical motion tenderness
- CMV . . . . . .Cytomegalovirus
- CN . . . . . .Cranial nerves
- CNS . . . . . .Central nervous system
- c/o . . . . . .Complains of
- CO . . . . . .Cardiac output
- COLD . . . . . .Chronic obstructive lung disease

- COPD . . . . . .Chronic obstructive pulmonary disease
- Cor . . . . . .Heart
- CP . . . . . .Cerebral palsy
- CP . . . . . .Chest pain
- CPAP . . . . . .Continuous positive airway pressure
- CPK . . . . . .Creatinine phosphokinase
- CPR . . . . . .Cardiopulmonary resuscitation
- CRF . . . . . .Chronic renal failure
- CRP . . . . . .C-reactive protein
- CSF . . . . . .Cerebrospinal fluid
- CT . . . . . .Computed tomography
- CV . . . . . .Cardiovascular
- CVA . . . . . .Cerebrovascular accident
- CVA . . . . . .Costovertebral angle
- CVP . . . . . .Central venous pressure
- c/w . . . . . .Consistent with
- CW . . . . . .Caucasian woman
- CXR . . . . . .Chest x-ray
- D&C . . . . . .Dilation and curettage
- D5W . . . . . .Dextrose 5% in water
- DAT . . . . . .Diet as tolerated
- DAW . . . . . .Dispense as written
- DC . . . . . .Discontinue
- d/c . . . . . .Discharge
- DDx . . . . . .Differential diagnoses
- DI . . . . . .Diabetes insipidus
- DIC . . . . . .Disseminated intravascular coagulopathy
- DIP . . . . . .Distal interphalangeal
- DJD . . . . . .Degenerative joint disease
- DKA . . . . . .Diabetic ketoacidosis
- DM . . . . . .Diabetes mellitus
- DNA . . . . . .Deoxyribonucleic acid
- DNR . . . . . .Do not resuscitate
- DNR-CC . . . . . .Do not resuscitate–comfort care
- DOA . . . . . .Dead on arrival
- DOB . . . . . .Date of birth
- DOE . . . . . .Dyspnea on exertion
- DPT . . . . . .Diphtheria, pertussis, tetanus (immunization)
- DRG . . . . . .Diagnosis related group
- DTR . . . . . .Deep tendon reflexes
- DTs . . . . . .Delirium tremens

- DVT . . . . . .Deep vein thrombosis
- Dx . . . . . .Diagnosis
- EBL . . . . . .Estimated blood loss
- ECG (EKG) . . . . . .Electrocardiogram
- ECHO . . . . . .Echocardiogram
- ECT . . . . . .Electroconvulsive therapy
- ED . . . . . .Emergency department
- EEG . . . . . .Electroencephalogram
- EENT . . . . . .Eyes, ears, nose, throat
- EMG . . . . . .Electromyogram
- EMT . . . . . .Emergency medical technician
- EMT . . . . . .Emergency medical treatment
- ENT . . . . . .Ears, nose, throat
- EOM . . . . . .Extraocular movement
- EOMI . . . . . .Extraocular muscle intact
- ER . . . . . .Emergency Room
- ERCP . . . . . .Endoscopic retrograde cannulation–pancreatic duct
- ESLD . . . . . .End-stage liver disease
- ESR . . . . . .Erythrocyte sedimentation rate
- ESRD . . . . . .End-stage renal disease
- ETA . . . . . .Estimated time of arrival
- ET . . . . . .Endotracheal
- ETOH . . . . . .Ethanol (alcohol)
- ETT . . . . . .Endotracheal tube
- ETT . . . . . .Exercise tolerance test
- FB . . . . . .Foreign body
- FBS . . . . . .Fasting blood sugar
- F/C . . . . . .Fever/chills
- FEV . . . . . .Forced expiratory volume
- FEV1 . . . . . .Forced expiratory volume in 1 second
- FFP . . . . . .Fresh frozen plasma
- FH . . . . . .Family history
- FIO_2 . . . . . .Forced inspiratory oxygen
- FOS . . . . . .Full of stool
- FROM . . . . . .Full range of motion
- FSH . . . . . .Follicle stimulating hormone
- FTA . . . . . .Fluorescent treponemal antibody test
- FTT . . . . . .Failure to thrive
- F/U . . . . . .Follow-up
- FUO . . . . . .Fever of unknown origin
- FVC . . . . . .Forced vital capacity

- Fx . . . . . .Fracture
- GA . . . . . .General anesthesia
- GB . . . . . .Gallbladder
- GC . . . . . .Gonorrhea
- GERD . . . . . .Gastroesophageal reflux disease
- GFR . . . . . .Glomerular filtration rate
- GH . . . . . .Growth hormone
- GI . . . . . .Gastrointestinal
- g . . . . . .Gram
- GN . . . . . .Glomerulonephritis
- gr . . . . . .Grain (1 grain = 65 milligrams)
- GSW . . . . . .Gunshot wound
- gtt . . . . . .Guttae (Drops)
- GTT . . . . . .Glucose tolerance test
- GU . . . . . .Genitourinary
- GYN . . . . . .Gynecological
- H&P . . . . . .History and physical
- HA . . . . . .Headache
- HAV . . . . . .Hepatitis A virus
- Hb . . . . . .Hemoglobin
- HBV . . . . . .Hepatitis B virus
- HC . . . . . .Head circumference
- HC . . . . . .Hemoccult
- HC . . . . . .Hydrocortisone
- HCG . . . . . .Human chorionic gonadotropin
- HCO_3 . . . . . .Bicarbonate
- Hct . . . . . .Hematocrit
- HCTZ . . . . . .Hydrochlorothiazide
- HD . . . . . .Heart disease
- HDL . . . . . .High-density lipoprotein
- HEENT . . . . . .Head, eyes, ears, nose, throat
- Heme . . . . . .Blood; hematology
- Hgb . . . . . .Hemoglobin
- HIV . . . . . .Human immunodeficiency virus
- HJR . . . . . .Hepatojugular reflux
- HLA . . . . . .Histocompatibility locus antigen
- HMO . . . . . .Health maintenance organization
- H/O . . . . . .History of
- HOB . . . . . .Head of bed
- HPI . . . . . .History of presenting illness
- HPV . . . . . .Human papilloma virus

- HS . . . . . .At hour of sleep (bedtime)
- HSM . . . . . .Hepatosplenomegaly
- HSV . . . . . .Herpes simplex virus
- HTN . . . . . .Hypertension
- HUS . . . . . .Hemolytic uremic syndrome
- HVD . . . . . .Hypertensive vascular disease
- Hx . . . . . .History
- I&D . . . . . .Incision and drainage
- I&O . . . . . .Intake and output
- IAN . . . . . .Intern admission note
- IBD . . . . . .Inflammatory bowel disease
- IBS . . . . . .Irritable bowel syndrome
- ICU . . . . . .Intensive care unit
- ID . . . . . .Infectious disease
- IDDM . . . . . .Insulin-dependent diabetes mellitus
- Ig . . . . . .Immunoglobulin
- IHD . . . . . .Ischemic heart disease
- IHSS . . . . . .Idiopathic hypertropic subaortic stenosis
- IM . . . . . .Intramuscular
- IND . . . . . .Investigational new drug
- INH . . . . . .Isoniazid
- IOP . . . . . .Intraocular pressure
- IP . . . . . .Intraperitoneal
- IP . . . . . .Interphalangeal
- IPPB . . . . . .Intermittent positive pressure breathing
- IT . . . . . .Intrathecal
- ITP . . . . . .Idiopathic thrombocytopenic purpura
- IUD . . . . . .Intrauterine device
- IV . . . . . .Intravenous
- IVC . . . . . .Inferior vena cava
- IVC . . . . . .Intravenous cholangiogram
- IVCD . . . . . .Intraventricular conduction delay
- IVDA . . . . . .Intravenous drug abuse
- IVP . . . . . .Intravenous pyelogram
- IVPB . . . . . .Intravenous piggy-back
- IVSD . . . . . .Interventricular septal defect
- JRA . . . . . .Juvenile rheumatoid arthritis
- JVD . . . . . .Jugular vein (venous) distention
- JVP . . . . . .Jugular vein (venous) pressure
- Kg . . . . . .Kilogram
- KOH . . . . . .Potassium hydroxide

- KUB . . . . . .Kidneys, ureters, bladder
- KVO . . . . . .Keep vein open
- L . . . . . .Left
- LA . . . . . .Left anterior
- LA . . . . . .Left atrium
- LAD . . . . . .Left anterior descending
- LAD . . . . . .Left axis deviation
- LAH . . . . . .Left anterior hemiblock
- LAN . . . . . .Lymphadenopathy
- LBBB . . . . . .Left bundle branch block
- LBP . . . . . .Low back pain
- LDH . . . . . .Lactose dehydrogenase
- LDL . . . . . .Low-density lipoprotein
- LE . . . . . .Lower extremity
- LE . . . . . .Lupus erythematosus
- LES . . . . . .Lower esophageal sphincter
- LFT . . . . . .Liver function test
- LGI . . . . . .Lower gastrointestinal
- LH . . . . . .Luteinizing hormone
- LLL . . . . . .Left lower lobe
- LLQ . . . . . .Left lower quadrant
- LML . . . . . .Left middle lobe
- LMP . . . . . .Last menstrual period
- LOA . . . . . .Leave of absence
- LOA . . . . . .Level of activity
- LOC . . . . . .Level of consciousness
- LOC . . . . . .Loss of consciousness
- LP . . . . . .Lumbar puncture
- LPH . . . . . .Left posterior hemiblock
- LPN . . . . . .Licensed practical nurse
- LSB . . . . . .Left sternal border
- LUL . . . . . .Left upper lobe
- LUQ . . . . . .Left upper quadrant
- LVEDP . . . . . .Left ventricular end-diastolic pressure
- LVH . . . . . .Left ventricular hypertrophy
- MAO . . . . . .Monoamine oxidase
- MAP . . . . . .Mean arterial pressure
- MAT . . . . . .Multifocal atrial tachycardia
- MBT . . . . . .Maternal blood type
- MBD . . . . . .Minimal brain dysfunction
- MCH . . . . . .Mean corpuscular hemoglobin

- MCHC . . . . . .Mean corpuscular hemoglobin concentration
- MCV . . . . . .Mean cell volume
- MDI . . . . . .Metered dose inhaler
- MI . . . . . .Mitral insufficiency
- MI . . . . . .Myocardial infarction
- MICU . . . . . .Medical intensive care unit
- mL . . . . . .Milliliter
- MM . . . . . .Morbidity and mortality
- MM . . . . . .Multiple myeloma
- MMR . . . . . .Measles, mumps, rubella
- MP . . . . . .Metacarpophalangeal
- MR . . . . . .Medical record
- MR . . . . . .Mitral regurgitation
- MRG . . . . . .Murmurs, rubs, gallops
- MRI . . . . . .Magnetic resonance imaging
- MRSA . . . . . .Methicillin-resistant *Staphylococcus aureus*
- MS . . . . . .Mental status
- MS . . . . . .Mitral stenosis
- MS . . . . . .Morphine sulfate
- MS . . . . . .Multiple sclerosis
- MVA . . . . . .Motor vehicle accident
- NAD . . . . . .No active disease
- NC . . . . . .Nasal cannula
- NCAT . . . . . .Normocephalic, atraumatic
- ND . . . . . .Nondistended
- NG . . . . . .Nasogastric
- NIDDM . . . . . .Non–insulin-dependent diabetes mellitus
- NKA . . . . . .No known allergies
- NKC . . . . . .Nonketonic coma
- NKDA . . . . . .No known drug allergies
- NMT . . . . . .Nebulized mist treatment
- NPH . . . . . .Neutral protamine Hagedorn (insulin)
- NPO . . . . . .Nothing by mouth
- NR . . . . . .Nonreactive
- NRB . . . . . .Nonrebreather mask
- NS . . . . . .Normal saline
- NSAID . . . . . .Nonsteroidal anti-inflammatory drug
- NSR . . . . . .Normal sinus rhythm
- NT . . . . . .Nasotracheal
- NT . . . . . .Nontender
- NTG . . . . . .Nitroglycerin

- N/V . . . . . .Nausea, vomiting
- OA . . . . . .Osteoarthritis
- OB . . . . . .Obstetrics
- OBS . . . . . .Organic brain syndrome
- OCG . . . . . .Oral cholecystogram
- OD . . . . . .Overdose
- OD . . . . . .Right eye
- OM . . . . . .Otitis media
- ONC . . . . . .Oncology
- OOB . . . . . .Out of bed
- OR . . . . . .Operating room
- OS . . . . . .Left eye
- OT . . . . . .Occupational therapy
- OU . . . . . .Both eyes
- p̄ . . . . . .After
- P . . . . . .Pulse
- P&A . . . . . .Percussion and auscultation
- PA . . . . . .Posterior anterior
- PA . . . . . .Physician's assistant
- PA . . . . . .Pulmonary artery
- PAB . . . . . .Premature atrial beat
- PABA . . . . . .Para-aminobenzoic acid
- PAC . . . . . .Premature atrial contraction
- PAP . . . . . .Papanicolaou (cervical) smear
- PAP . . . . . .Pulmonary arterial pressure
- PAWP . . . . . .Pulmonary artery wedge pressure
- PC . . . . . .Platelet concentrate
- pc . . . . . .Post cibum (after meals)
- PCN . . . . . .Penicillin
- PCP . . . . . .*Pneumocystis carinii* pneumonia
- PCP . . . . . .Primary care provider
- PCWP . . . . . .Pulmonary capillary wedge pressure
- PDA . . . . . .Patent ductus arteriosus
- PDR . . . . . .Physician's Desk Reference
- PE . . . . . .Physical examination
- PE . . . . . .Pleural effusion
- PE . . . . . .Pulmonary embolism
- PEEP . . . . . .Positive end expiratory pressure
- PERRLA . . . . . .Pupils equal, round, reactive to light and accommodation
- PFT . . . . . .Pulmonary function test
- PID . . . . . .Pelvic inflammatory disease

- PIP . . . . . .Proximal interphalangeal (joint)
- PKU . . . . . .Phenylketonuria
- PMH . . . . . .Past medical history
- PMI . . . . . .Point of maximum impulse
- PMS . . . . . .Pre-menstrual syndrome
- PND . . . . . .Paroxysmal nocturnal dyspnea
- PND . . . . . .Postnasal drip (postnasal drainage)
- PO . . . . . .Per os (by mouth)
- POD . . . . . .Postoperative day
- PPD . . . . . .Pack per day (smoking)
- PPD . . . . . .Purified protein derivative
- PR . . . . . .By rectum
- PRBC . . . . . .Packed red blood cells
- PRN . . . . . .As needed, as necessary
- PS . . . . . .Pulmonic stenosis
- PSA . . . . . .Prostatic specific antigen
- PSVT . . . . . .Paroxysmal supraventricular tachycardia
- PT . . . . . .Client
- PT . . . . . .Physical therapy
- PT . . . . . .Prothrombin time
- PTA . . . . . .Prior to arrival, prior to admission
- PTCA . . . . . .Percutaneous transluminal coronary angioplasty
- PTH . . . . . .Parathyroid hormone
- PTT . . . . . .Partial thromboplastin time
- PUD . . . . . .Peptic ulcer disease
- PVB . . . . . .Preventricular beat
- PVC . . . . . .Premature ventricular contraction
- PVD . . . . . .Peripheral vascular disease
- q . . . . . .Every, each (e.g., “q 4 hours” = every 4 hours)
- Q . . . . . .Perfusion
- qd . . . . . .Daily
- qh . . . . . .Hourly
- qid . . . . . .Four times daily
- qod . . . . . .Every other day
- QUAD . . . . . .Quadriplegic
- R . . . . . .Respirations
- R . . . . . .Right
- RA . . . . . .Rheumatoid arthritis
- RA . . . . . .Right anterior
- RA . . . . . .Right atrium
- RAD . . . . . .Right axis deviation

- RAN . . . . . .Resident admission note
- RBBB . . . . . .Right bundle branch block
- RBC . . . . . .Red blood cell
- RDS . . . . . .Respiratory distress syndrome
- RF . . . . . .Renal failure
- RF . . . . . .Respiratory failure
- RF . . . . . .Rheumatoid factor
- RF . . . . . .Rheumatic fever
- RFT . . . . . .Renal function test
- RHD . . . . . .Rheumatic heart disease
- RIA . . . . . .Radioimmunoassay
- RICU . . . . . .Respiratory intensive care unit
- RLL . . . . . .Right lower lobe
- RLQ . . . . . .Right lower quadrant
- RML . . . . . .Right middle lobe
- RNA . . . . . .Ribonucleic acid
- RND . . . . . .Radical neck dissection
- R/O . . . . . .Rule out
- ROM . . . . . .Range of motion
- ROS . . . . . .Review of systems
- RPR . . . . . .Reactive plasma regain (test)
- RR . . . . . .Respiratory rate
- RRR . . . . . .Regular rate and rhythm
- RSB . . . . . .Right sternal border
- RT . . . . . .Radiation therapy
- RT . . . . . .Respiratory therapy
- RUL . . . . . .Right upper lobe
- RUQ . . . . . .Right upper quadrant
- RV . . . . . .Residual volume
- RV . . . . . .Right ventricle
- RVH . . . . . .Right ventricle hypertrophy
- Rx . . . . . .Prescription, therapy, treatment
- $\bar{s}$ . . . . . .Sans (without)
- S_1 . . . . . .First heart sound
- S_2 . . . . . .Second heart sound
- S_3 . . . . . .Third heart sound
- S_4 . . . . . .Fourth heart sound
- San . . . . . .Sinoatrial node
- SBE . . . . . .Subacute bacterial endocarditis
- SBO . . . . . .Small-bowel obstruction
- SC . . . . . .Subcutaneous

- SCID . . . . . .Severe combined immunodeficiency
- SCM . . . . . .Sternocleidomastoid
- SG . . . . . .Swan-Ganz
- SGOT . . . . . .Serum glutamic-oxaloacetic transaminase
- SGPT . . . . . .Serum glutamic-pyruvic transaminase
- SIADH . . . . . .Syndrome of inappropriate antidiuretic hormone
- SICU . . . . . .Surgical intensive care unit
- sig . . . . . .Write on label (e.g., prescription)
- SL . . . . . .Sublingual
- SLE . . . . . .Systemic lupus erythematous
- SOA . . . . . .Shortness of air
- SOB . . . . . .Shortness of breath
- s/p . . . . . .Status post (after)
- SQ . . . . . .Subcutaneous
- s/s . . . . . .Signs and symptoms
- SSA . . . . . .Sickle cell anemia
- SSHgb . . . . . .Sickle cell hemoglobin
- STAT . . . . . .Immediately
- STD . . . . . .Sexually transmitted disease
- SVC . . . . . .Superior vena cava
- SVD . . . . . .Spontaneous vaginal delivery
- Sx . . . . . .Surgery
- Sx . . . . . .Symptoms
- T . . . . . .Temperature
- T_3 . . . . . .Triiodothyronine
- T_4 . . . . . .Tetraiodothyronine
- T&A . . . . . .Tonsillectomy and adenoidectomy
- T&C . . . . . .Type and cross
- T&H . . . . . .Type and hold
- Tab . . . . . .Tablet
- TAH . . . . . .Total abdominal hysterectomy
- TB . . . . . .Tuberculosis
- TBA . . . . . .To be announced
- TBI . . . . . .Total body irradiation
- TBI . . . . . .Traumatic brain injury
- Td . . . . . .Tetanus-diphtheria toxoid
- TFT . . . . . .Thyroid function test
- TIA . . . . . .Transient ischemic attack
- TIBC . . . . . .Total iron-binding capacity
- TID . . . . . .Three times daily
- TLC . . . . . .Total lung capacity

- TM . . . . . .Tympanic membrane
- TMJ . . . . . .Temporomandibular joint
- TMP/SMX . . . . . .Trimethoprim/sulfamethoxazole
- TO . . . . . .Telephone order
- tPA . . . . . .Tissue plasminogen activator
- TPN . . . . . .Total parenteral nutrition
- TPR . . . . . .Temperature, pulse, respirations
- TSH . . . . . .Thyroid-stimulating hormone
- TT . . . . . .Thrombin time
- TTP . . . . . .Thrombocytic thrombocytopenic purpura
- TURP . . . . . .Transurethral resection procedure
- TVH . . . . . .Total vaginal hysterectomy
- Tx . . . . . .Treatment
- UA . . . . . .Urinalysis
- UAO . . . . . .Upper airway obstruction
- UC . . . . . .Ulcerative colitis
- UE . . . . . .Upper extremity
- UGI . . . . . .Upper gastrointestinal
- URI . . . . . .Upper respiratory infection
- US . . . . . .Ultrasound
- UTI . . . . . .Urinary tract infection
- UV . . . . . .Ultraviolet
- VC . . . . . .Venous capacity
- VCUG . . . . . .Voiding cystourethrogram
- VD . . . . . .Venereal disease
- VDRL . . . . . .Venereal disease research laboratories (Syphilis test)
- VF . . . . . .Ventricular fibrillation
- VMA . . . . . .Vanillylmandelic acid
- VO . . . . . .Verbal order
- V/Q . . . . . .Ventilation and perfusion ratio
- VRE . . . . . .Vancomycin-resistant enterococcus
- VS . . . . . .Vital signs
- VSD . . . . . .Ventricular septal defect
- VSS . . . . . .Vital signs stable
- VT . . . . . .Ventricular tachycardia
- WB . . . . . .Whole blood
- WBC . . . . . .White blood cells (count)
- WD . . . . . .Well-developed
- WDWN . . . . . .Well-developed, well-nourished
- WF . . . . . .White female

- WM . . . . . .White male
- WN . . . . . .Well-nourished
- WNL . . . . . .Within normal limits
- WPW . . . . . .Wolff-Parkinson-White (syndrome)
- WO . . . . . .Weeks old
- WO . . . . . .Wide open
- W/O . . . . . .Without
- WO . . . . . .Written order
- WTD . . . . . .Wet-to-dry
- W/U . . . . . .Work-up
- x . . . . . .Times (e.g., x4 days = times 4 days)
- XM . . . . . .Cross match
- XOM . . . . . .Extraocular movements
- XRT . . . . . .X-ray therapy
- YO . . . . . .Years old
- ZES . . . . . .Zollinger-Ellison syndrome

Abbreviations Easily Misinterpreted

Although any abbreviation can be misinterpreted, a number of them are easier to misread than others. Therefore, care must be exercised any time a nurse is reading documentation to make sure that the information is being interpreted correctly.

In an effort to decrease the concerns and errors associated with abbreviated documentation, The Joint Commission (2008) affirmed a "Do Not Use" list of abbreviations in 2005. The Commission is also working on a list of potential abbreviations that will move to the "Do Not Use" list in the future. The following tables illustrate these lists.

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on preprinted forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms, and Symbols[1]

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full

Continued

Additional Abbreviations, Acronyms, and Symbols[1]—*cont'd*

Do Not Use	Potential Problem	Use Instead
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
Cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
Ug	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

[1]For possible future inclusion in the Official "Do Not Use" List.

Templates and Example Forms

Templates are predesigned formats, often listing criteria for documentation with check-boxes, on which the nurse can mark whether each criterion applies to the client. Templates exist for histories, review of systems, assessments, treatments, and discharge teaching. It is important to remember that on the following templates, data about the client have not been completed and that these examples have been formatted to fit within *DocuNotes*. These templates serve as examples to use when constructing documentation that is client-specific.

An example of an assessment template might look like this:

General (Constitutional)
❒ Vital signs reviewed

Eyes
❒ Conjunctiva pink and moist
❒ Sclera clear

Ears, Nose, and Throat
❒ Tympanic membranes clear
❒ Mucous membranes moist

- ❒ Oropharynx without exudate
- ❒ Nasal mucosa pink and moist
- ❒ No sinus tenderness

Neck
- ❒ Supple
- ❒ No masses
- ❒ Symmetrical
- ❒ Nontender
- ❒ Trachea midline
- ❒ Thyroid size normal

Respiratory
- ❒ No accessory muscle use
- ❒ No nasal flaring
- ❒ Lungs clear to auscultation bilaterally

Lymphatic
- ❒ No nodes present in neck, groin, or axillae

Cardiovascular
- ❒ No murmurs noted
- ❒ Heart sounds S_1 and S_2 audible
- ❒ No peripheral edema

Gastrointestinal/Abdomen
- ❒ No masses or tenderness
- ❒ Bowel sounds normoactive in all quadrants
- ❒ No hepatosplenomegaly

Skin
- ❒ No rashes, lesions, or ulcers noted

Musculoskeletal
- ❒ Gait steady
- ❒ No joint tenderness

Neurological
- ❒ Cranial nerves intact

Psychological
- ❒ Oriented to person, place, and time

Template charting can help you to quickly identify normal or expected findings. Templates themselves can also be exceptional tools for reminding you of things that you need to assess. Concerns about templates, however, include the potential for you to forget to write in abnormal findings or to omit charting about items other than those included in the template.

If your facility uses template charting, take advantage of this efficient way to record findings quickly, but be certain to include pertinent narrative charting to substantiate your findings or elaborate on other occurrences in your client's day that need to be noted.

Below, you will find an example of a template that could be used by a nurse practitioner. Notice that it has places to record diagnostic test results, as well as a place in the right lower corner to place the assessment (medical diagnosis) and planning (medical orders).

<table>
<tr><td>T</td><td colspan="2">Name:</td></tr>
<tr><td>P</td><td colspan="2">MR number:</td></tr>
<tr><td>R</td><td colspan="2">DOB:</td></tr>
<tr><td>BP</td><td colspan="2">PCP:</td></tr>
<tr><td>SpO_2</td><td colspan="2">Gender:</td></tr>
<tr><td>CC/HPI:</td><td rowspan="6">Medications taken:</td><td>Lab & Test data:
  </td></tr>
<tr><td>Allergies</td><td rowspan="2">Other lab results:</td></tr>
<tr><td>PMH</td></tr>
<tr><td>PSxH</td><td>EKG results:</td></tr>
<tr><td>PSH</td><td>X-ray results:</td></tr>
<tr><td>PFH</td><td>CT or MRI results:</td></tr>
<tr><td colspan="2">Physical examination data:</td><td>Assessment/Planning:
1.
2.
3.
4.
5.

Signature_____</td></tr>
</table>

Kardex

A Kardex is a form, generally printed on index-card style paper, that is kept in a flip folder at the nurse's station on a hospital unit. It contains information that is directly pertinent about the client's immediate condition and reflects primary care provider orders that the nurse should be aware of in a quick and easily referenced fashion. Kardexs are considered "moving targets," in other words, they are routinely updated to reflect the changing status of the client. For example, if the client was in contact isolation, but then was discontinued from such, the Kardex would be updated right away to reflect that the client is no longer in isolation. The Kardex is a handy tool to get a "bird's-eye-view" of the client, but should never be used as the sole reference upon which care planning is built.

Kardex
XYZ Hospital
Keystone City, Kansas

Name _____
Room numb _____
Diagnosis _____ Surgery _____
Allergies _____

Isolation

❒ Airborne
❒ Contact
❒ Droplet
❒ Neutropenic
❒ Strict

Organism: _____
Devices

❒ Catheter ❒ Foley ❒ Straight
❒ Chest tube
❒ Drain List: _____
❒ IV
❒ NG tube
❒ G button
❒ Other List: _____

Activity

❒ Ambulate how often: _____
❒ Bathroom priv.
❒ Bedrest
❒ Bedside commode
❒ Cane ❒ Walker
❒ Elevate head of bed

Nutrition

❒ NPO ❒ Puree ❒ ADA diet calories: _____
❒ Soft ❒ Heart healthy ❒ TPN
❒ Liquid—full ❒ Liquid—clear
❒ NG tube
❒ G-button
❒ J-tube

IV

❒ Central line Side: _____ Type: _____
❒ Heparin lock Side: _____ Type: _____
❒ PCA Side: _____ Type: _____
❒ PICC Side: _____ Type: _____
❒ PORT Side: _____ Type: _____
❒ Saline lock Side: _____ Type: _____
❒ TPN Side: _____ Type: _____

Rehab

❒ Occupational therapy Frequency: _____
❒ Physical therapy Frequency: _____
❒ Speech therapy Frequency: _____

Daily Tests

❒ CBC
❒ Chest x-ray
❒ Metabolic profile
❒ Urinalysis
❒ Other List: _____

Oxygenation

❒ Oxygen Rate: _____ ❒ Cannula ❒ Mask
❒ ABGs Frequency: _____
❒ Pulse oximetry
❒ Spirometry
❒ Vent FIO2 _____ IMV/CMV _____
TV _____ CPAP/PEEP _____
QPAP _____ PG _____

Cardiovascular

❒ Art line
❒ CVP
❒ PA
❒ Swan-Ganz
❒ Circulatory checks Frequency: _____
❒ EKG

Consults

❒ Cardiology ❒ Immunology ❒ Surgery
❒ Neurology ❒ Infectious disease ❒ GI
❒ Respiratory ❒ Ear/Nose/Throat ❒ GU

Code Status

❒ Full code
❒ Advance directives
❒ Living will
❒ DNR (do not resuscitate)
❒ DNR CCO (do not resuscitate, comfort care only)

Place client identification sticker here

Medication Administration Record

The Medication Administration Record (MAR) provides a forum for the nursing professional to document medications that were administered or withheld. (If medications are withheld for any reason, the rationale for withholding should be documented in the medical record also.) The MAR will generally be sent to the nursing unit upon admission to the unit. The nursing professional should closely observe the MAR, and compare it to the list of client medications that were provided on the admission orders. This is called "medication reconciliation," and serves to validate that all pertinent medications have been consistently ordered. When documenting in the MAR, be careful to complete it thoroughly, reflecting exact times of administration and any refusals or holds of medication. Follow up in the narrative charting regarding situations involving patient refusal of medications, and rationales for holding medications.

Medication Administration Record 123456			Date: 11 December 2009	
Client's Name: Doe, John J.			Room number: 334-B	
Diagnosis: CVA			Allergies: Penicillin	
Weight: 225 pounds				
Medications	RN initials	0700 to 1459	1500 to 2259	2300 to 0659
Plavix, 75 mg 1 tab q am				
HCTZ, 25 mg 1 tab q am				
Lipitor, 40 mg 1 tab q hs				

Signature Initials

_____( )
_____( )
_____( )
_____( )
_____( )

Signature Initials

_____ ( ) ❒ Scheduled medications
_____ ( ) ❒ Sliding scale medications
_____ ( ) ❒ PRN medications
_____ ( )
_____ ( )

Place Client Label Here

List of Home Medications for the Client

List of Home Medications for the Client

If your illness is related to a heart attack (myocardial infarction or MI), heart failure, open heart surgery, or you had a heart catheterization with a stent (PCI): ASK your NURSE or DOCTOR about taking helpful heart medications such as ASPIRIN, beta blockers, ACE inhibitors (ACI), or angiotension blockers (ARBS).

Check medication here if new	Name of medication	Dose (How Much)	How often (NO ABBREVIATIONS)	Reason for Medication	Next Dose Due	Education Sheet

STOP TAKING THESE MEDICATIONS LISTED BELOW

Drug to Be Stopped	Dose	How Often (NO ABBREVIATIONS)	Comments

Medication instructions reviewed with client/ family.

Medication instructions reviewed with client/ family.
_____ Signature of RN or physician/Date

The above medication instructions have been reviewed with me and I understand them.
_____ Signature of client or family member/Date

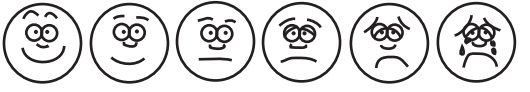
Place Client Label Here

Nursing Progress Notes Sample

Nursing Progress Notes XYZ Hospital Keystone City, Kansas

Date	Time	Notation
11-Dec-09	1900	Physical assessment complete (see template); states has a headache of 8/10 on a 1–10 scale. Sinus tenderness noted upon palpation. PERRLA. No weakness in extremities noted. Speech appropriate; no slurring or difficulty finding words. Dr. Jones paged. _____ _____ *C. Nurse, RN*
11-Dec-09	1923	Dr. Jones returned page; ordered Tylenol 650 milligrams to be given every 4 to 6 hours as needed. Administered Tylenol, pulled shades down to block sun, as client felt this might be aggravating the headache. Educated to use call light before getting out of bed. Understanding verbalized. _____ *C. Nurse, RN*
11-Dec-09	1945	Sitting in bed watching television; states pain is now at 3/10 and states, "I feel much better." _____ _____ *C. Nurse, RN*

Wong-Baker FACES Pain Rating Scale



Explain to the client that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he does not hurt at all. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you do not have to be crying to feel this bad. Ask the person to choose the face that best describes how he or she is feeling. This rating scale is recommended for persons age 3 years and older.

Source: From Hockenberry, M. J., Wilson, D., Winkelstein, M. L. (2005). *Essentials of pediatric nursing* (7th ed.). St. Louis: Moseby, p. 1259. Used with permission. Copyright Mosby.

NANDA-Approved Nursing Diagnoses

Activity Intolerance
Activity Intolerance, Risk for
Airway Clearance, Ineffective
Anxiety
Anxiety, Death
Aspiration, Risk for
Attachment, Parent/Infant/Child, Risk for Impaired
Autonomic Dysreflexia
Autonomic Dysreflexia, Risk for
Blood Glucose, Risk for Unstable
Body Image, Disturbed
Body Temperature: Imbalanced, Risk for
Bowel Incontinence
Breastfeeding, Effective
Breastfeeding, Ineffective
Breastfeeding, Interrupted
Breathing Pattern, Ineffective
Cardiac Output, Decreased
Caregiver Role Strain
Caregiver Role Strain, Risk for
Comfort, Readiness for Enhanced
Communication: Impaired, Verbal
Communication, Readiness for Enhanced
Confusion, Acute
Confusion, Acute, Risk for
Confusion, Chronic
Constipation
Constipation, Perceived
Constipation, Risk for
Contamination
Contamination, Risk for
Coping: Community, Ineffective
Coping: Community, Readiness for Enhanced
Coping, Defensive
Coping: Family, Compromised
Coping: Family, Disabled

Coping: Family, Readiness for Enhanced
Coping (Individual), Readiness for Enhanced
Coping, Ineffective
Decisional Conflict
Decision Making, Readiness for Enhanced
Denial, Ineffective
Dentition, Impaired
Development: Delayed, Risk for
Diarrhea
Disuse Syndrome, Risk for
Diversional Activity, Deficient
Energy Field, Disturbed
Environmental Interpretation Syndrome, Impaired
Failure to Thrive, Adult
Falls, Risk for
Family Processes, Dysfunctional: Alcoholism
Family Processes, Interrupted
Family Processes, Readiness for Enhanced
Fatigue
Fear
Fluid Balance, Readiness for Enhanced
Fluid Volume, Deficient
Fluid Volume, Deficient, Risk for
Fluid Volume, Excess
Fluid Volume, Imbalanced, Risk for
Gas Exchange, Impaired
Grieving
Grieving, Complicated
Grieving, Risk for Complicated
Growth, Disproportionate, Risk for
Growth and Development, Delayed
Health Behavior, Risk-Prone
Health Maintenance, Ineffective
Health-Seeking Behaviors (Specify)
Home Maintenance, Impaired
Hope, Readiness for Enhanced
Hopelessness
Human Dignity, Risk for Compromised

Hyperthermia
Hypothermia
Immunization Status, Readiness for Enhanced
Infant Behavior, Disorganized
Infant Behavior: Disorganized, Risk for
Infant Behavior: Organized, Readiness for Enhanced
Infant Feeding Pattern, Ineffective
Infection, Risk for
Injury, Risk for
Insomnia
Intracranial Adaptive Capacity, Decreased
Knowledge, Deficient (Specify)
Knowledge (Specify), Readiness for Enhanced
Latex Allergy Response
Latex Allergy Response, Risk for
Liver Function, Impaired, Risk for
Loneliness, Risk for
Memory, Impaired
Mobility: Bed, Impaired
Mobility: Physical, Impaired
Mobility: Wheelchair, Impaired
Moral Distress
Nausea
Neurovascular Dysfunction: Peripheral, Risk for
Noncompliance (Specify)
Nutrition, Imbalanced: Less than Body Requirements
Nutrition, Imbalanced: More than Body Requirements
Nutrition, Imbalanced: More than Body Requirements, Risk for
Nutrition, Readiness for Enhanced
Oral Mucous Membrane, Impaired
Pain, Acute
Pain, Chronic
Parenting, Impaired
Parenting, Readiness for Enhanced
Parenting, Risk for Impaired

Perioperative Positioning Injury, Risk for
Personal Identity, Disturbed
Poisoning, Risk for
Post-Trauma Syndrome
Post-Trauma Syndrome, Risk for
Power, Readiness for Enhanced
Powerlessness
Powerlessness, Risk for
Protection, Ineffective
Rape-Trauma Syndrome
Rape-Trauma Syndrome: Compound Reaction
Rape-Trauma Syndrome: Silent Reaction
Religiosity, Impaired
Religiosity, Readiness for Enhanced
Religiosity, Risk for Impaired
Relocation Stress Syndrome
Relocation Stress Syndrome, Risk for
Role Conflict, Parental
Role Performance, Ineffective
Sedentary Lifestyle
Self-Care, Readiness for Enhanced
Self-Care Deficit: Bathing/Hygiene
Self-Care Deficit: Dressing/Grooming
Self-Care Deficit: Feeding
Self-Care Deficit: Toileting
Self-Concept, Readiness for Enhanced
Self-Esteem, Chronic Low
Self-Esteem, Situational Low
Self-Esteem, Risk for Situational Low
Self-Mutilation
Self-Mutilation, Risk for
Sensory Perception, Disturbed (Specify: Auditory, Gustatory, Kinesthetic, Olfactory, Tactile, Visual)
Sexual Dysfunction
Sexuality Pattern, Ineffective
Skin Integrity, Impaired
Skin Integrity, Risk for Impaired
Sleep Deprivation

Sleep, Readiness for Enhanced
Social Interaction, Impaired
Social Isolation
Sorrow, Chronic
Spiritual Distress
Spiritual Distress, Risk for
Spiritual Well-Being, Readiness for Enhanced
Spontaneous Ventilation, Impaired
Stress, Overload
Sudden Infant Death Syndrome, Risk for
Suffocation, Risk for
Suicide, Risk for
Surgical Recovery, Delayed
Swallowing, Impaired
Therapeutic Regimen Management: Community, Ineffective
Therapeutic Regimen Management, Effective
Therapeutic Regimen Management: Family, Ineffective
Therapeutic Regimen Management, Ineffective
Therapeutic Regimen Management, Readiness for Enhanced
Thermoregulation, Ineffective
Thought Processes, Disturbed
Tissue Integrity, Impaired
Tissue Perfusion, Ineffective (Specify: Cerebral, Cardiopulmonary, Gastrointestinal, Renal)
Tissue Perfusion, Ineffective, Peripheral
Transfer Ability, Impaired
Trauma, Risk for
Unilateral Neglect
Urinary Elimination, Impaired
Urinary Elimination, Readiness for Enhanced
Urinary Incontinence, Functional
Urinary Retention
Ventilatory Weaning Response, Dysfunctional
Violence: Other-Directed, Risk for
Violence: Self-Directed, Risk for
Walking, Impaired
Wandering
Urinary Incontinence, Overflow

Urinary Incontinence, Reflex
Urinary Incontinence, Stress
Urinary Incontinence, Total
Urinary Incontinence, Urge
Urinary Incontinence, Risk for Urge

Source: NANDA Nursing Diagnoses: Definitions and Classification, 2007–2008. Philadelphia: North American Nursing Diagnosis Association. Used with permission.

Frequently Used Phone Numbers

Overhead Code:	99/Blue:
Security:	**Emergency ext:**
Admitting:	
Blood Bank:	
Burn Unit:	
CICU (CCU):	
Chaplain—Pastor:	
Computer Help (IS, IT):	
CT (Computed Tomography):	
Dietary—Dietician:	
ECG—12 Lead:	
ICU:	
Interpreter Services:	
Laboratory:	
Maintenance—Engineering:	
Med-Surg:	
MRI (Magnetic Resonance Imaging):	
Nutrition—Food Services:	
OT (Occupational Therapy):	
PACU (Recovery):	
Pediatrics:	
Pharmacy (Rx):	

Continued

Poison Control:	USA – 1-800-222-1222
PT (Physical Therapy):	
Respiratory (RT):	
Social Services:	
Speech Language Pathology (SLP):	
Supervisor—Manager:	
Surgery—Inpatient (OR):	
Surgery—Day/Outpatient:	
Telemetry Unit:	
X-Ray:	

Community Resources

Abuse/Assault—Physical/Sexual	
■ Children	
■ Women	
■ Rape/Sexual	
■ Men	
■ Elderly	
Abuse—Substance	
■ Alcohol	
■ Drug	
Communicable Disease Programs	
■ AIDS	
■ Hepatitis	
■ TB	

Continued

Food/Clothing	
■ Food Kitchen	
■ Meals on Wheels	
■ Salvation Army	
Shelters/Homeless	
Mental Health	
■ Suicide	
Medical/Hospitals	
■ State Program	
■ Dept. of Health	
■ Free Clinics	
Teen/Children	
■ Immunization	
■ Pregnancy	
■ Runaway	
Other	

Basic English-to-Spanish Translation

English Phrase	Pronunciation	Spanish Phrase
Introductions—Greetings		
Hello	**oh**-lah	Hola
Good morning	**bweh**-nohs **dee**-ahs	Buenos días
Good afternoon	**bweh**-nohs **tahr**-dehs	Buenos tardes
Good evening	**bweh**-nahs **noh**-chehs	Buenas noches
My name is	*meh* **yah**-*moh*	Me llamo
I am a nurse	soy lah oon en-fehr-**meh**-ra	Soy la enfermera
What is your name?	koh-moh seh yah-mah oo-sted?	¿Cómo se llama usted?
How are you?	**koh-moh eh-stah oo-stehd?**	¿Como esta usted?
Very well	mwee b' yehn	Muy bien
Thank you	grah-s'yahs	Gracias
Yes, No	see, noh	Sí, No
Please	pohr fah-vohr	Por favor
You're welcome	deh **nah**-dah	De nada
Assessment—Areas of the Body		
Head	kah-beh-sah	Cabeza
Eye	oh-hoh	Ojo
Ear	oh-ee-doh	Oído
Nose	nah-reez	Nariz
Throat	gahr-gahn-tah	Garganta
Neck	kweh-yoh	Cuello
Chest, Heart	peh-choh, kah-rah-sohn	Pecho, corazón
Back	eh-spahl-dah	Espalda
Abdomen	ahb-doh-mehn	Abdomen
Stomach	eh-stoh-mah-goh	Estómago
Rectum	rehk-toh	Recto
Penis	peh-neh	Pene
Vagina	vah-hee-nah	Vagina
Arm, Hand	brah-soh, mah-noh	Brazo, Mano
Leg, Foot	p'yehr-nah, p'yeh	Pierna, Pie

Continued

English Phrase	Pronunciation	Spanish Phrase
Assessment—History		
Do you have…	T'yeh-neh oo-stehd…	¿Tiene usted…
• Difficulty breathing?	di-fi-kul-thad	¿Dificultad para respirar?
• Chest pain?	doh-lorh hen lh peh-chow	¿Dolor en el pecho?
• Abdominal pain?	doh-lorh ab-do-minl	¿Dolor abdominal?
• Diabetes?	dee-ah-beh-tehs	¿Diabetes?
Are you…	ehs-tah	¿Esta…
• Dizzy?	ma:r-eh-a-dho(dha)	¿Mareado(a)?
• Nauseated?	ka:n now-she-as	¿Con nauseas?
• Pregnant?	¿ehm-bah-rah-sah-dah?	¿Embarazada?
Are you allergic to any medications?	¿ehs ah-lehr-hee-koh ah ahl-goo-nah meh-dee-see-nah?	¿Es alergico a alguna medicina?
Assessment—Pain		
Do you have pain?	T'yeh-neh oo-stehd doh-lorh?	¿Tiene usted dolor?
Where does it hurt?	dohn-deh leh dweh-leh?	¿Donde le duele?
Is the pain…	es oon doh-lor…	¿Es un dolor…
• Dull?	Leh-veh	¿Leve?
• Aching?	ka:ns-tan-the	¿Constante?
• Crushing?	ah-plahs-than-teh?	¿Aplastante?
• Sharp?	ah-goo-doh?	¿Agudo?
• Stabbing?	ah-poo-neo-lawn-teh	¿Apuñalante?
• Burning?	Ahr-d'yen-the?	¿Ardiente?
Does it hurt when I press here?	Leh dweh-leh kwahn-doh ah-pree-eh-toh ah-kee?	¿Le duele cuando le aprieto aqui?
Does it hurt to breath deeply?	S'yen-teh oo-sted doh-lor kwahn-doh reh-spee-rah pro-foon-dah-men-teh?	¿Siente usted dolor cuando respira profundamente?
Does it move to another area?	Lh doh-lor zeh moo-eh-veh a oh-thra ah-ri-ah	¿El dolor se mueve a otra area?
Is the pain better now?	c-n-the al-goo-nah me-horr-i-ah	¿Siente alguna mejoria?

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Note: Page numbers followed by "f" and "t" indicate figures and tables, respectively.

ENGLISH FOR NURSES AND HEALTH PROFESSIONALS

An English for Specific Purposes Course Book

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Topics sourced from McGraw Hill English for Nursing and Health Care (Bradley, 2008),

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and

Oxford English for Professionals Nursing 2 (Grice & Greenan, 2008)

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Unit 1

A. The Hospital Team

It is essential for you to know the people who you are going to work with in the hospital. You must know the different roles played by these people as well. They could be doctors, nurses, medical professionals, and staff. Let's get to know them and what they do.

porter	receptionist	paramedic	scrub nurse	pharmacist
radiologist	lab technician	charge nurse	cardiologist	midwife
pediatrician	consultant	physiotherapist	anesthetist	surgeon

Exercise 1.1 Choose the correct word from the box to complete the sentences.

1. A _____ is a doctor who treats children
2. A _____ is a medical professional who attends births and delivers babies.
3. A _____ is a doctor who specializes in illnesses of the heart and blood vessels.
4. A _____ is a staff who moves patients, equipment, furniture, etc. around the hospital.
5. A _____ is a medical professional who takes x-rays and other images.
6. A _____ is a nurse who supports surgeons in the operating room.
7. A _____ is a nurse who prepares medicines to give to medical staff or patients.
8. A _____ is a medical professional who responds to emergencies and gives first aid.
9. A _____ is a doctor who performs surgical operations.
10. A _____ is a medical professional who examines samples and tissues under a microscope.
11. A _____ is a nurse who supervises staff nurses in a ward.
12. A _____ is a staff who assists people with appointments and directions.
13. A _____ is a nurse who administers drugs to patients to prevent pain during surgery.
14. A _____ is a doctor who gives expert opinion to other doctors and surgeons.
15. A _____ is a medical professional who helps patients with physical difficulties resulting from illness, injury, disability.

Introducing Yourself and the Hospital Staff

When it's your first day at work or if you are moved from one department or ward to another, you must make sure that you can introduce yourself properly to your new colleagues. In turn, you should be able to introduce yourself and your colleagues to the patient. Here are sample conversations:

Introducing yourself to the patient

Parn: Hello! I'm Parn, a Staff Nurse here at Naresuan University Hospital. May I know your name?
Moo: Hi! My name is Moo. How are you?
Parn: I'm good, thanks for asking. I'd like you to meet Jam, she is our nursing assistant.
Moo: Nice to meet you Jam.
Jam: Nice to meet you too. If you need anything, just let me know.
Parn: Thanks Jam. Could you please get some water for Moo.
Jam: Sure, I'll be back in a minute.

Introducing your colleagues

Parn: Hi Bam. Have you met the Ward Charge Nurse?
Bam: No, we haven't met yet.
Parn: May I introduce you to Sister Tam.
Bam: Good morning, my name is Bam. How do you do?
Tam: I'm doing well. How about you?
Bam: I'm great! It's a pleasure to meet you.
Tam: The pleasure is mine.

When you are to meet people for the first time, you have to use formal or informal words to address them. Typically, if you are meeting someone new from work, especially if they are someone older or more senior than you, you have to use formal words. If you are meeting new friends or colleagues at the same level as you are then you can use informal words.

	Introduction	**Response**
Informal	Hello / Hi! I'm … May I know your name? I'd like you to meet … How are you? Nice to meet you. I'm glad to meet you	Hello / Hi! I'm … I'm fine, thanks. And you? I'm good, thanks for asking. Nice to meet you too. I'm glad to meet you too.
Formal	May I introduce you to … ? How do you do? Have you met … ? It's a pleasure to meet you.	Good morning. My name is …. I'm doing well. How about you? No, we haven't met yet. Yes, we have met yesterday / last week. I'm very pleased to meet you too. The pleasure is mine.

Speaking Activity

Form a group of three and practice the introductions and responses. Prepare to present your introductions in front of the class.

Different countries, Nationalities and Languages

It is important for nurses to know the different countries, nationalities and languages of their patients.

Exercise 1.2 Write the nationality and language spoken of the people from these countries.

Country	Nationality	Language(s)	Country	Nationality	Language(s)
Australia			Myanmar		
Cambodia			Philippines		
China			Singapore		
France			Spain		
Germany			Switzerland		
Italy			Thailand		
Japan			The United States		
Korea			Vietnam		
Malaysia			Malaysia		

B. In and Around the Hospital

The names of the wards can be formed by adding a suffix from the departments and used as an adjective.

e.g. surgery becomes the surg**ical** ward *for obstetrics we use the **labor ward**
medicine becomes the medic**al** ward
gynecology becomes the gynecolog**ical** ward

Exercise 1.3 Make an adjective from these words by removing the letters in bold and adding a suffix.

1. Neurolog**y** _____
2. Cardiolog**y** _____
3. Gastrolog**y** _____
4. Dermatolog**y** _____
5. Opthalmolog**y** _____
6. Neonat**e** _____
7. Pharmacolog**y** _____
8. Urolog**y** _____

Ask your partner the following questions:

1. Where can a mother go to visit her premature baby?
2. Where do you ring to order a patient's medications?
3. Where can I find a doctor to look at my moles?
4. Where do patients usually go if they have a heart attack?
5. Where do patients go when they have an infection in their bladder?

Look at the prepositions used in the following examples:

A pediatric nurse works **in** the nursery **in** the children's ward.
My friend works **in** the Operating Theatre **on** the 6th floor.
The Surgical Ward is **next to** the Orthopedic Ward **on** the same floor.

We use different expressions depending on the situation:

We **go to** a ward or department.
We **work in** a ward, but we **work at** the hospital.
We **take/send** a patient to a department but he is **in the** ward, hospital, or theatre.

C. Hospital Admissions

What is the Standard Admission Procedure where you work? With a partner, put the following points into a possible sequence. (1-9)

___ a. Tell the patient what is going to happen to him/her in the next 12-24 hours.
___ b. Co-ordinate between the patient, the doctors and other health care workers.
___ c. Put on the patient's name band and signs necessary on the bed (e.g. nil orally or fasting)
___ d. Inform the doctor in charge of the patient's arrival.
___ e. Welcome the patient in a calm, friendly manner.
___ f. Introduce yourself and the other patient (s) in the room. Introduce other staff and the Ward Charge Nurse where possible.
___ g. Complete the admission form and appropriate charts.
___ h. Show the patient where to find the bathroom, the Nurse's station, the Day Room (Sitting Room).
___ i. Demonstrate the handset with the overhead light and the call bell (or buzzer) and the patient how to use the remote – if a TV is provided.

Reading

On Monday, Mark is admitted to hospital and arrives in the Surgical Ward with Julie. They meet the Charge Sister and Sister Joanna, who takes them to a room. Mary, the Ward Help, is in the room cleaning the bedside tables. There are 2 beds in the room but both are empty.

Sister Pat: This is your room, Mark – number 612. You will be **on your own** for a couple of days so you can choose the bed near the window or this one near the bathroom. Hello Mary, this is Mark Andrews and his wife Julie.

Mary: Good morning, Mr. and Mrs. Andrews. Can I get you a bottle of water and a glass?

Sister Pat: Thank you Mary, but mark is having more tests today and **can't have anything to eat or drink** until later. Mary is a wonderful help and will help us to look after you, Mark.

Mark: Thank you. I'd like to have the bed near the window if that's all right.

Sister Pat: Yes, of course. I'll leave you to **change into your pyjamas** and hop into bed and then I'll come back in a few minutes to ask you a few questions. You can put your clothes in the cupboard on the left, but it isn't very big so it's probably a good idea to take the suitcase home with you, Mrs. Andrews. Mark, you can put **the things you need** in the cupboard near the bed.

Mark: Yes, thank you. Jules will take the case with her when she goes – you've got the car, love, so that's no problem, is it? Can my wife stay here this morning, Sister?

Sister Pat: Yes, that's fine. I'll come back to speak to you both very soon. This is the handset. if you need anything, just call. This button is the buzzer and this one is to cancel your call – the light over the door turns off – this one is for the overhead light… OK?

Exercise 1.4 Read the dialogue to answer the following questions:

1. Who is Mary?
2. How many patients are in the room with Mark?
3. Does he have a choice of beds? Which one does he choose?
4. What is Julie taking home?
5. Is Mark fasting?

Speaking Activity

In groups of 3, practice the dialogue. Discuss the expressions in bold and how you can say them differently.

Unit 2

A. Accidents and Emergencies

As health care professionals, we have to know the terms used to get information in a patient's record.

Exercise 2.1 Complete the sentences with the words below.

a triage nurse	treatment	an initial assessment	cubicle
life-threatening	a priority	waiting room	registration

1. Take a seat in the _____.
2. The first nurse you meet will be a specialist called _____.
3. This nurse will make _____ of your problem.
4. This helps decide who is_____.
5. A patient with a _____ condition will see a doctor immediately.
6. A nurse will get personal details from you and fill in a hospital _____ form.
7. When there is a free _____, a doctor will see you.
8. The doctor will decide on the _____.

Patient Record

Surname	Grady	First name	Jim	
DOB	2.3.50	Gender	(M)	F
Occupation		retired		
Marital status		widowed		
Next of kin		son		
Contact no.		07765432178		
Smoking intake		n/a		
Alcohol intake		30 units per week		
Reason for admission		chest pains		
Medical history		high blood pressure		
Allergies		none		
GP		Dr. Parkinson		
		Central Surgery		

Exercise 2.2 Find words and abbreviations in the patient record with these meanings.

_____ 1. job
_____ 2. bad reactions, e.g. certain medications
_____ 3. family doctor
_____ 4. closest relative
_____ 5. the amount of something you eat, drink, etc. regularly
_____ 6. date of birth
_____ 7. male / female
_____ 8. pass illnesses and injuries
_____ 9. married / single /divorced /widowed
_____ 10. not applicable (not a question for this patient)
_____ 11. in each (day, week, etc.)
_____12. number

Giving Instructions

We need to be able to give instructions clearly to our patients or to other health care professionals to be able to provide the best possible care.

To tell somebody what to do, you can use the *Imperative.* Start the sentence with a verb without a subject.

> **Check** for signs of circulation
> **Apply** the pads to his chest

To tell what not to do, add *Don't* before the imperative

> **Don't remove** burnt clothing

To emphasize that is <u>important</u>, you can use *Make sure* **…**

> **Make sure** the wound is clean.
> **Make sure** you don't touch his body.

When asking for instructions, you can use the Present Simple, have to, shall and should.

> What **do I do** now?
> Do I **have to** immobilize his leg?
> **Shall I** take off the dressing now?
> What dosage **should I** give him?

Exercise 2.3 Match the beginnings and endings of the sentence.

1. Check that	a. I count up to between breaths?
2. Make sure you	b. I give her?
3. What do	c. have to apply the pads?
4. Don't let	d. the patient is breathing.
5. Should I	e. the patient try to stand up
6. Shall I bandage	f. put the burnt area under running water?
7. Don't	g. the patient's pulse
8. What dosage shall	h. tie the bandage too tight!
9. Take	i. the wound now?
10. Where do I	j. use a sterile needle

Speaking Activity

Student A

1. You are a parent. Five minutes ago a poisonous snake bit your child. You phone an emergency helpline. Explain the situation to the helpline nurse, then listen and use these notes to find out what to do. Note down the instructions that you are given.

Example: What shall I do with ……?
Should I put it on ice? Should I ……?

- wound – ice? bandage?
- child thirsty - milk OK?
- walk around?
- doctor?

2. A man you work with has spilt pesticide on his face, eyes and mouth. Phone the emergency helpline for instructions. Explain the situation to the helpline nurse, then listen and use these notes to find out what to do. Note down the instructions that you are given.

- difficulty breathing – walk around?
- drink?
- mouth? eyes? skin?
-

Student B

1. You are a nurse working on a telephone helpline. Listen to your caller explain the emergency, then use these notes to tell the caller what to do to answer any questions.

Example: Wash the wound with soap and water. Don't practice …

- wound – wash ✓ (soap and water), ice X, bandage ✓ (not too tight)
- immobilize the leg ✓ (lower than the heart)
- stand up, move X
- food, drink X
- hospital ✓

2. You are a nurse working on a telephone helpline. Listen to you caller explain the emergency, then use these notes to tell the caller what to do and to answer any questions.

Example: Make sure he gets fresh air!
Open windows and doors and …

- fresh air ✓✓ (windows /doors ✓, carry if necessary ✓, walk X)
- mouth – wash out ✓ (water)
- milk ✓ (alcohol X)
- skin – remove clothes if covered in pesticide ✓, wash ✓ (running water, soap)
- eyes – wash ✓ (running water, 15 minutes +, chemicals x)
- touch pesticides XX (gloves ✓✓)

B. Admissions by Referral

Polite Phrases

When talking to patients and staff, it is important to use polite words and tone. We have to remember that we are the people who patients face every day and should be courteous and kind as possible. Even though some patients can be difficult, we should still compose ourselves and treat them nicely as we would like to be treated the same.

Nurse: I've forgotten [1] your name.
Patient: It's Mrs. Stein.
Nurse: Of course, Mrs. Stein. Give me [2] your letter of referral.
Patient: Here it is.
Nurse: Thanks. So, Mrs. Stein, you've come in for removal of varicose veins?
Patient: Yes. The operation is this afternoon.
Nurse: Confirm [3] one or two things. First, are you on [4] any medications?
Patient: Yes, I take Venlafaxine.
Nurse: What for [5]?
Patient: I take it for depression.
Nurse: OK. Now, tell me [6] about your lifestyle. Report [7] any alcohol or drug problems you have.
Patient: None, I don't drink and I don't take drugs.
Nurse: Also, tell me if you have [8] any contact with HIV in the past six months.
Patient: I haven't had any contact with HIV, no.
Nurse: Fine, and who's [9] paying for your treatment?
Patient: I'm covered by medical insurance.
Nurse: Great, and lastly, you must [10] take off your make up and rings.

Exercise 2.4 Replace each underlined phrase in the dialogue with an alternative polite phrase from the list.

____ would you mind if I ask you to
____ it's important to know about
____ can you tell me how you are
____ could you tell me if you take
____ I'm sorry, I can't remember
____ I need to know if you have
____ can you let me have
____ I'd like to check
____ may I ask why
____ I have to ask

Getting Verbal Consent

A 64-year-old woman with MS is admitted. The doctor thinks she should be placed on a feeding tube. In the morning the patient is confused. A nurse talks to her about the feeding tube and she consents. However, later in the day when the tube is going to be placed, the patient says she doesn't want it in. The following morning, the patient is vague and the nurse tries once more and again the patient consents to the procedure.

Is the patient able to decide? Should the nurse place the feeding tube or not?

Work in pairs. Discuss these questions

1. When is it necessary to get a patient's verbal 'informed consent'?
2. When should a patient sign a consent form and when is it not necessary?
3. Listening to a heartbeat through a stethoscope is a medical procedure – does this need the patient's informed consent.

C. Outpatients

In some countries, outpatients don't make appointments; they just turn up. Discuss if a 'first come, first served' system has any advantages at all compared to an 'appointments only' system.

Exercise 2.5 Use this words in the box to identify the kinds of appointments described in sentences 1-12.

cancelled	initial	previous	confirmed
missed	routine	delayed	out-of-hours
double-booked	postponed	vacant	follow-up

_____1. An outpatient's appointment after an operation
_____2. When two people are given the same appointment time
_____3. When a patient tells you they will definitely keep their appointment
_____4. An appointment for eight o'clock in the evening
_____5. When the consultant is running late
_____6. The first appointment
_____7. An appointment made for Monday, but changed to Wednesday
_____8. When a patient doesn't turn up
_____9. An appointment slot that is available
_____10. A regular appointment
_____11. Not this appointment, but the one before
_____12. All the appointments after this one.

Group Activity

Deciding who should have an appointment
Work in groups of 4. You work in a hospital x-ray department. The next four weeks are almost fully booked, but there is one vacant slot today. Four patients want the vacancy and you must decide who gets it. Read the information that will be given to you and talk about it with your group.
Patient 1
On the telephone is a woman. She wants to make an appointment for her 12-year-old child. Mother and daughter have missed the last two appointments; the first because they decided to go to the cinema instead, the second because they forgot.

Patient 2
In reception is a patient who is a heavy smoker. She has a bad cough, but has not stopped smoking despite doctor's warnings. An x-ray was taken last month, but the hospital has lost her records.

Patient 3
In reception is a patient who is worried about a slight intermittent pain in his chest. He already has an appointment, but it is in four weeks' time and he wants an earlier one.
He has already been waiting for two hours.

Patient 4
On the telephone is a young man who is not ill, but needs a chest x-ray in order to start a new job. He says his new employers cannot wait and he must have the x-ray done now or lose the job.

Unit 3

A. Signs and Symptoms

As a healthcare worker, it is vital to be able to determine signs and symptoms of the patients illness or disease.

Signs are what you can observe, see or feel for yourself.

The nurse can observe changes in recorded **observations** – blood pressure, temperature, pulse or respiration.

- a **bruise** or **bruising** – that is **hematoma**
- a **rash**, which is an area of red lumps or pimples on the skin, which can be a type of **erythema** or **urticaria** (allergy rash)
- changes in the color of the skin: **anemic –looking** - white or pale
  cyanosis – blue color
  jaundice – yellow color
  inflammation – redness
- signs of **weight loss** (losing weight) or **weight gain** (putting on weight)
- **swelling** or **puffiness** – extra fluid in the tissues under the skin (edema)
- **cuts**, **wounds** or **lacerations**: breaks in the skin

Symptoms are things that the patient feels and tells the nurse about.

The patient may say that:

- he **feels like vomiting** – or he feels sick in the stomach (nauseated)
- he has **pain**
- he cannot sleep (suffers from **insomnia**)
- he had **diarrhea** – frequent, loose stools/bowel actions
- he feels **dizzy** or **giddy** (vertigo)
- he is very **thirsty** or dehydrated
- he feels **numbness** or **tingling** (‘pins and needles’) – loss of sensation or changed sensation

Signs or Symptoms
Palpations are a _____ when the patient tells you he can feel his heart racing or thumping.
It could also show as a _____ on an ECG.

Shortness of Breath may be visible or only felt by the patient ‘on exertion’ (SOB-OE)

Exercise 3.1 Work with a partner and decide if the following words are signs or symptoms.

1. an irregular pulse _____
2. stomach ache _____
3. thirst _____
4. hunger _____
5. extreme weight loss _____
6. shallow respirations _____
7. dyspnea _____
8. pallor _____
9. lacerations _____
10. headache _____

Question forms

When we want to get information from the patient or from our colleagues, we have to be able to make good questions. Here are ways on how you can ask questions:

1. We change the order to form a question with be, with tenses that are formed with be and have, and with modal verbs such as *can, will, should, etc*. Switch the subject and the verb.

    Are you all right? (NOT: You are all right?)
    What **is she** doing?
    Where **have they** put the wheelchair?
    Can you move your toes?

2. We use the verb *do* to make questions with the Present Simple and Past Simple

    What side effects **does** this drug **have**?
    Did you **take** your medication last night?
    Do you **smoke** or drink alcohol?

3. If what, who, etc. asks about the subject of the verb, do is not necessary

    What **happened**? (NOT: What did happen?)
    Who **said** that? (NOT: Who did say that?)

4. We often use question tags to check information, to express surprise, to be friendly etc.

    This is your first time on this ward, **isn't it**?
    You **don't** eat meat, **do you**?

5. We sometimes leave out the verb, if it is easily understood.

    Any pain? = Do you have any pain?
    Comfortable? = Are you comfortable?

Exercise 3.2 Match the beginnings of the questions with the endings.

1. OK,	a. it hurt?
2. What	b. Mrs. Hales?
3. Where does	c. are you?
4. What about	d. broken?
5. Let's have a look – swollen	e. happened to you?
6. You've had an x-ray	f. haven't you?
7. Anything	g. your shoulder?
8. You aren't on any other medication,	h. isn't it?

Write questions to go with these answers.

Nurse: _____
Patient: Not bad, thanks – a bit sore.
Nurse: _____
Patient: I fell off my bike.
Nurse: _____
Patient: Here, around my wrist.
Nurse: _____
Patient: Yes, I can, slowly.
Nurse: _____
Patient: Yes, very! I've also got a cut on my leg – look.
Nurse: _____
Patient: Yes, it is deep. Will I need stitches?
Nurse: _____
Patient: No, never – and I don't want any!
Nurse: _____
Patient: No. I haven't seen him yet.

B. Monitoring the Patient

Taking 'OBs' (Patient Observations)

Write down the full meaning of these abbreviations.

BP _____ T _____ P_____ R _____

What measurements are considered within normal limits for an adult's BP, T, P, R?

BP _____ T _____ P _____ R _____

Taking vital signs

Exercise 3.3 Put the words in order to make sentences. Which vital signs is the nurse taking in each case?

___ 1. tongue / pop / your / under / just / this. _____

___ 2. roll / your / can / you / sleeve? _____

___ 3. cold / a / feel / bit / your / may / on / chest. / this _____

___ 4. and / out / in / just / normally / breathe. _____

___ 5. relax / me / for / your / arm. _____

___ 6. shirt / you undo / please? / your/ for me, / could _____

Describing Readings

Exercise 3.4 Complete the sentences with the words below, and match each one to a graph.

's up	rising	fell	stable
up and down	went up	varies	back to

_____1. His temperature was _____ all night, but now it's a_____ at 37.5.

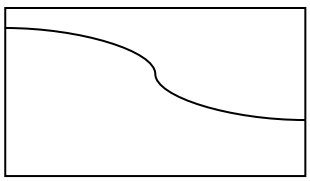
_____2. Her heart rate _____ at 20 bpm, but now it's _____ again.

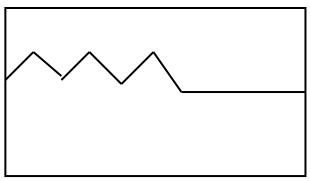
_____3. His blood pressure _____ from 120/80 to 160/100.

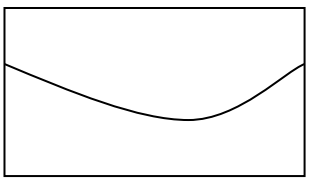
_____4. Her pulse rate was extremely low, but now it _____ to 70.

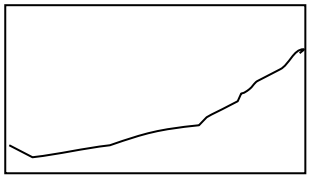
_____5. His respiratory rate _____ between 10 and 25 bpm.

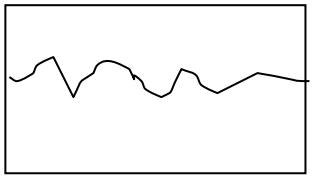
_____6. He was running a fever, but his temperature's _____ normal now.

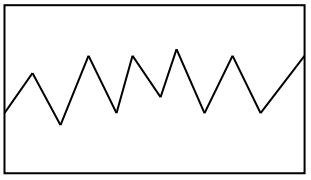
a. 

b. 

c. 

d. 

e. 

f. 

The Passive Form

- Passive verb forms are very common in medical English. We use Passive verbs to say what is done to people and things.

  The patient's progress **is monitored** every hour.
  Mr. West **was treated** for multiple injuries

- Often, you can choose whether to use an Active form or a Passive form. Compare these sentences:

  Paramedics **treated** the man for hypothermia. (_____)
  The man **was treated** for hypothermia. (_____)

- The Passive form focuses on the action, not on the person or thing that does the action. If you want to say who does the action use *by*.

  The man **was treated** for hypothermia **by** paramedics.

Exercise 3.5 Underline the correct form of the verbs in italics.

Mrs. Ramone *admitted /was admitted* [1] to hospital for an operation. She *didn't give / wasn't given* [2] food for eight hours. She *brought / was brought* [3] to theatre at sixteen hundred hours.
She *was prepared / prepared* [4] for theatre. The nurse *was shaved / shaved* [5] the area which was going to *cut / be cut* [6], and Mrs. Ramone *put on / was put on* [7] a theatre gown. Her dentures *removed / were removed* [8], and her wedding ring taped to her wrist.

Exercise 3.6

Kim Deva was woken up one night by severe abdominal pains. Read the notes, and write sentences to describe his experience using the Passive. You can say who did each action if you want to.

example: admit / hospital = He was admitted to hospital.

1. give / general anesthetic _____
2. perform / appendectomy _____
3. insert / stitches / wound _____
4. prescribe / painkillers _____
5. discharge from hospital _____

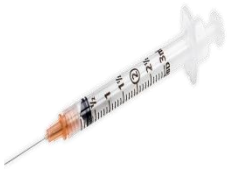
C. Medication

Types and Forms of Medication

a 

b 

c 

d 

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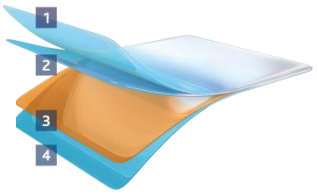
g 

h 

i 

Exercise 3.7 Match the pictures with the forms of medications:

1. syringe	_____	6. suppository	_____
2. inhaler	_____	7. adhesive patch	_____
3. ointment	_____	8. vial	_____
4. capsules	_____	9. dropper	_____
5. IV drip	_____	10. ampoule	_____

Exercise 3.8 Complete each sentence with a type of medication.

a painkiller	a sedative	an anti-inflammatory	an inoculation
an antibiotic	an antihistamine	a stimulant	an antidepressant
a laxative	a supplement		

1. _____ kills bacteria and other germs.
2. _____ protects you against infectious diseases.
3. _____ relieves pain.
4. _____ reduces swelling.
5. _____ encourages bowel movement.
6. _____ provides a substance that the body lacks.
7. _____ treats allergies
8. _____ increases activity in the body.
9. _____ reduces feelings of extreme sadness.
10. _____ makes you relaxed and sleepy.

Medication dosage can be measured differently:

for liquids: teaspoon (tsp), tablespoon (tbsp.), millilitres (mL), litres (L) 1 L = ____ mL 1 tbsp = ____ tsp.

for solids: milligrams (mg), grams (g), micrograms (mcg) 1 g = ____ mg 1 mg = ____ mcg

Speaking Activity.
Work in pairs. You are going to exchange details about patients' medications.

Student A
Ask Student B questions to complete this information about patient's medication.

Patient's name	dosage	medication	frequency
Mrs. Dupont	½ teaspoon		3 / day at mealtimes
Mrs. Francis		painkiller	
Miss Wang	500 mg		1 / day x 2 days
Miss Ekobu		antihistamines	
Mr. Strauss			1 / day on an empty stomach
Mr. Rossi	75 mg capsule	Tamiflu	
Mr. Metcalf		laxative	
Mr. Takahashi	injection 30mg		1 / hours

Student B
Ask Student A questions to complete this information about patient's medication.

Patient's name	dosage	medication	frequency
Mrs. Dupont		antibiotic	
Mrs. Francis	infusion		4 mg / minute
Miss Wang		iron supplement	
Miss Ekobu	2 capsules		one / 4 hours (with water)
Mr. Strauss	1 capsule	vitamin supplement	
Mr. Rossi			2 / day x 5 days
Mr. Metcalf	1 teaspoon		when needed
Mr. Takahashi		painkiller	

Unit 4

A. Mental Health Nursing

Exercise 4.1 Match each word with its definition.

a. posture	___1. not sure where you are
b. unemotional	___2. not wanting to talk to people
c. hallucinations	___3. not logical, not making sense
d. maniac	___4. behaving on an abnormally excited way
e. paranoia	___5. not showing your feelings
f. disoriented	___6. a way of standing or sitting
g. uncommunicative	___7. feelings of extreme uncontrollable sadness
h. delusions	___8. strange and false ideas that somebody believes are true
i. irrational	___9. occasions when you imagine you see things that are not really there
j. depression	___ 10. the false belief that somebody is trying to harm you, or that they are somebody very important

Present Perfect v Past Simple

We use the Present Perfect

- to talk about past actions in an unfinished period of time, for example 'in my whole life' or 'today'
  I'**ve** never done this before.
  Have you seen Ana this morning?
- when past actions has a result in the present
  He**'s had** his medication and is feeling sleepy.
- when we give news of recent, finished events
  The psychiatrist **has** just **spoken** to the patient's family
- when we say how much we have completed, how many times we have done something, etc.
  I **have told** him six times to take his medication.
- with yet, to talk to about whether or not tasks have been completed.
  I've taken Mr. Pool's temperature, but I **haven't checked** his blood pressure **yet**.
- with for and since to talk about when a present situation started
  I'**ve worked** at this hospital for six months.

We use the Past Simple, not the Present Perfect

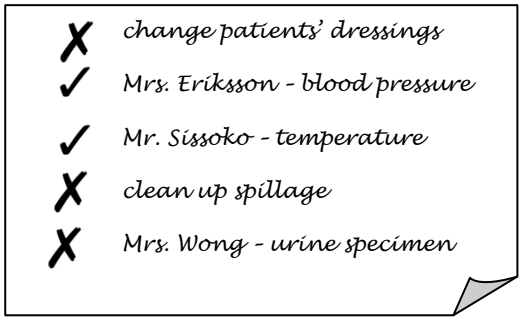
- when we talk about a finished time in the past, especially with time expressions such as ago, last week, in 2016.
  I **graduated** from college two years ago.
  I **finished** my hospital training in 2016.
  The patient **went** to the hospital last week.

Exercise 4.2 Complete each sentence using one of the verbs below. Use the Present Perfect where possible. In other sentences, use the Past Simple.

attend	go	see	study	be	finish
have	start	write	finish	reply	

1. We _____ the assessment. You'll get the report tomorrow.
2. The doctor _____ the patient three times today.
3. I _____ working here a year ago.
4. Mrs. Linton is no longer in hospital. She _____ home.
5. I _____ three letters to the consultant, but he _____ yet.
6. I _____ until 11 o'clock last night.
7. The patient _____ the clinic since January.
8. The patient _____ in hospital for a week now.
9. _____ you ever _____ a general anesthetic?

Exercise 4.3 Paula is a nursing assistant. She is finishing her shift and Jack is starting his. Jack is checking the list of things to do. Look at the list and write five sentences about what Paula has done and hasn't done yet.



_____

_____

_____

_____

_____

Write the past participle of these verbs:

be	_____	give	_____	watch	_____
work	_____	forget	_____	talk	_____
take	_____	try	_____		

Speaking Activity

Write questions using *Have you ever ….* and the verbs above to find out about your partner's experience as a student nurse.

Example: Have you ever been late for duty?

Work in pairs and ask your questions. Each time you receive the answer yes to your question, ask another question using Past Simple to get more information.

A: Have you ever been late for duty?
B: Yes, I have.
A: Really how many times. / When was that?
B: Just once. / It was yesterday.

Reading

Schizophrenia – the facts

Every year, 1.5 million people worldwide are diagnosed with schizophrenia. It is a mental illness which has periods called 'psychotic episodes'. During a psychotic episode, a sufferer shows disturbing changes in behavior. They may seem very cold and unemotional, using few facial expressions, and say strange things in a slow, flat voice. They may lose all interest in life and spend days doing nothing at all, not even washing or eating. These distressing symptoms are shocking for family members who, of course, remember what the sufferer was like before the onset of the illness.

During a psychotic episode, there may be hallucinations. Hearing voices that other people do not hear is the most common type of hallucination. The voices give orders and carry on conversations. Sometimes the voices swear and make threats.

Someone with schizophrenia may have delusions, believing for example that they are a famous, historically important person, or that people on television send them special messages.

People with schizophrenia may not think logically. They are isolated because conversation with them is very difficult, so they have no one to communicate with.

It is relatively common for schizophrenia sufferers to commit suicide – 10 per cent of people with schizophrenia (especially younger adult males) kill themselves. Violence and threats against others, on the other hand, are not symptoms of the illness.

There is medication that can reduce the symptoms, but it often has bad side effects, and some sufferers discontinue treatment because of this. Although many sufferers can continue to lead a relatively normal life, it has been estimated that no more than one in five individuals recovers completely, and most will require long-term treatment.

We do not yet know the cause of schizophrenia. Researchers have looked at links with genes, with brain development, with infections before birth, and with traumatic life events.

Exercise 4.4 Read the article about schizophrenia and decide if these sentences are true of false.

_____1. There are 1.5 million sufferers of schizophrenia.

_____2. A psychotic episode is a symptom of schizophrenia.

_____3. People with schizophrenia are usually not violent and dangerous.

_____4. Suicide is not connected with schizophrenia.

_____5. We understand what causes schizophrenia.

Join the word combinations without looking at the text. Choose some of the combinations to learn.

1. changes	a. relatively normal life
2. facial	b. completely
3. the onset of	c. side effects
4. think	d. suicide
5. commit	e. expressions
6. reduce the	f. treatment
7. have bad	g. the illness
8. lead a	h. in behavior
9. recover	i. logically
10. long-term	j. symptoms

B. Neurology

Exercise 4.5 Read about the Glasgow coma scale and complete the text with the adjectives and adverbs below. The order of responses has been mixed, read each section and number the responses in correct order. (eye response 1-4, verbal response 1-5, motor response 1-6)

appropriately	bent	coherently	deeply
incomprehensible	random	spontaneously	verbal

The **Glasgow coma scale** is used for measuring how _____ [1] unconscious a patient is, in order to assess the extent of brain damage. Eye response, verbal response, and motor response are tested. For each of these tests, he patient receives a score, with the minimum being 1 for no response. The total for the three tests gives the patient's GCS score.

Eye response

___a. eyes opening to _____ [2] command

___b. no eye opening

___c. eyes opening in response to pain

___d. eyes opening _____ [3]

Verbal response

___a. confused (the patient responds to questions but there is _____ [4], some confusion)

___b. none

___c. inappropriate words (_____ [5] speech, but no conversational exchange)

___d. _____ [6] sounds (moaning, but no words)

___e. oriented (the patient responds _____ [7] to simple questions)

Motor response

___a. withdrawal (pulls arm away) from pain

___b. extension (arms straight by sides) in response to pain

___c. no motor response

___d. obeys commands (the patient does simple things as asked)

___e. localizing pain (moves hands towards pain)

___f. flexion (arms _____ 8 up to chin) to pain

Case study – a head injury

Exercise 4.6 You are going to read the case study of a young female patient who received brain injuries four months ago. Tick which injuries Katie sustained.

1. a fractured skull	☐	4. a broken leg	☐
2. a broken arm	☐	5. internal injuries	☐
3. chest injuries	☐		

Katie Martin is a nine-year-old female who was in a car crash. At the scene here Glasgow coma scale was 3. She was intubated and transported by helicopter to hospital. She was taken to the intensive care unit due to her intracranial hemorrhage which 24 hours later resulted in evacuation. She was placed on a ventilator and a tracheostomy was performed. Katie's pre-operative diagnosis was left frontal hemorrhagic contusion and multiple skull fracture. She had a left frontal craniotomy with evacuation of the intracerebral hematoma. The dural tear and skull fracture were repaired. Additionally she suffered lacerations to the liver, face, left eyelid, and a right femur fracture.

Group Activity

Form groups of 4 people. Read the lyrics of the song “Unwell” and identify mental health conditions that are mentioned.

All day staring at the ceiling
Making friends with shadows on my wall
All night hearing voices telling me
That I should get some sleep
Because tomorrow might be good for something

Hold on
Feeling like I'm headed for a breakdown
And I don't know why

But I'm not crazy, I'm just a little unwell
I know right now you can't tell
But stay awhile and maybe then you'll see
A different side of me
I'm not crazy, I'm just a little impaired
I know right now you don't care
But soon enough you're gonna think of me
And how I used to be, me

I'm talking to myself in public
Dodging glances on the train
And I know, I know they've all been talking about me
I can hear them whisper
And it makes me think there must be something wrong with me
Out of all the hours thinking
Somehow I've lost my mind

I've been talking in my sleep
Pretty soon they'll come to get me
Yeah, they're taking me away

Unit 5

A. Nutrition and Obesity

As healthcare workers, we must know the right kind of food for the patient's diet. We should be able to know the differences between the different types of diets and food for our health teaching.

Main Course
A (choose one)
two grilled burgers
tuna fish pie
a cheese pizza
lentil soup
egg noodles
two slices of roast beef
two fried eggs
tofu curry
a lamb kebab

+B (choose two)
fried rice
boiled potatoes
salad
baked beans in tomato sauce
tinned tomatoes
stir-fried mushrooms
fried onion rings
steamed broccoli

Dessert
chocolate pudding
a banana
yoghurt
a doughnut

Drink
a bottle of cola
a glass of orange juice
a glass of wine
a glass of milk

Exercise 5.1 Look at the list and answer the questions.

1. Find two good sources of protein _____
2. Find two good sources of carbohydrate _____
3. Find two dairy products _____
4. Find seven ways of cooking food _____
5. Which foods on the list are high on fat? _____
6. Which foods contain high levels of vitamin C? _____
7. Which foods are low in vitamins? _____
8. Which items on the list are junk foods? _____
9. Which food do you think is highest in calories?_____

With your partner, use the list to create:

10. The most nutritious meal possible
11. the meal for a diabetic
12. the meal for somebody who needs to lose weight

10.

11.

12.

Exercise 5.2 Complete the descriptions of vitamins, minerals and oils with the words below. Some words are used more than once.

teeth	organs	enzymes	nervous system	cells
brain	eyes	skin	immune system	
blood	muscles	bones	cardiovascular system	

Vitamin C is needed to help the _____[1] repair itself when it is cut or damaged. It is found in fruit, especially citrus fruit like oranges and grapefruit.
The **B-vitamins** keeps the _____[2] healthy and help reduce stress. They are found in foods like wholegrain bread and cereals.
Vitamin A keeps the _____[3] healthy and is important for good vision. It is found in fatty foods like butter, cheese, whole milk and yoghurt.
Vitamin D is needed for healthy bones and _____[4] because it helps the body absorb calcium. Our body makes Vitamin D when our _____[5] is exposed to sunlight.
Calcium is needed for children's _____[6] and teeth to grow. It is found in foods like milk, cheese and yoghurt.
Iron helps your _____[7] carry oxygen. If you do not get enough iron, you will be pale and tired and you may get anemia. Iron is found in red meats, especially liver.
Zinc makes your _____[8] stronger so that you can fight colds and infections. It is found in shellfish, nuts and seeds.
Omega-3 is an essential fatty acid which helps your _____[9] function well. It is found in oily fish like mackerel, sardines, salmon and tuna.
Protein builds up, maintains and replaces the tissues in your body. Your _____[10], your _____[11], and your immune system are made up mostly of protein.
Carbohydrates are sugars which are broken down by _____[12] then stored in the _____[13] as a source of energy. Grain products such as rice, bread and pasta are sources of carbohydrate.
Fats fuel the body and help absorb some vitamins. They are also the building blocks of hormones, and they insulate nervous system tissue in the body. Unsaturated fats, found in oils and nuts, for example, are believed to protect the _____[14].

Should / Shouldn't

- We use should/ shouldn't to give advice and to say what would be correct

  You **should give up** smoking.

  Your blood sugar **shouldn't go** over 240 mg/dL

- Should is weaker than must. That means the person you are giving an advice to doesn't have to follow them.

  I **should stop** eating sweets – but I'm not going to!

- Here are some other ways of giving advice

  It would be a good idea to lose some weight.

  I'd see a nutritionist **if I were you**.

Exercise 5.3 Complete the sentences using should or shouldn't + verb.

1. You _____ _____ some water before you go running.
2. I'm getting fat. I _____ _____ more exercise.
3. You _____ _____ breakfast – it wakes up the body and provides fuel for the day.
4. People with high blood pressure _____ _____ too much salt on their food.
5. You _____ _____ plenty of vitamin C in your diet.
6. People with diabetes _____ _____ large meals.
7. A person with an eating disorder help from psychologist.
8. Children _____ _____ too many sweets.

Giving an Advice

A close friend has written you an email asking for advice. She is worried about her eating habits.

Exercise 5.4 Complete the email with the words below.

addicted to	bad for you	cut down	cut out	skip meals
feel depressed	fills my stomach	get cravings	losing weight	

New Message

To:
Bcc:
Subject:

and that's terrible because I should be only 65 kilos! I'm really shocked. Every time I look in a mirror I _____ [1], but that just makes me ear more. I am so busy these days, and I don't have any time for exercise. Of course, I know fast food is _____[2], but every time I stop eating it I _____[3] for a burger. I suppose I must be _____[4] fast foods. Nothing _____[5] in the same way.

I am trying hard to lose a kilo a week. Sometimes I _____[6] , but it doesn't work. I just feel hungry and then I give in and have spaghetti or steak – they're better for me than burgers, aren't they? I will stop eating fast foods, I promise – but don't say I should do without cola, because I have _____[7] on chocolate and even _____ [8] sugar from hot drinks completely. I thought, being a nurse, you should know about _____ [9] and diet, and you could give me some advice.

Love,
Hesta

Discuss with a partner what advice to give Hesta to help her lose weight successfully and in a healthy way. Think about these topics then write an email replying to Hesta.

exercise	what not to eat
how much weight to lose	when to eat
how quickly to lose weight	what to drink
what to eat	other good habits

Speaking Activity

Think of a problem and tell your partner about it. Ask his/her advice. Give each other pieces of advice and perform it in class.

e.g.

A

I have a doctor's appointment tomorrow but we have an exam. What do you think should I do?

I think you should cancel or change the appointment.

B

B. Hygiene

To avoid infecting ourselves and the patients, we should always practice proper hygiene.

Exercise 5.5 Match each of these items of hygiene equipment to a picture.

___bin

___bucket

___cloth

___mop

___sink

___ clinical waste disposal bag

___ detergent

___ disposable gloves

___ paper towels

___ soap dispenser

a 

b 

c 

d 

e 

f 

g 

h 

i 

j 

Exercise 5.6 Complete the sentences with the words in the box.

contamination	antimicrobial agent	pathogens	swab
disinfectant	susceptible	resistant	spotless

1. An _____ will kill microorganisms.
2. Use a sterile _____ to get a sample from the back of the throat.
3. Our bodies have ways to kill _____ such as viruses and bacteria.
4. The old, the young, and the very ill are most _____ to hospital infection.
5. Staphylococcus is _____ to most antibiotics.
6. There is a risk of _____ from urine and blood.
7. Wash floors and door handles with _____.
8. A home doesn't have to be _____, but it does have to be clean.

Exercise 5.7 Test your knowledge of hygiene by doing this quiz.

1. What is MRSA?	a. a virus	b. a bacterium	c. an antibiotic
2. How do you catch MRSA?	a. from dirty plates	b. poor hospital hygiene	c. drinking bad water
3. Which is not associated with bacteria?	a. wine making	b. yoghurt	c. common cold
4. Which breaks rules in an OR?	a. wearing mask	b. wearing your hair loose	c. wearing make-up
5. Where do staph bacteria live?	a. in noses	b. in soil	c. in toilets
6. How long should you wash your hands in hot water to be sure they are clean?	a. fifteen seconds	b. half a minute	c. one minute

Unit 6

A. Blood

Blood Groups

Can you work out the names of the women?
Maddy's blood can't be given to other women.
Holly could receive blood from Katie and Alex.
Only Katie could donate blood to Freya.
Four of the women could give blood to Maddy.
Alex can't be given blood by any of the others.

A- = _____
A+= _____
O+= _____
AB+= _____
AB-= _____

RED BLOOD CELL COMPATIBILITY TABLE

Recipient \ Donor	O-	O+	A-	A+	B-	B+	AB-	AB+
O-	✓	✗	✗	✗	✗	✗	✗	✗
O+	✓	✓	✗	✗	✗	✗	✗	✗
A-	✓	✗	✓	✗	✗	✗	✗	✗
A+	✓	✓	✓	✓	✗	✗	✗	✗
B-	✓	✗	✗	✗	✓	✗	✗	✗
B+	✓	✓	✗	✗	✓	✓	✗	✗
AB-	✓	✗	✓	✗	✓	✗	✓	✗
AB+	✓	✓	✓	✓	✓	✓	✓	✓

Testing blood

Exercise 6.1 Complete the text using the words below.

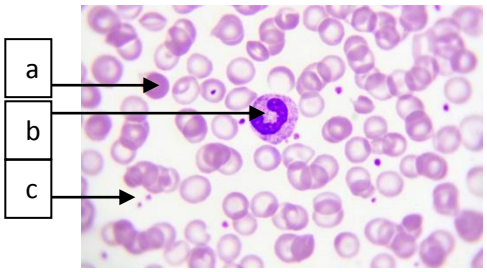
slide	drop	microscope	syringe
vein	test tube	pipette	

Use a _____ [1] to take some blood from a _____ [2] in the patient's arm. Put the blood into _____[3]. Then, use a _____ [4] to put a _____[5] of the blood onto a _____[6].
Examine it under a _____[7]. What do you see?

Describing blood cells

Identify each type of blood cell in the picture below.

____ platelets
____ white blood cells
____ red blood cells



Find three or more mistakes in this description.

There are many rectangular red blood cells moving freely in the plasma. The centers of the red blood cells are a light color and the cells are all the same size. There are white blood cells in the diagram. They are more regular in shape than the larger red blood cells. There are many platelets in this drop of blood. They are small, dark, oval-shaped bodies.

A blood test

Exercise 6.2 Complete the description of a Complete Blood Count (CBC) with the words below.

infection	platelets	hemoglobin	clot
oxygen	red blood cells	white blood cells	

A CBC measures the number of different cells that make up the blood. It looks at:

- _____[1] – these take _____[2] from the lungs to the body's tissues, and take carbon dioxide away at the same time. The CBC also measures the amount of _____[3] (a protein in the cells that carries oxygen), and looks at the size and shape of the cells.
- _____[4] – these protect the body against _____[5].
- _____[6] – these make blood _____[7].

B. Coronary

The Heart

Exercise 6.3 Complete the descriptions with the words in the box.

pump	leaves	valve	enters	artery	flows
atrium	fills	aorta	opens	closing	beat

The heart is a muscle as big as your fist in the center of the chest. It is an efficient _____[1] that can get blood to the furthest cell in your body within sixty seconds.

On its circular journey around the body, blood _____[2] the heart twice, once with oxygen and once without oxygen.

Blood without oxygen comes into the right side of the heart. It _____[3] the right atrium. Then the tricuspid valve _____[4] and the blood goes into the right ventricle. Then the pulmonary _____[5] opens the blood _____[6] through the pulmonary _____[7].

Blood carrying oxygen comes into the left side of the heart. The left _____[8] fills, the mitral valve opens and the blood _____[9] into the left ventricle. The aortic valve opens and the blood leaves through the _____[10].

When you listen to a heart _____[11] you hear 'lub dub, lub dub'. This is the sound of the valves _____[12].

Zero and First Conditional

- We use the Zero Conditional to talk about what always happens in a particular situation. It is often used to talk about scientific facts.

  If you heat water to 100°C, **it boils**.

  When you get pregnant, **you put on** weight.

- The Present Simple tense is used in both parts of the sentence.

  What **happens** to the blood when you **take** aspirin?

- We use the First Conditional to talk about possible future actions or situations.
  If you remind me later, **I'll come** and help you.
  You **won't get** there on time **if you don't hurry**.
  You **won't get** there on time **unless you hurry**.

- We don't use *will / won't* after *if / when / unless*. We use the Present Simple.
  If **you go** through the swing doors, you'll see the office on the left.

Exercise 6.3 Complete the sentences using the Zero or the First Conditional.

1. If you explain the problem to Mew, she _____ (tell) you what to do.
2. When you have an anesthetic, it _____(stop) you from feeling pain.
3. If I have time this evening, I _____ (help) you with your homework.
4. You _____ (have) a fever if your temperature _____ (be) over 37.5°C.
5. If a person's brain _____ (not get) oxygen, they _____ (die).
6. If you _____ (take) a sleeping pill before you go to bed, you _____(sleep) well tonight.

Speaking Activity
With a partner, write three scientific facts using the Zero Conditional, two true and one false. Read them to the class. They have to guess which one is false.

Reading

Blood Pattern Analysis

Even a tiny drop of blood at the scene of a violent crime can give important information to the police. Blood is there either because it has dripped out of a small wound, sprayed out from an artery, oozed out through a large wound, or flown off a weapon. Using blood pattern analysis, police can learn a lot about what happened from the shape of the blood drops.

Sometimes a murderer cleans the crime scene very carefully, and if detectives cannot see any blood they spray a chemical called Luminol across the scene. This makes it possible to see the blood in the dark. Luminol can show up very small drops of blood.

From the blood at the scene of a crime, police can learn about the person the blood came from. They can tell the person's blood type and, because male and female blood cells are different, they can also work out if the blood comes from a man or a woman. Also, 80% of us are 'secretors', which means our blood type is contained in other bodily fluids. This can also help identify suspects.

In 1984 a man, Graham Backhouse, was found injured near his home with deep cuts across his face and chest. A neighbor lay dead nearby. Backhouse said the neighbor attacked him, and so he shot the neighbor to defend himself. But the shape of the blood drops showed that Backhouse was standing still when he was wounded, and there was also no blood from Backhouse on his gun or near the victim. Police were sure Backhouse shot the victim and then wounded himself. He was found guilty of murder.

Exercise 6.5 Read the article and decide if these sentences are true or false.

_____1. Blood from a cut artery drips out.

_____2. Blood pattern analysis looks at the shape of drops of blood.

_____3. Luminol tells you the blood type.

_____4. Male blood is different from female blood.

_____5. Graham Backhouse's neighbors shot himself.

Find words in the text with these meanings.

1. (used about a thick liquid) to move slowly o_____
2. a knife, gun, or other things used to hurt people w_____
3. saliva, semen, and other liquids in the body b_____ _____
4. people who the police believe committed a crime. s_____
5. hurt by a weapon w_____
6. responsible for a crime g_____

Case Study

Three people have been seriously injured in a road accident, and brought to hospital. In one car was twelve-year-old Sally Cook and her 70-year-old grandfather William Cook. Sally has lost a lot of blood, and needs a transfusion. Her grandfather is unconscious and needs a bed on ICU and a ventilator to keep him alive.
Fred Ellis is 21 years old, and was driving the second vehicle. Police say Fred caused the accident. He has severe injuries, and he will need a ventilator and a bed on ICU.

Discuss the following problems in small groups.
1. Sally's parents belong to a religious group which is against organ and blood donation. They do not want their daughter to have someone else's blood. Should the hospital respect their wishes, or should they give her transfusion?

2. There is only one bed available on ICU. Who should have the bed, William Cook or Fred Ellis?

3. Have you ever been in a car accident? Have you ever seen one? Describe what happened.

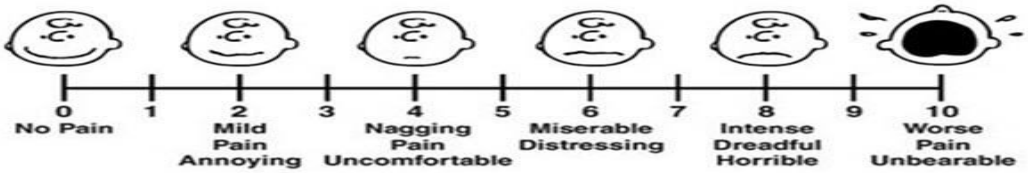
Unit 7

A. Pain

Pain is a basic bodily sensation that is induced by a noxious stimulus, is received by naked nerve endings, is characterized by physical discomfort (as pricking, throbbing, or aching), and typically leads to evasive action

Assessing Pain using the Pain Scale

Since pain is a symptom and can't be seen by the healthcare professional, we can ask the patient to rate their pain from 0 to 10, 0 as the lowest and 10 the highest.



Describing Pain

To be able to know specifically what type of pain the patients are feeling, healthcare workers can ask the patients to describe it using layman's terms. We can also use these descriptions if the patient can't describe their pain. Although it is subjective, we can't disregard what pain the patient is feeling and we should be sensitive to their needs.

Exercise 7.1 Match these words for types of pain with their descriptions.

1. a throbbing pain	a. feels like it is eating you
2. a sharp pain	b. travels fast along part of your body
3. a burning pain	c. is steady and not too painful
4. a stabbing pain	d. feels like a muscle is being squeezed
5. a shooting pain	e. feels like something sharp is stuck into you
6. a dull ache	f. comes and goes rhythmically
7. a gnawing pain	g. feels like fire
8. a cramping pain	h. is strong and sudden

Phrasal Verbs

Phrasal verbs are often used in informal spoken English. It is formed of a verb and a preposition. Both patients and healthcare professionals may use them in consultations. A phrasal verb may have several meanings according to context.

Exercise 7.2 Match the Phrasal Verbs and their meaning

1. bring on	a. lessen, reduce
2. bring up	b. happen in the end
3. carry on	c. gain
4. come on	d. commence, start
5. give up	e. expectorate, vomit
6. put on	f. cause, induce
7. turn out	g. continue
8. turn up	h. stop
9. cut down	i. appear unexpectedly
10. carry out	j. to complete a task

Exercise 7.3 Fill in the blanks with the correct phrasal verbs to complete the sentences.

1. When does the pain _____?
2. Is there anything special that _____ the pain?
3. When you cough, do you _____ any phlegm?
4. I've _____ a lot of weight last month or so.
5. The rash just _____ out of nowhere.
6. She had all the tests and it _____ to be cancer.
7. You should _____ on sweets, it causes tooth decay.
8. My advice is to _____ smoking.
9. We need to _____ surgery.
10. _____ taking the painkillers for another week.

Making comparisons

- We use comparatives to say how things are different.

  These painkillers are **milder than** those.
  Last night the pain was **more severe** than it was this morning.

- To make a comparative stronger, we often use much or a lot.

  You look **much better** today.

- The opposite of *more* is *less*.

  It's much **less sore** than it was yesterday, thanks.

- We can use *more* and *less* with a noun to talk about quantity.

  They have **more beds** in the City Hospital.

- We use superlatives to compare something to all other things of the same type.

  This is **the strongest** painkiller available without a prescription.

- The opposite of *most* is the *least*.

  This is the **least serious** type of fracture.

- We can use *most* with a noun to talk about a large proportion of something.

  Most women choose to have pain relief when giving birth.

Exercise 7.4 Look at the information about these three painkillers. Complete the sentences, then write three more of your own.

Painkiller	Effective	Cost	Side effects
Nuradeine	✓✓✓✓	$$	✓
Ibroxen	✓	$	✓✓✓
Solpafen	✓✓	$$$$	✓✓

1. Nuradine is much _____ (effective) than Ibroxen.
2. Ibroxen is _____ (cheaper) than Nuradeine.
3. Ibroxen has _____ (side effects) than Nuradeine.
4. Nuradeine is _____ (effective).
5. _____
6. _____
7. _____

B. Death and Dying

Talking about dying

Talking about death to a patient or a family member is a sensitive matter and needs to be handled professionally and respectfully as possible. Here are words about death that you we can use.

Exercise 7.5 Match these words with a definition.

1. terminal	a. (of an accident or illness) that causes death
2. fatal	b. to become more and more weak or ill
3. go downhill	c. an examination of a body to find out how the person died
4. coma	d. the use of machines to keep a person alive
5. life-support	e. (of an illness) that cannot be cured, and causes death
6. pass away	f. a room in a hospital where dead bodies are taken and stored
7. mortuary	g. an unconscious state that a person cannot wake from
8. post-mortem	h. a polite word meaning 'to die'

Complete the sentences using the words above.

1. This boy has serious head injuries. He has been in a _____ for a week.
2. The patient stopped breathing, and is now on a _____ machine.
3. We need a porter to take the body to the _____.
4. I'm afraid your father _____ in his sleep last night.
5. There was a _____ accident outside the hospital – both drivers were killed.
6. The _____ showed that the elderly lady died of a stroke.
7. After a bad fall, Mr. Deans _____ very fast and died the following week.
8. This gentleman has _____ cancer. With treatment, he may live another year.

The body after death

Exercise 7.6 What happens to the different parts of the body when we die? Complete the descriptions with the words in the box.

beating	breathing	slightly	cools	stops
rigid	release	ceases	open	enlarge

1. Brain activity _____.
2. The skin _____.
3. The eyelids _____ slightly and the pupils _____.
4. The pulse _____.
5. The jaw relaxes and opens _____.
6. _____ stops.
7. The heart stops _____.
8. The bowel and bladder _____ their contents.
9. The limbs become _____.

Reading

Read the article about a children's hospice, and match each of these headings to a paragraph.

1. Saying goodbye ____

2. Using the sense ____

3. A home from home ____

4. Personal care ____

5. Helping the family ____

The Hope Children's Hospice

A

The Hope Children's Hospice provides free specialist care for children with life-limiting conditions who are not expected to live into adulthood. It cares for up to eight terminally-ill children at one time, and aims to care for them in the same way their families would care for them at home. When families prefer to do the caring themselves, a hospice carer will go to their home and help them.

B

Life-limiting conditions present many long term medical and emotional problems – not only for the child, but for parents and siblings too. So the hospice offers respite care – short stays for child alone of for the whole family together. At these times, parents hand over responsibilities to the staff and have a 'holiday'. Short stays give terminally-ill children an opportunity to meet other with similar conditions.

C

Each child at the hospice has their own carer and their own care plan. A normal day might start with a jacuzzi bath followed by a massage from a complementary therapist. Some children go to school, while others play with hospice play specialists.

D

The hospice has a multi-sensory room. This is a special room which stimulates the children's sense with lights, music, touch, and smell. It has touch-screen computers, video games, paddling pools, and space for wheelchair dancing. Children have music therapy and can record their own music, not only as a way to express their feelings, but to leave something for their family and friends to listen to in the years to come.

E

The hospice has a number of quiet rooms where we care for children during and after death. These are places where families and friends can say goodbye. Our support does not end with the death. We help not just grieving parents, but also siblings who are experiencing bereavement. We give everyone opportunities to discuss their fears about death and dying.

Answer the following questions about the article.

1. Do children have to stay at the hospice all the time? _____

2. How does the hospice help the children's families? _____

3. How many children does each carer look after? _____

4. What can children do in the multi-sensory room? _____

5. How is music used at the hospice? _____

6. How are the special quiet rooms used? _____

Speaking Activity

Student A
Read these guidelines for preparing the body. Then exchange information with Student B. Ask questions, for example: What do you do with the mouth? What about washing? etc. Make notes as you listen to Student B.

eyes	Close the eyes if you can. It is not always possible.
mouth	
hair	Comb the hair. You may need to use a wet comb to make it tidy.
washing	
position	Sit the body up on a pillow. Place the patient's arms b their sides and outside the bed sheets, so that relatives can touch or hold them.
jewellery	
lines (IV, catheters, etc.)	If there is going to be an autopsy, leave all IVs and catheters in. If there is no autopsy, you can remove them. But remember that the site can bleed post-mortem, so cover these with gauze.
the room	

Speaking Activity

Student B
Read these guidelines for preparing the body. Then exchange information with Student B. Ask questions, for example: What do you do with the eyes? What about the hair? etc. Make notes as you listen to Student A.

eyes	
mouth	Put dentures in if worn. These will be difficult to put in later. Try to close the mouth if possible. Putting petroleum jelly on the lips may help.
hair	
washing	Wash the whole body. Make sure that the face and hands are perfectly clean before the family sees the body.
position	
jewellery	Put this is a bag marked with the patient's name to give to the family.
lines (IV, catheters, etc.)	
the room	Put chairs in the room for relatives to sit on. Put one or two boxes of tissue in the room. Clear away dirty linen, rubbish, and medical equipment that is no longer needed. Put on gentle music if appropriate.

Unit 8

A. Activities of Daily Living

Activities of daily living (ADL) refer to the things we do in the course of our daily routine – often they are almost automatic, i.e. we do them without having to think about them. It is only when we are disabled in some way or when we are in a situation which is abnormal, that conscious effort has to be made. All therapy must include consideration of the following factors for each individual patient. We can use the mnemonic OATSS which stands for Occupation, Activity, Task, Skill, and Sequencing.

- Occupation refers to a habitual, balanced state of being and the ways each individual person maintains his/her health throughout life.
- Activity refers to doing specific things and productive action. Activity is necessary for man's survival and existence.
- Task is a component or one element of an activity.
- Skill is having the ability to do something well, i.e. having expertise. A skill can be acquired or learned.
- Sequencing is being able to link (join together) specific tasks in a logical order to complete an activity

Personal Care is one of the ADLs that is under self-maintenance.

Exercise 8.1 Six components of personal care that must be considered for each patient. What tasks and processes are involved in doing this activities? What do you think is the role of the nurse in each of these?

ADL	**Patient's tasks and processes**	**Nurse's roles**
Toileting		
Bathing		
eating / feeding		
dressing / grooming		
walking or moving around		
transferring		

Can or Can't /Could or Couldn't

Can and could expresses ability or are used to make polite requests or commands. Can is used for present abilities while could is used for past abilities. Can't is the short form of cannot and couldn't is the short form of could not. 'Can' and 'Could' are modal verbs and are always followed by the infinitive (V1). It stays in the same form for all persons. To make questions, switch the modal verb and the subject.

e.g.

		positive	negative
I / he / she / it / you / we / they	Present	I **can drink** water.	They **can't eat** solid food.
	Past	He **could walk** alone.	We **couldn't save** his life.
		Yes / No questions	Short answers
I / he / she / it / you / we / they	Present	**Can** you **move** your left shoulder?	Yes, I **can**. No, I **can't**.
	Past	**Could** she **raise** her right leg?	Yes, she **could**. No, she **couldn't**.

You can only use can and could when you want to make a polite request.

e.g. **Could** you take off your shirt, please?
Can you please untie your shoes?

Exercise 8.2

Arrange these words into polite requests and questions and rewrite them on the lines.

e.g. Could you puff your cheeks, please?

1. you / open / mouth / your / please? / Could _____
2. take / her / blood pressure? / Can / you _____
3. roll / right? / to / Could / please / you / your _____
4. raise / arm? / Can / you / his _____
5. bend / knees?/ Could / you / please / your _____

Exercise 8.3

The table below shows what Sally was able to do before and after her heart surgery. Write sentences using Can or Could and the information from the table.

e.g. Sally couldn't exercise before her surgery, but she can exercise now.

Activities	SN	RN	
eat junk food	☺	⊘	1. _____
climb the stairs	⊘	☺	2. _____
smoke	☺	⊘	3. _____
stand for long hours	⊘	☺	4. _____
drink alcohol	☺	⊘	5. _____

B. Pressure Areas and Pressure Sores

The Norton Scale of Assessment is used to calculate the risk of pressure sores by recognizing a potential risk because sores can be prevented. These pressure sores start as a redness of the skin on the pressure points (or pressure areas) on the body – areas where there is not much fat or 'padding' over a bony prominence. The redness can easily become a sore when the skin breaks down. Some patients are more are risk than others and for this reason Norton Scale is used for assessment. Very thin people and those that are in poor nutritional state are at risk. Very heavy (obese) people are at risk because they are less likely to be mobile, and unconscious and paralyzed patients are at risk because they are unable to move. Incontinent patients are at risk because urine and feces 'burn' fragile skin tissue and the friction of wet skin surfaces on the bed and chair causes redness and damage to the skin.

TABLE 35-7
Norton Scale for Pressure Ulcer Risk

PHYSICAL CONDITION		MENTAL CONDITION		ACTIVITY		MOBILITY		INCONTINENT		TOTAL SCORE
Good	4	Alert	4	Ambulant	4	Full	4	Not	4	
Fair	3	Apathetic	3	Walk/help	3	Slightly limited	3	Occasional	3	
Poor	2	Confused	2	Chairbound	2	Very limited	2	Usually/urine	2	
Very bad	1	Stupor	1	Bed	1	Immobile	1	Doubly	1	

How to use the Norton Scale
By adding the numbers from each column for the individual patient, the risk factor can be ascertained:

When the total score is 20, there is **no risk** at all.
When the total score is 15-19, there is **low risk**.
When the total score is 11-14, there is **medium risk**.
When the total score is 5-10, there is **high risk**.

Exercise 8.4 Check the body parts that may be considered pressure points in an unconscious or bedfast patient.

__ the shoulder blades
__ the elbows
__ the belly
__ the buttocks
__ the hips
__ the sacrum
__ the chest
__ the heels
__ the outer ankles
__ the hands
__ the back of the knees
__ the perineum (between the genitals and anus)
__ the thighs
__ the neck
__ the hips

Exercise 8.5 The following statements are either True or False. Write T or F and correct the false statements

___ 1. Patients are at risk of getting pressure sore have a high score on the Norton Scale.
___ 2. All patients in hospital are at risk of getting pressure sores.
___ 3. Patients who are incontinent of both urine and feces are at high risk
___ 4. The first sign of a pressure area is a small red area or an abrasion over a bony surface.
___ 5. Fat people are not at risk because they have 'protective padding'.
___ 6. Pressure areas can be prevented by keeping the skin clean and dry and by encouraging the patient to move and change his position or by turning unconscious or paralyzed patients every 2 hours.
___ 7. Ring pads, cushions and pillows can be used to keep the affected area off the surface of the bed.
___ 8. Special mattresses, called ripple mattresses, are available for immobile or unconscious patients. They are connected to a motor which circulates air inside the mattresses and increases the blood circulation.

Speaking Activity
Group into 4 to 5 people. Think of an admitted patient that you had and determine their risk factor for pressure sores. Share your experience with your group. Whoever had a patient with the highest score in will share it with the class.

Describing Appearance

Appearance is the way someone or something looks like.

In describing how people look we use adjectives. Start with the hair followed by the face. You can describe the hair by telling the length, texture, color respectively. Words that can be used to describe hair are short, long, medium length, straight, curly, wavy, dark, gray, red, brown and blonde.

When describing the face, you can start with the shape of the face, then the color of the eyes, size of the ears, nose, and lips. Words to describe the face are round, long, heart-shaped, square, chubby; describe the color of the eyes like black, brown, blue; size for the ears and nose for example small, medium, big or pointy; and thin or thick lips. For men, describe if they have facial hair like moustache and beard.

You can also describe the color of the skin like fair, tan, or dark.

For example:

He has got short, curly, gray hair.
He has got a round face with black eyes, big ears, big nose, a moustache and a beard.
He has got a tan skin.

She has got long, wavy, red hair.
She has got a round face with black eyes, small nose, and thin lips.
She has got a light skin.

Exercise 8.6
A. Describe the people in the pictures.

1. 

She has got _____
_____
_____
_____

2. 

He has got _____
_____
_____
_____

3. 

She has got _____
_____
_____
_____

GAME: The Doctor is In
(The teacher should prepare the printable pages 46-48 beforehand)
1. Form groups of 3, 1 will be doctor, 1 will be nurse and 1 will be patient.
2. The doctors and the patients will stand on opposite sides of the room.
3. The patients will open an envelope containing information of people.
4. The patients will describe the picture to the nurses then the nurses will tell the doctors of the patient's appearance without looking at the paper.
5. Then, the doctors will look for the patient's chief complaint, diagnosis and treatment and will inform the nurse. The nurse will go back to the patient and tell them the information. The patient will use glue to paste the pieces of paper on the paper with the correct sequence.
6. The group who finishes first with the correct answers will be the winner.

Unit 9

A. Surgery

When you decide to be a scrub nurse or a circulating nurse in the OR, you have to be familiar with the things that the surgeon will use. Often times, nurses have to anticipate the instrument that the surgeon will need and have it ready before he even asks for it. Nurses should also be aware of the number of the instruments at all times to avoid causing unnecessary injury to the patient, and at the same time maintaining their sterility.

Exercise 9.1 Match each word with its description. How many of the items can you find in the pictures?

drapes	forceps	an implant	a swab	retractors
scalpel	suction	sutures	gown	staples

_____1. a tool with a sharp blade for cutting
_____2. a scissor-like tool for gripping tissue
_____3. tubes attached to a pump for removing blood or other fluids from the surgical site
_____4. a device or artificial part that is inserted into the body, to replace or assist a defective part
_____5. stitches that are inserted to close a wound
_____6. sterile covers for the parts of the patient's body not involved in the operation
_____7. small piece of wire that are pushed with a machine into each side of a wound to close it
_____8. tools that hold organs out of the way to allow access to the surgical site
_____9. a loose sterile piece of clothing worn by people in the operating theatre
_____10. a piece of material, such as cotton, that is used to absorb blood during surgery

Preparing the patient for surgery

If you were having abdominal surgery, how much would the following things worry you? Mark them between 0 (it wouldn't worry me at all) and 5 (it would worry me a lot). Compare your answers with your partner.

- dying during surgery ___
- having the wrong operation done ___
- MRSA ___
- pain after the operation ___
- pain during the operation ___
- scarring ___

Future forms

will + infinitive

We use will / won't to talk about the future in general, and to make predictions, offers, or promises. The short form *'ll* is used in conversations. The negative form is *will not*, or more commonly, *won't*.

The scar **will fade** over the next few months.

You **won't be** able to drive after the operation.

***be* going to + infinitive**

We use *be going to* to talk about intentions, schedules, or plans. A course of action has already been decided.

I **am going to give** you some pain relief.

Is the doctor **going to see** me today?

should + infinitive

We can use *should* to mean 'probably' if it refers to an outcome with less certainty than will.

The scar **should fade** over the next few months.

may/might + infinitive

May and might have almost no difference in meaning. They are both used to talk about possibility.

We **may / might have to** change your prescription.

Note: We can't use modal verbs after these forms. We use *be able to* instead of *can* and *have to* instead of *must*. NOT ~~You won't can't talk~~ after the operation.

Exercise 9.2 Complete the sentences with the verbs below. Some of the verbs are used more than once.

be going to	ask	give	may	be	make	might
let	wake up	will/'ll/won't	leave	should	feel	be able to

a. I'm worried that the anesthetic <u>won't be</u> strong enough, and I _____ in pain, but _____ speak.

b. If you like, I _____ the anaesthetist to explain exactly what he does.

c. It _____ quite a neat little scar actually.

d. In a moment I _____ you a pre-med.

e. How _____ I _____ when I _____?

f. You_____ a little sick or you _____ really hungry.

Exercise 9.3 Work in pairs and discuss the questions.

1. Which sentences in 9.2 predict or imagine the future? _____
2. Which sentence states someone's intention? _____
3. Which sentence includes an offer or promise to do something? _____
4. Which modal verbs are used to mean 'possibly'? _____
5. Which modal verb is used to mean 'probably, if everything goes well'?_____
6. In which sentences is a present tense used to talk about the future? _____

B. Post-operative Complications

Different types of surgery have different types of complications. Generally though, patients face the following risks. We should be aware of the signs and symptoms of these complications so we can detect them early and better prevent them for happening.

Exercise 9.4 Match the common complications 1-6 with the information about them A-F.

A. Atelectasis
B. Deep-vein thrombosis
C. Low urine output
D. Post-operative pain
E. Post-operative wound infection
F. Pyrexia

1. _____ treated by antibiotics.
2. _____ (fever) a symptom of infection either at the surgical site, in the lungs (for example, pulmonary edema) or in the urinary tract.
3. _____ the standard treatment is by intramuscular opioid (usually Morphine).
4. _____ after surgery, there is a tendency for patients to retain fluid, and urinary output is a measure of the performance of the liver and the kidneys.
5. _____ this occurs when a blood clot develops, usually in the lower leg. It can cause a fatal pulmonary embolism. Early signs of the clot formation include hypertension and cold feet. Heparin is commonly used as a prophylactic (a course of action to prevent a disease)
6. _____ (collapsed lung) caused by blocked air passages. One of the first signs is abnormally high heart rate (tachycardia) and abnormally rapid breathing (tachypnea). Mechanical ventilation is provided to help patients breathe.

Suffixes

Match the meanings 1-6 with the group of words a-f.

a. cutting into
b. making a puncture in order to drain off fluid or air
c. making a passage from an organ to the skin
d. optical examination
e. surgical removal
f. surgically changing the shape

1. thoraco<u>centesis</u>, amnio<u>centesis</u>, arthro<u>centesis</u>
2. end<u>oscopy</u>, gastr<u>oscopy</u>, colon<u>oscopy</u>
3. hyster<u>ectomy</u>, vas<u>ectomy</u>, tonsill<u>ectomy</u>
4. trache<u>ostomy</u>, col<u>ostomy</u>, esoph<u>agostomy</u>
5. lapar<u>otomy</u>, gastr<u>otomy</u>, nephr<u>otomy</u>
6. dermato<u>plasty</u>, tympano<u>plasty</u>, abdomino<u>plasty</u>

Unit 10

A. Caring for the Elderly

Exercise 10.1 Discuss the questions with a partner

1. Would you like to live in a care home when you are old? Why / Why not?
2. Think of an elderly person you know well and how ageing has affected them. Think about the answers to these questions. Then talk to your partner about the person.

a. What daily tasks does he / she need help with? _____
b. How does he / she keep physically fit? _____
c. How happy is he / she? _____
d. How healthy is he / she? _____
e. What worries him / her? _____

3. Discuss what special difficulties are faced by elderly patients and the staff who are caring for them. Use the words below to help you, and write sentences. e.g. *They may have more side effects from drugs.*

medication		getting around	daily tasks	food
recovery	mind	home	complications	diagnosis

Alzheimer's disease

Exercise 10.2 Decide if each symptom is more connected with movement (M), thought (T), or behavior (B). Then compare your ideas with your partner.

Alzheimer's disease damages the brain, destroying memory and reason. People with Alzheimer's disease suffer confusion and loss of cognitive function. They need more and more nursing care as they become progressively more helpless, and finally die. The illness has three stages:

early stage
- forgetting recent conversations or events ____
- minor changes in abilities and behavior ____
- repetition ____

middle stage
- needing some help with ADLs ____
- wandering ____
- loss of interest in other people ____
- unusual behavior ____
- shuffling gait ____

later stage
- needing constant help with ADLs ____
- forgetting names ____
- complete loss of memory ____
- inability to recognize people, objects or places ____
- getting easily upset or aggressive ____
- confusing night and day ____
- confinement to bed or a wheelchair ____
- difficulty in swallowing ____
- loss of speech ____

Will

We use will:

- to talk about future facts.
  In twenty years time, there **will be** more old people and fewer young people.

- to make predictions and express hopes about the future. We often use words such as *I think*, *I hope,* and *probably* when we do this.
  I think I'll die when I'm 90!
  I don't think I'll play sport when I'm 80.
  I hope I won't live in a care home.
  With family around, you**'ll probably have** a long and healthy old age.

- when we decide what to do, have, etc.
  Tea or coffee? Er … **I'll have** coffee, please.

- to make offers, requests, and promises. We can also use Shall I…? for offers.
  I'll get you a drink.
  Shall I get you something to eat?
  Will you do me a favor?
  I won't be back late, so don't worry.

Exercise 10.3 Complete the sentences with the words below. Then decide if each one is a future fact (F), a prediction (P), or a decision you're making (D).

'll be able	'll have	'll probably
'll sleep	Shall I	will open

1. The new hospital _____ in 2010. _____
2. I don't think you _____ tonight if you have a nap now. _____
3. _____ go out tonight? Er … no, I think I'll stay at home. _____
4. You _____to go home a week after your operation. _____
5. I _____ chicken curry with rice, please. _____
6. I'm working tonight, so I _____ be tired tomorrow. _____

Exercise 10.4 Complete this dialogue of offers and requests. Use 'll, will, or won't and add one of the verbs below.

fall	pass	stand	do	see

A: _____[1] you _____[2] me my glasses? Then I _____[3] be able to _____[4] the television.
B: Here you are.
A: Thanks. Oh and _____[5] you _____[6] me another favor?
B: What now?
A: _____[7] you help me _____[8] up? I want to switch it on.
B: You _____[9] probably _____[10] over. I _____[11] do it.
A: Thank you. I _____[12] trouble you again.

B. Problems and aids

Exercise 10.5 Work in pairs. Match the adjectives with the cases. Say the adjectives as you do the exercises.

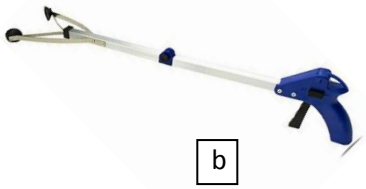
An elderly person who …

1. cannot leave her bed	a. frail
2. often wets himself	b. immobile
3. breaks a bone easily	c. bedridden
4. can't hear very well	d. confused
5. cannot move around freely	e. independent
6. often can't remember things	f. forgetful
7. wears his pyjamas in the street	g. incontinent
8. can't see very well	h. shortsighted
9. likes to be free	i. deaf

Exercise 10.6 Match each vocabulary item with a picture.

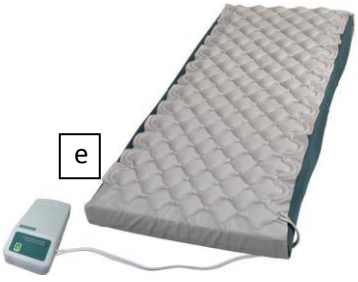
___1. hearing aid	___7. power chair
___2. walking stick	___8. helping hand
___3. glasses	___9. false teeth
___4. pressure bed	___10. artificial hip
___5. incontinence pad	___11. walking frame
___6. bath lift	___12. commode


a


b


c


d


e


f


g


h


i


j

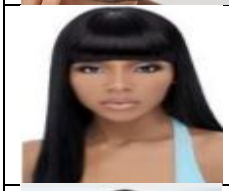
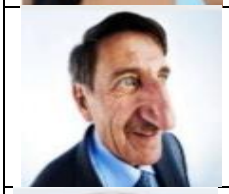
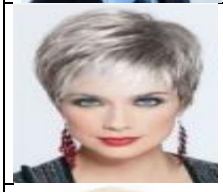

k


l

Print this page and give a copy to the doctors

Picture	Chief Complaint	Diagnosis	Treatment
	painful jaw	locked Jaw	NSAIDS
	difficulty in breathing	asthma	Albuterol
	watery stools	diarrhea	Loperamide
	stomach ache	appendicitis	surgery
	high body temperature	fever	paracetamol
	frequent urination	incontinence	anticholinergics
	difficulty in hearing	earwax blockage	earwax drip
	paleness and fatigue	iron deficiency anemia	Iron supplements
	chest pain	GERD	antacids
	nausea and vomiting	pregnant	vitamin B6

Print this page and give a copy to the patients.

Picture	Chief Complaint	Diagnosis	Treatment
			
			
			
			
			
			
			
			
			
			

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	frequent urination	incontinence	anticholinergics
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	paleness and fatigue	iron deficiency anemia	Iron supplements
	chest pain	GERD	antacids
	nausea and vomiting	pregnant	vitamin B6

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HISTORY-TAKING IN ENGLISH

A Booklet for Physicians

2014

F. MIYAMASU
UNIVERSITY OF TSUKUBA

Communicating With Patients: Basic Questions

Initiating the Session

Calling the patient into the office

"Ms Jones—please come into room 5."

Greeting the patient

"Hello, I'm Jun Suzuki (a student doctor working with Dr Maeno). Please sit down. It's Mary Jones, isn't it?"

"Come and sit down. I'm Jun Suzuki. … Can I just confirm that you're Mary Jones?"

Asking About the Chief Complaint (CC)

Opening question

"What problems have you been having?"

"What's been troubling you?"

"How can I help you?"

Follow-up question

"Tell me more about the headaches."

Screening and confirming

"So you've been having some headaches and backache. Anything else at all?"

"So you've been having headaches and backache, and you've been feeling more tired than usual. Did I get that right? … Is there anything else you want to talk about?"

Agenda setting

"Okay, now I'd like to ask you a few questions about each of your symptoms. Let's start with the headaches, and then we'll talk about the backache, and then about the tiredness. Is that okay?"

Taking the History of the Present Illness (HPI)

When? →	When did it start?
Where? →	Where is the pain?
Quality? →	What is the pain like?
Quantity? →	What does the pain feel like?
Aggravating & **A**lleviating factors? →	What makes it worse? What makes it better?
Associated factors? →	Have you noticed anything else?

Initiating the Consultation

Calling the Patient Into the Office

"Ms Jones—Please come into room 5."

Greeting the Patient

(*importance of first impressions: welcoming & comfortable environment; respect & interest in the patient; verbal & nonverbal behavior: stand up to greet/shake hands/smile/eye contact)*

"Hello, I'm Dr Suzuki. Please sit down. It's Mary Jones, isn't it?"

"Come and sit down. I'm Dr Suzuki. Can I just confirm that you're Mary Jones?"

"Good morning, Mrs Jones. Take a seat. I'm Dr Suzuki."

"Come in and sit down. Am I right in thinking that we haven't met before? I'm Dr Suzuki. What would you prefer me to call you?"

"Hello, Mary. Good to see you."

Asking About the Chief Complaint (CC)

(patient-centered; attentive listening to ensure accurate and efficient information gathering with facilitative responses: 'uh-huh,' 'Go on,' 'I see')

Opening question

"What problems have brought you here today?"

"Tell me what problems you've been having."

"Tell me what you've come to see me about."

"What's brought you to the hospital today?"

"What's been troubling you?"

"How can I help you?"

"What can I do for you?"

"I see that you have backache. Please tell me more about it."

Follow-up question

"Tell me more about the headaches."

"Can you tell me more about it?"

"Tell me all about it from the beginning."

Screening and confirming

(*try to pick up all of the patient's problems)*

"So you've been having headaches and some backache. Anything else at all?"

"So you've been having headaches and backache and have been feeling more tired than usual. Is that right?"

"Is there anything else (you want to talk about)?"

Agenda Setting

"Okay, now I'd like to ask you a few questions about each of your symptoms. Let's start with the headaches, and then we'll talk about the backache, and then about the tiredness. Is that okay?

Taking the HPI

When?

Onset

When did the pain start / begin?

When did the pain first come on?

How long have you been having this pain?

Onset (Precipitating) factors

Does anything bring the pain on?

Does the pain come on at any particular time?

What usually brings it on?

…..When does the pain usually come on?

Character of onset

Does the pain come on gradually or all of a sudden?

Duration

How long does the pain usually last?

Frequency

How often do you have the pain?

How often have you had the pain?

How many times have you had the pain?

Course

Is the pain getting better or worse?

Does the pain come and go?

Is the pain constant, or does it come and go?

Where?

Where does it hurt?

Show me where it hurts.

Please point to where it hurts.

Which part of your back is affected?

(*radiation*) Does the pain spread /move /travel anywhere else?

Quality?

What is the pain like?

What does the pain feel like?

Could you describe the pain?

What do you mean by 'weird' pain?

Quantity?

How bad is the pain?

On a scale of 1 to 10, with 10 being the worst pain, how would you rate the pain?

How is the pain affecting your life?

Aggravating and Alleviating Factors

Does anything make the pain better?

Does anything make it worse?

Does lying down help (relieve) the pain?

Associated Factors

Have you noticed any other problems related to the pain?

Have you noticed anything else?

Gathering Background Information

Past Medical History (PMH)

Now I'm going to ask you about your health in general / in the past.

Have you had anything like this before?

Have you ever had a major illness?

Have you ever had a major injury?

Have you ever had major surgery / a major operation?

Do you have any allergies? / Are you allergic to anything?

Medications (Meds)

Are you taking any medications at the moment? / Are you on any medications?

Do you take any over-the-counter drugs?

How about any Kampo medicines or Chinese herbal medicines?

Do you take any vitamins or other supplements?

(asking for detail) What do you take?

(Could you spell that for me?)

What do you take it for?

(dose) How many times a day do you take it?

(compliance) Do you always remember to take it?

(side effects) Do you have any side effects?

→ What kind?

(allergies) Do you know if you have any drug allergies?

→Which drug are you allergic to?

→What symptoms do you get?

Family History (FH)

Now, I'd like to ask about your family's health.

Are your parents alive and well?

Are all your close relatives fit and well?

Does anyone in your family have a serious illness?

How old was he when he died?

What did he die of? / Do you know the cause of death?

Social History (SH)

Now, I'm going to ask you some personal questions. Everything we talk about is confidential.

Do you have a partner?

Do you have any children?

Who do you live with?

Is there any stress at home?

Do you work?

Do you have any troubles at work? / Is there any stress at work?

…..Do you smoke? → How many a day? → Have you tried to give up?

Do you use recreational drugs?

Do you drink?

→Wine, beer, spirits?

→How much do you usually drink in a week?

→ Can you give up drinking when you want?

Do you have any hobbies or interests?

Review of Systems (ROS)

Now, I'm just going to ask you a few more questions, but it's important that I haven't missed anything.

How have you been feeling in general?

What's your appetite like? / How's your appetite? / Has there been any change in your appetite?

Have you had any loss or gain in weight?

→How many kilos did you lose (gain)?

→Was the weight loss (gain) intentional? / Were you on a diet?

Are your periods regular?

Do you have any …….	night sweats?	
Have you noticed any …….	headaches?	
Any ……	problems with vision?	
What about any ……..	dizziness?	ringing in the ears?
	nosebleeds?	sore throat?
	coughing?	coughing up blood?
	wheezing?	shortness of breath?
	chest pain?	palpitations?
	swelling of the ankles?	blackouts? / fainting?
	nausea?	vomiting?
	heartburn?	indigestion?
	abdominal pain?	constipation?
	diarrhea?	blood in your stool? / urine?
	problems urinating?	loss of bladder control?
	pain in your muscles or joints?	
	rashes?	itching?
	problems sleeping?	changes in mood?

Patient's Ideas, Concerns, Expectations (ICE)

(ideas) What do you think might have brought this on? / What do you know about this illness?

(concerns) What are your worries about this? / How does this affect <u>your family</u>?

(expectations) How were you hoping I could help you today?

And, finally …

What kinds of questions do you have for me?

Expressing Empathy

Responding to the patient's physical stress

- It's obviously very painful (for you).
- I can see you're in a lot of pain / having a lot of trouble.
- You're obviously in a lot of pain / having a lot of trouble. I can see that.
- That seemed to be hard work—lifting your foot.
- That seemed to give you a lot of pain—raising your arm.
- That must be (must have been) very painful (for you).
- I'm sorry that you've been having such a hard time.

Responding to the patient's emotional stress

- I can see you're upset / annoyed / frustrated.
- I can understand why you're upset / annoyed / frustrated.
- I can certainly understand that you're angry about having to wait so long.
- I can sense how angry you've been feeling about your illness.
- This must be very difficult for you.

Responding to the patient's reserve

- I can see you're finding it difficult to talk about this.
- It must be very hard to talk about this.
- This is very hard (for you), I know.
- This is very tough, isn't it?
- Can you bear to tell me more about _____.
- Just take your time.

Responding to the patient's worries

- I can understand your concern. We'll check that out carefully.

Responding to the patient's embarrassment

- I'm sorry if this exam is embarrassing for you. I'll try to make it as quick and easy as I can.

Acronyms and abbreviations are used throughout nursing and the healthcare profession

1. Types of Nurses

1) APRN - Advanced Practice Registered Nurse
2) CMA - Certified Medical Assistant
3) CNA - Certified Nursing Assistant
4) CNE - Certified Nurse Educator
5) CNL - Clinical Nurse Leader
6) CNS - Clinical Nurse Specialist
7) AGCNS- Adult-Gerontology Clinical Nurse Specialist
8) AOCNS - Advanced Oncology Certified Clinical Nurse Specialist
9) DCNS - Diabetic Clinical Nurse Specialist
10) HHCNS - Home Health Clinical Nurse Specialist
11) NCNS- Neonatal Clinical Nurse Specialist
12) OCNS-C - Orthopaedic Clinical Nurse Specialist – Certified
13) PCNS- Pediatric Clinical Nurse Specialist
14) PMHCNS - Psychiatric and Mental Health Clinical Nurse Specialist
15) UCNS- Urologic Clinical Nurse Specialist
16) CNM - Certified Nurse Midwife
17) CRNA - Certified Registered Nurse Anesthetist
18) DNP - Doctor of Nursing Practice
19) LPN - Licensed Practical Nurse
20) LVN - Licensed Vocational Nurse
21) NA - Nursing Assistant or Nursing Aide
22) NP - Nurse Practitioner
23) ACHPN - Palliative Care Nurse Practitioner
24) ACNP - Acute Care Nurse Practitioner
25) ACONP - Oncology Nurse Practitioner
26) AGACNP-BC or ACNPC-AG - Adult-Gerontology Acute Care Nurse Practitioner
27) AGPCNP-BC or A-GNP - Adult-Gerontology Primary Care Nurse Practitioner

28) ANVP - Advanced Neurovascular Practitioner
29) CPNP-AC - Pediatric Acute Care Nurse Practitioner
30) CPNP-AC - Pediatric Acute Care Nurse Practitioner
31) CUNP - Certified Urologic Nurse Practitioners
32) DCNP - Dermatology Nurse Practitioner
33) ENP-BC or ENP - Emergency Nurse Practitioner
34) FNP-BC or FNP - Family Nurse Practitioner
35) NNP-BC - Neonatal Nurse Practitioner
36) ONP-C - Orthopedics Nurse Practitioner
37) PMHNP-BC - Psychiatric-Mental Health Nurse Practitioner
38) PPCNP-BC or CPNP-PC - Pediatric Primary Care Nurse Practitioner
39) SNP-BC - School Nurse Practitioners
40) TNP - Telephone Nursing Practitioner
41) WHNP-BC - Women's Health-Gender Related Nurse Practitioner
42) PRN - Pro re nata (per diem nurse)
43) RN - Registered Nurse
44) CNO - Chief Nursing Officer
45) FAANP - Fellow of the American Association of Nurse Practitioners
46) NE - Nurse Executive
47) NM - Nurse Manager
48) ND - Nurse Director

2. Nursing Degrees

1) AAS - Associate of Applied Science
2) ADN - Associate's Degree in Nursing
3) ASN - Associate of Science in Nursing
4) BPS- Bachelor of Professional Studies with a concentration in Nursing
5) BS- Bachelor of Science with Nursing Major
6) BSN - Bachelor's of Science in Nursing
7) D.N.Sc. or DNS - Doctor of Nursing Science
8) DHA - Doctor of Healthcare Administration
9) DNAP - Doctor of Nurse Anesthesia

10) DNP - Doctor of Nursing Practice
11) EdD - Doctor of Education
12) MBA - Master of Business Administration in Healthcare Management
13) MHA - Master of Healthcare Administration
14) MPH - Master of Public Health
15) MSN - Master of Science in Nursing
16) Ph.D. - Doctor of Philosophy

3. Certifications

1) AAS - Associate of Applied Science
2) ADN - Associate's Degree in Nursing
3) ASN - Associate of Science in Nursing
4) BPS- Bachelor of Professional Studies with a concentration in Nursing
5) BS- Bachelor of Science with Nursing Major
6) BSN - Bachelor's of Science in Nursing
7) D.N.Sc. or DNS - Doctor of Nursing Science
8) DHA - Doctor of Healthcare Administration
9) DNAP - Doctor of Nurse Anesthesia
10) DNP - Doctor of Nursing Practice
11) EdD - Doctor of Education
12) MBA - Master of Business Administration in Healthcare Management
13) MHA - Master of Healthcare Administration
14) MPH - Master of Public Health
15) MSN - Master of Science in Nursing
16) Ph.D. - Doctor of Philosophy

4. Nursing Exams & Tests

1) NCLEX-RN - National Council Licensure Examination Registered Nurse
2) NCLEX-PN - National Council Licensure Examination Practical Nurse

3) BLS - Basic Life Support
4) ACLS - Advanced Cardiovascular Life Support
5) PALS - Pediatric Advanced Life Support
6) NRP - Neonatal Resuscitation Program
7) STABLE - Sugar, Temperature, Airway, Blood Pressure, Lab work, Emotional Support of the newborn
8) ECC - Emergency Cardiovascular Care

5. Common Hospital Units

1) ACU - Acute Care Unit
2) CCN - Continuing Care Nursery
3) CCU - Coronary Cardiac Unit
4) CICU - Cardiac Intensive Care Unit
5) ED - Emergency Department
6) ER - Emergency Room
7) HEM-ONC - Hematology-Oncology
8) ICCU - Intermediate Cardiac Care Unit
9) ICU - Intensive Care Unit
10) L&D - Labor and Delivery
11) NBN - Newborn Nursery
12) NICU - Neonatal Intensive Care Unit
13) OR - Operating Room
14) PACU - Post-Anesthesia Care Unit
15) PCU - Progressive Care Unit
16) PICU - Pediatric Intensive Care Unit
17) TCU - Transitional Care Unit
18) TICU - Trauma Intensive Care Unit
19) SDU - Special Delivery Unit
20) SICU - Surgical Intensive Care Unit
21) VICU - Vascular Intermediate Care Unit

6. Medical Chart & Record Abbreviations & Acronyms

1) A&D - Admission and discharge
2) AAA - Abdominal Aortic Aneurysm
3) AAT - Animal Assisted Therapy
4) ABC - Airway, Breathing, Circulation
5) Abd - Abdomen
6) ABG - Arterial Blood Gas

7) ABG - Arterial Blood Gas
8) ABI - Ankle-Brachial Index
9) ABO - Blood Types
10) ABR - Absolute Bed Rest
11) Ac - Before Meals
12) ACL - Anterior cruciate ligament
13) AD - Advance Directive
14) ADH - Antidiuretic hormone
15) ADHD - Attention deficit hyperactivity disorder
16) ADL - Activities of daily living
17) Ad lib - As Desired
18) ADR - Adverse drug reaction
19) AD - Right Ear
20) AEB - As Evidenced By
21) AED - Antiepileptic Drug
22) AF - Atrial Fibrillation
23) AF - Atrial Fibrillation
24) AFR - Acute renal failure
25) AGC - Atypical Glandular Cells
26) AHF - Antihemophilic Factor
27) AIDS- Acquired immune deficiency syndrome
28) AIH - Autoimmune Hepatitis
29) AIHA - Autoimmune Hemolytic Anemia
30) AIN - Acute Interstitial Nephritis
31) AKA - Above Knee Amputation or Alcoholic Ketoacidosis
32) AKI - Acute kidney injury
33) ALL - Acute lymphoblastic leukemia
34) ALP - Alkaline Phosphatase
35) ALT - Alanine Aminotransferase
36) ALTE - Apparent Life-Threatening Episode
37) AMA - Against Medical Advice
38) Amb - Ambulatory
39) AMI - Acute myocardial infarction
40) AML - Acute Myelogenous Leukemia
41) Amt - Amount
42) AN - Anorexia Nervosa
43) ANA - Antinuclear Antibody
44) ANCA - Antineutrophil Cytoplasmic Antibody
45) Angio - Angiogram
46) AP - Anterior/Posterior

47) AP - Appendectomy
48) AR - Aortic Regurgitation
49) ARB - Angiotensin Receptor Blocker
50) ARDS - Acute respiratory distress syndrome
51) ARF - Acute Renal Failure
52) AROM - Active Range of Motion
53) ARVD/C-Arrhythmogenic right ventricular dysplasia/cardiomyopathy
54) ARR - Absolute Risk Reduction
55) ASA - Acetylsalicylic Acid (aspirin)
56) ASD - Atrial Septal Defect
57) AS - Left Ear or Aortic Stenosis
58) AST - Aspartate Aminotransferase
59) ATP - Adenosine Triphosphatase
60) AUS - Abdominal Ultrasound
61) AV - Atrioventricular
62) AVB - Atrioventricular Block
63) AVCD - Atrioventricular Canal Defect
64) AVN - Avascular Necrosis
65) AVP - Arginine Vasopressin
66) AXR - Abdominal X-ray
67) BA - Bone Age
68) B-ALL - B-cell acute lymphoblastic leukemia
69) BAS - Balloon Atrial Septostomy
70) BB- Beta Blocker
71) BE - Barium Enema
72) BG - Blood Glucose
73) BiPAP - Bilevel Positive Airway Pressure
74) BKA - Below Knee Amputation
75) BLE - Bilateral Lower Extremity
76) BM - Bowel Movement or Breastmilk
77) BMA - Bone Marrow Aspirate
78) BMD - Bone Mineral Density
79) BMI - Bone Mass Index
80) BMP - Basic Metabolic Panel
81) BMR - Basal Metabolic Rate
82) BP - Blood Pressure
83) BPD - Borderline Personality Disorder
84) BPD - Bronchopulmonary Dysplasia
85) BPH - Benign Prostatic Hypertrophy
86) BPM - Beats Per Minute

87) BrS- Brugada Syndrome
88) BSA - Body Surface Area
89) BSE - Breast Self Examination
90) BUE - Bilateral Upper Extremity
91) BUN - Blood Urea Nitrogen
92) C/O - Complaint of
93) C&S - Culture and Sensitivity
94) CaBG - Coronary Artery Bypass Graft
95) CAD - Coronary Artery Disease
96) CAM - Complementary/Alternative Medicine
97) Cath - Catheter
98) CBC - Complete blood count
99) CBD - Common Bile Duct
100) CBG - Capillary Blood Gas
101) CBR - Complete bed rest
102) CC - Chief Complaint
103) CEA - Carcinoembryonic Antigen
104) CHD - Congenital Heart Disease or Congenital Heart Defect
105) CHF - Congestive Heart Failure
106) CK - Creatine Kinase
107) CL - Child Life Specialist
108) Cl - Chloride
109) CMP - Complete Metabolic Panel
110) CMV - Cytomegalovirus
111) CN - Cranial Nerve
112) CNS - Central Nervous System
113) COA - Coarctation of the Aorta
114) COPD - Chronic Obstructive Pulmonary Disease
115) CPAP: Continuous POsitive Airway Pressure
116) CPK - Creatine Phosphokinase
117) CPR - Cardiopulmonary resuscitation
118) CPVT- Catecholaminergic polymorphic ventricular tachycardia
119) Cr - Chromium
120) CRP - C-Reactive Protein
121) CRT- Cardiac resynchronization therapy
122) CSF - Cerebrospinal Fluid
123) CSM - Circulation, Sensation, Motion
124) CT - Computed Tomography
125) CT scan - Computerized Axial Tomography Scan
126) Cu - Copper

127) CVA - Cerebrovascular accident or stroke
128) CXR - Chest X-Ray
129) D&C - Dilation and Curettage
130) DCM- dilated cardiomyopathy
131) DC or d/c - Discontinue
132) DFT- Defibrillation threshold testing
133) DIS - Disseminated Intravascular Coagulation
134) DJD - Degenerative Joint Disease
135) DMD - Diabetes Mellitus
136) DNR - Do Not Resuscitate
137) DOA - Dead on Arrival
138) DOB - Date of Birth
139) DOE - Dyspnea on ExertionETOH - Alcohol
140) DORV - Double Outlet Right Ventricle
141) DVT - Deep Vein Thrombosis
142) Dx - Diagnosis
143) ECF - Extracellular Fluid
144) ECG - Electrocardiogram
145) ECMO - Extracorporeal membrane oxygenation
146) ECT - Electroconvulsive Therapy
147) EEG - Electroencephalogram
148) EEL - Emergency Exploratory Laparotomy
149) EENT - Ears, Eyes, Nose and Throat
150) EJ - external jugular
151) EMG - Electromyogram
152) EMI- Electromagnetic interference
153) ERCP - Endoscopic Retrograde Cholangiopancreatography
154) ERT - Estrogen Replacement Therapy
155) ESR - Erythrocyte Sedimentation Rate
156) ESRD - End Stage Renal Disease
157) ETT - Endotracheal Tube
158) EVAD - Explantable Venous Access Device
159) FAS - Fetal Alcohol Syndrome
160) FBD - Functional Bowel Disease
161) FBE - Foreign Body Extraction
162) FBM - Fortified Breast Milk
163) FBS - Fasting blood sugar
164) FCU - Flexor Carpi Ulnaris
165) FDP - Flexor Digitorum Profundus
166) FDS - Flexor Digitorum Superficialis

167) FESS - Functional Endoscopic Sinus Surgery
168) FF - Forced feeding or forced fluids
169) FFP - Fresh Frozen Plasma
170) FOBT - Fecal Occult Blood Test
171) FSH - Follicle-Stimulating Hormone
172) FTP - Failure To Progress
173) FTT - Failure To Thrive
174) FTSG - Full Thickness Skin Grafting
175) FVD - Fluid Volume Deficit
176) FVS - Fetal Valproate Syndrome
177) Fx - Fracture
178) GB - Gallbladder
179) GBS - Group B Streptococcus
180) GCE - Glycine Encephalopathy
181) GCS - Glasgow Coma Scale
182) GDD - Global Developmental Delay
183) GERD - Gastroesophageal Reflux
184) GFR - Glomerular Filtration Rate
185) GH - Growth Hormone
186) GI - Gastrointestinal
187) GT - Gastronomy Tube
188) gtt/min - Drops per minute
189) Gtt - drop
190) GTT - Glucose tolerance test
191) GUI - Genitourinary
192) Gyn - Gynecology
193) GYN - Gynecology
194) H&H - Hemoglobin and Hematocrit
195) hCG - Human Chorionic Gonadotropin
196) HC - Head Circumference
197) HCM- hypertrophic cardiomyopathy
198) Hct - Hematocrit
199) HDL - High Density Lipoprotein
200) Hep B - Hepatitis B
201) HEENT - Head, Ears, Eyes, Nose, and Throat
202) HFJV - High Frequency Jet Ventilation
203) HFNC - High Flow Nasal Cannula
204) HFOV - High Frequency Oscillator Ventilator
205) HFV - High Frequency Ventilation
206) Hgb - Hemoglobin

207) HIV - Human Immunodeficiency Virus
208) HMF - Human Milk Fortifier
209) HM - Human Milk
210) HOB - Head of bed
211) HPI - History of Present Illness
212) HPT - Hemoperitoneum
213) HR - Heart Rate
214) HRT - Hormone Replacement Therapy
215) HTN - Hypertension
216) HUS - Head Ultrasound
217) I&D - Incision and Drainage
218) I&O - Intake and output
219) IAB - Induced Abortion
220) IBG - Iliac Bone Graft
221) IBS - Irritable bowel syndrome
222) ICD- Implantable Cardioverter Defibrillator
223) ICF - Intracellular fluid
224) ICS - Intercostal Space
225) IDDM - Insulin dependent diabetes mellitus
226) ID - Intradermal
227) IDM - Infant of Diabetic Mother
228) IgG - Immunoglobulin G
229) IgM - Immunoglobulin M
230) IIH - Indirect Inguinal Hernia
231) IJ - internal jugular
232) IM - Intramuscular
233) IMV - Intermittent Mandatory Ventilation
234) In vivo - in the body
235) IPF - Idiopathic Pulmonary Fibrosis
236) Isol - Isolation
237) IUFD - Intrauterine Fetal Demise
238) IUGR - Intrauterine Growth Restriction
239) IUI - Intrauterine Insemination
240) IU - International units
241) IVAD - Implantable Vascular Access Device
242) IVC - Inferior Vena Cava
243) IVF - In Vitro Fertilization
244) IVH - Intraventricular Hemorrhage
245) IV - Intravenous
246) IVPB - intravenous Piggyback

247) IVP - Intravenous Push
248) KCL - Potassium Chloride
249) KD - Kawasaki Disease
250) Kg - kilogram
251) KUB - Kidneys/Ureters/Bladder
252) KVO - Keep Vein Open
253) LBBB- left bundle branch block
254) LDL - Low Density Lipoprotein
255) LE - Lupus Erythematosus
256) LES - Lower Esophageal Sphincter
257) LFT - Liver Function Test
258) LGA - Large for Gestational Age
259) LH - Luteinizing Hormone
260) LLE - Left Lower Extremity
261) LLSB - Lower Left Sternal Border
262) LMP - Last Menstrual Period
263) LOC- Level of Consciousness
264) LP - Lumbar Puncture
265) LQTS- Long QT syndrome
266) LSB - Left Sternal Border
267) LUE - Left Upper Extremity
268) LUQ - Left Upper Quadrant
269) MAOI - Monoamine Oxidase Inhibitor
270) MAO - Monoamine Oxidase
271) MAP - Mean Airway Pressure
272) MAR - Medication Administration Record
273) MAS - Meconium Aspiration Syndrome
274) MCL - Medial Collateral Ligament
275) MCL - Midclavicular Line
276) MDI - Metered-Dose Inhaler
277) MDR - Multidrug-Resistant
278) MICU - Medical Intensive Care Unit
279) MI - Myocardial Infarction
280) mL - Milliliter
281) MMR - Measles, Mumps, Rubella
282) MRI - Magnetic Resonance Imaging
283) MRSA - Methicillin-Resistant Staphylococcus Aureus
284) MS - Morphine Sulfate
285) N/V - Nausea or vomiting
286) NaCl - Sodium Chloride

287) NA - Not applicable
288) NC - Nasal Cannula
289) NG - Nasogastric
290) NICU - Neonatal Intensive Care Unit
291) Noct - At night
292) NO - Nitric Oxide
293) NPO - Nothing by mouth
294) NS - Normal Saline
295) NSR - Normal Sinus Rhythm
296) NTD - Neural Tube Defect
297) OB - Obstetrics
298) Obs - Observation
299) OD - Right Eye
300) OG - oral - gastric tube
301) Oint. - Ointment
302) ORIF - Open Reduction/Internal Fixation
303) OS - Left Eye
304) OTC - Over the counter
305) OT - Occupational Therapist
306) OU - Both Eyes
307) PAC- Premature Atrial Contraction
308) PAF - Paroxysmal Atrial Fibrillation
309) PCA - Patient-Controlled Analgesia
310) PCL - Posterior cruciate ligament
311) PCP - Primary Care Provider
312) PC - Pressure Control
313) PCR - Polymerase Chain Reaction
314) PDA - Patent Ductus Arteriosus
315) PE - Pulmonary embolism
316) PERRLA - Pupils Equal, Round, Reactive to Light and Accommodation
317) PFO - Patent Foramen Ovale
318) PFT - Pulmonary Function Test
319) PICC - Peripherally inserted central catheter
320) PIE - Pulmonary Interstitial Emphysema
321) PIH - Pregnancy Induced Hypertension
322) PIP - Peak Inspiratory Pressure
323) PKU - Phenylketonuria
324) PLSVC- Persistent Left superior vena cava
325) PMH - Past Medical History
326) PMS - Premenstrual Syndrome

327) PNS - Peripheral Nervous System
328) PO - By mouth
329) Post-op spec - After surgery urine specimen
330) PPBS - Post-Prandial Blood Sugar
331) PPE - Personal Protective Equipment
332) PPHN - Persistent Pulmonary Hypertension
333) PPS - Peripheral Pulmonic Stenosis
334) PROM - Passive Range of Motion
335) PROM - Premature Rupture of Membrane
336) PS - Pressure Support
337) PTL - Preterm Labor
338) PT - Patient, pint
339) PT - Physical Therapist
340) PTT - Partial Thromboplastin Time
341) PVC- Premature Ventricular Contraction
342) PVD - Peripheral Vascular Disease
343) PVL - Periventricular Leukomalacia
344) Qd - every day
345) Qh - every hour
346) Qid - four times a day
347) Qod - every other day
348) QTc- corrected QT interval
349) R/T - Related to
350) RA - Room Air
351) RBBB- Right bundle branch block
352) RBC - Red Blood Count
353) RCM - Right Costal Margin
354) RDS - Respiratory Distress Syndrome
355) REM - Rapid Eye Movement
356) RLQ - Right Lower Quadrant
357) RLS - Restless Leg Syndrome
358) RLU - Right Lower Extremity
359) ROM - Range of motion
360) ROS - Review of System
361) RPR - Rapid Plasma Reagin
362) RSB - Right Sternal Border
363) RUE - Right Upper Extremity
364) RUQ - Right Upper Quadrant
365) RV - Residual Volume
366) SC/SQ - Subcutaneous

367) SCI - Spinal Cord Injury
368) SGA - Small for Gestational Age
369) SICU - Surgical Intensive Care Unit
370) SIDS - Sudden infant death syndrome
371) SIMV - Synchronized Intermittent Mandatory Ventilation
372) SL - Sublingual
373) SOAP - Subjective Data, Objective Data, Assessment, Plan
374) SOB - Shortness of breath
375) SQTS- Short QT Syndrome
376) SSS- sick sinus syndrome
377) Stat - At once, immediately
378) STD - Sexually Transmitted Disease
379) ST- Sinus Tachycardia
380) ST - Speech Therapist
381) Supp - Suppository
382) Susp - Suspension
383) SVC - Superior Vena Cava
384) SVT - Supraventricular tachycardia
385) SVT- supraventricular tachycardia
386) SVT- Sustained Ventricular Tachycardia
387) TAPVR - Total Anomalous Pulmonary Venous Return
388) TA - Truncus Arteriosus
389) TBC - Total Body Cooling
390) TBI - Traumatic Brain Injury
391) TB - Tuberculosis
392) TCM - Transcutaneous Monitor
393) TEN - Total Enteral Nutrition
394) TF - Tube Feeding
395) THA - Total Hip Arthroplasty
396) TIA - Transient Ischemic Attack
397) TICU - Trauma Intensive Care Unit
398) TOF - Tetralogy of Fallot
399) TPN - Total Parenteral Nutrition
400) TPR - Temperature, pulse, respiration
401) Trach - Tracheostomy
402) TSE - Testicular Self Examination
403) TSH - Thyroid-Stimulating Hormone
404) TTN - Transient Tachypnea of the Newborn
405) U/A - Urinalysis
406) UAC - Umbilical Arterial Catheter

407) ULQ - Upper Left Quadrant
408) URQ - Upper Right Quadrant
409) US - Ultrasound
410) UTI - Urinary Tract Infection
411) UVC - Umbilical Venous Catheter
412) VAD - Ventricular Assist Device, Vascular Access Device
413) VBG - Venous Blood Gas
414) VF- Ventricular fibrillation
415) VLDL - Very Low-Density Lipoprotein
416) VRE - Vancomycin-Resistant Enterococci
417) VSD - Ventricular Septal Defect
418) VS - Vital signs
419) VT- Ventricular tachycardia
420) VUS- Variant of unknown significance
421) W/C - Wheelchair
422) WBC - White Blood Count
423) WNL - Within Normal Limits
424) WPW- Wolff–Parkinson–White syndrome

Office use only:

Allergy sticker to be placed here

Patient label to be placed here

nexus | Insight Private Hospital

ABN: 78 601 453 892
Level 5, 470 Wodonga Place
ALBURY 2640
P 02 6058 0800
F 02 6058 0888

bookings@insightprivate.com.au
www.insightprivate.com.au

PATIENT ADMISSION REQUEST FORM

Please complete this form and deliver to Insight Private at least 7 days prior to your admission.
Alternatively, you may fax, email or post your admission form. Please bring the original form when you attend your appointment.

RESET FORM

PATIENT DETAILS

Treating Surgeon:	Referring Dr:	Procedure Date:	
Surname: ◯ Mr ◯ Master ◯ Mrs ◯ Ms ◯ Miss			
Given Names:	Previous Surname:		
Address:	Town/City:	State:	Postcode:
PO Box:			
Date of Birth:	Occupation:		
Phone (Home):	(Work):	(Mobile):	
Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Other:			
Language: ☐ English ☐ Other:	Do you require an interpreter? ◯ Yes ◯ No		
Country of birth:	Religion:		
Are you an Aboriginal or Torres Strait Islander? ◯ Yes ◯ No			
Have you been admitted to Insight Private Hospital previously? ◯ Yes ◯ No If yes, what year:			
• Do you live on your own? ◯ Yes ◯ No			
• Do you have an Advanced Care Directive/Treatment limiting order in place? ◯ Yes ◯ No			

PERSON TO CONTACT / NEXT OF KIN

Surname:	Given Names:		
Address:	Town/City:	State:	Postcode:
Phone (Home):	(Work):	(Mobile):	
Relationship to patient:			
• Person collecting you upon discharge if different from your Next of Kin:			
Name:	Telephone number/s:		
Do you have an Enduring Power of Attorney for health matters? ◯ Yes ◯ No			
Contact name:	Telephone number/s:		

• It is hospital policy to discharge all day case patients into the care of a friend or relative for the first 24hrs post-surgery.
This must be organised by you prior to admission to the hospital, failure to do so may lead to your procedure being postponed.

Patient label to be placed here

ACCOUNT DETAILS

MEDICARE No:	Expiry:	Position on Card:
Safety Net Card Number: SC/CN		

Please **TICK ONE** of the following and provide details:

☐ **UNINSURED** please obtain your estimate of fees, payable prior to surgery.		
☐ **HEALTH INSURANCE**		
Fund Name:	Member No:	Excess:

The following 3rd party insurers must have prior approval.

☐ **VETERAN'S AFFAIRS** File No:	Card Colour: ◯ Gold ◯ White	Exp. Date:
☐ **DEPARTMENT OF DEFENCE**		
DAN:	EPID:	
☐ **WORKERS COMPENSATION** or ☐ **THIRD PARTY / LEGAL** ☐ **TAC** (approval to be attached) ☐ **SPORTING**		
Insurance Company:	Address:	
Claim No:	Date of Injury:	Approval No:
Case Manager:	Email:	
Telephone No:	Employer:	
Address:		Telephone No:

MEDICAL HISTORY and GENERAL PATIENT INFORMATION

The following questions, and your answers, will assist us in providing you the care that is **appropriate to your needs.**
(Please answer Yes/No and tick the boxes where they apply.)

1. Do you have any ALLERGIES or SENSITIVITIES to any drugs, materials or foods? ◯ Yes ◯ No
Please list:

2. Heart problems? ◯ Yes ◯ No

- ☐ Heart attack
- ☐ Vascular heart disease
- ☐ Bypass surgery
- ☐ Palpitations
- ☐ Heart valve replacement
- ☐ Stent
- ☐ Pacemaker – date last checked:

Heart Specialist Name:
Phone No:

3. Are you pregnant? ◯ Yes ◯ No

4. Have you had, or have, any of the following conditions?

- ☐ Blood clots
- ☐ Blood pressure
- ☐ Arthritis
- ☐ Depression
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ HIV/AIDS
- ☐ Neck or jaw trouble
- ☐ Stroke
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Renal disease
- ☐ Ankle swelling
- ☐ Asthma
- ☐ Current infection:

Details:

5. Do you currently smoke? ◯ Yes ◯ No

Number per day:

If you have smoked in the past, year ceased:

Our building is a smoke free building and is locked down between 7pm & 7am.
Patients staying overnight will be unable to leave Level 5 during these times.

Patient label to be placed here

6.	**Height:** **Weight:**
7.	**Do you have, or ever had the following?** • **Lung disease?** ◯ Yes ◯ No If yes, please list: • **Bladder / kidney problems?** ◯ Yes ◯ No If yes, please list: • **Bowel problems?** ◯ Yes ◯ No If yes, please list:
8.	**Have you had or do you currently have cancer?** If yes, please provide the location, and year of diagnosis: ◯ Yes ◯ No
9.	**Have you had or do you currently have an illness that is NOT listed on the previous questions?** If yes, please list: ◯ Yes ◯ No
10.	**Have you had surgery before?** ◯ Yes ◯ No If yes, please list most recent major surgery/s:
11.	**Have you (or any relatives) had any complications associated with anaesthetics?** ◯ Yes ◯ No

12.	**Do you have diabetes?** ◯ Yes ◯ No If yes, is it ☐ Type 1 or ☐ Type 2 List diabetic medications:
13.	**Are you currently taking any other medications?** If you are taking regular medication, we will require an up to date printout of your medications from your GP. ◯ Yes ◯ No If yes, please list:
14.	**Diet needs, i.e. lactose intolerant, vegetarian.** If yes, please list: ◯ Yes ◯ No
15.	**Do you regularly consume alcohol?** ◯ Yes ◯ No If yes, how often:
16.	**Do you have any sleep problems?** ◯ Yes ◯ No If yes, please list:
17.	**Do you currently need assistance to:** ◯ Yes ◯ No Please tick if required: ☐ Shower / Bathe ☐ Dress ☐ Walk ☐ Aids required:

DOCTOR / OFFICE USE ONLY

Proposed date of surgery:

☐ Day care ☐ Overnight ☐ No. of nights:

Equipment needs:

Estimated item numbers:

DOCTOR / Pre-Admission Orders

ECG Required: ◯ Yes ◯ No

Post-op appointment date:

CONSENT FOR OPERATIVE TREATMENT AND ANAESTHESIA

This page will need to be printed out, signed by authorised person/s, then scanned if sending back by email.

Patient label to be placed here

I _____ hereby request and consent to the following operation(s)

_____

_____

being performed upon _____ the nature and risks of the above operation(s),

have been fully explained to me by Dr. _____

I consent to a blood or blood product transfusion should it be associated with this operation.
I consent to any further operative procedures found to be necessary during the course of the operation(s) stated above.
I consent to the administration of any local, regional and / or general anaesthesia considered appropriate, by the anaesthetist of my surgeon's choice. I understand that my consent can be withdrawn at any time before surgery.

Dated this (day) _____ of (month) _____ 20 _____

Signed _____ Relationship to patient _____

Signature of witness _____ Name of witness _____

INSIGHT PRIVACY & INFORMATION POLICY

Insight Private Hospital is bound by State and Federal Privacy Laws. A copy of the National Privacy Principles is available for inspection at the reception desk.

A component of quality health care includes maintaining patient files. Your medical file is handled with the utmost respect for your privacy. Your file will be accessed by your doctor, nursing staff and by our administrative staff, who are trained and bound by strict confidentiality requirements. To protect your privacy, we maintain strict and secure, storage policies. We will not release the contents of your medical file without your consent, unless required to do so by law, or in a life-threatening situation.

We acknowledge, that you have rights of access to your medical information. Should you wish to access this information (we refer you to our handout entitled "Privacy and your Rights") or should you have a question or complaint in relation to privacy at Insight Private Hospital, please contact our Hospital Manager.

Any request for medical information or complaint must be made in writing and addressed to: The Hospital Manager, Insight Private Hospital, and marked "Private and Confidential".

PRIVACY POLICY ACCEPTANCE

I _____ hereby acknowledge that I have received and accept the Insight Privacy & Information Policy (as outlined above) prior to my admission, as required by the Privacy Amendment (Private Sector) Act 2000. I authorise Insight Private to obtain my medical history from my GP or specialist.

Signed _____ Date _____

FINANCIAL CONSENT – All Patients:

In the event that a Private Health Fund or other Third Party claim does not fully cover my surgery, I agree to be fully liable for any amounts owing in relation to my procedure. I hereby indemnify Insight Private Hospital, in the event of my unsuccessful account claim, against any health insurance company or third party.

Signature of Patient / Responsible Person _____

Insight Private Hospital
nexus

ABN: 78 601 453 892
Level 5, 470 Wodonga Place
ALBURY 2640
P 02 6058 0800
F 02 6058 0888

bookings@insightprivate.com.au
www.insightprivate.com.au

We acknowledge the traditional land owners of Australia and we welcome all Aboriginal and Torres Strait Islander people to our service.

Patient Information

Welcome and thank you for choosing Insight Private Hospital for your health care needs.

Insight Private Hospital prides itself on meeting patient's expectations as an outstanding, state of the art, modern private hospital, committed to quality patient care.

Please detach and keep this form for your information and return the remaining Admission Request form to Insight Private Hospital at least seven (7) days prior to your surgery.

- **Health fund –** Please contact your health fund to check that you are covered for your procedure and whether you have an excess or co-payment to pay. This must be paid prior to admission to the hospital.
- **Uninsured –** You will receive an estimation of fees which must be fully paid prior to admission.
- **Admission Time –** Please call Insight Private Hospital between 10am and 12MD the working day prior to your surgery (office hours Monday to Friday 8:00am – 4:30pm)
  Ph: 02 6058 0800
- **Day Cases Discharge from Hospital –** It is hospital policy to discharge patients into the care of a friend or relative for the first twenty-four (24) hours post surgery. This must be organised by you prior to admission to the hospital. This person will be called by our staff when you are ready for discharge.
- **Visiting hours –** 10am – 12MD and 2pm – 7pm.
- **Medications –** Please ensure you bring all current medication in original packaging with you to give to the admissions nurse on arrival. Only pharmacy issued "webster packs" will be accepted if you do not have original boxes for your medications. We will not be able to administer medications from any other pill container/box.
- **Health Summary** - If taking regular medications we require an up to date printout of your Health Summary including your current medications from your General Practitioner. Please bring/send your Health Summary with your Admission Request Form.
- **Jewellery & Makeup -** Please remove all jewellery, nail polish and make up before admission.
- **Smoking –** Insight Private Hospital and Gardens Medical Centre is a "No Smoking" facility this includes all car parks and surrounds. The building locks down from 7pm - 7am
  Patients staying overnight will be unable to leave level five (5) during these times.
- **Overnight Extended Day Only Bays (EDO Bays) –** These are private health care facility overnight bays for patients staying in hospital overnight i.e. less than twenty-three (23) hours for post-operative observation and pain relief. This bay consists of a bed, cabinet, privacy curtain, shared bathroom and eastern views through a large window. The patient lounge with TV and nurses station are within close proximity.
- **Short Stay Suites –** These are private health care facility suites for patients booked in for one (1) to four (4) days.
- **Queries –** Any queries please call our friendly reception staff on 02 6058 0800.
- **Parking –** 2hr parking is available on site, either in the basement or on level one for dropoff, pickup and visiting.

Insight Private Hospital

nexus

Parent Information for Overnight Stay with Child.

A parent who wishes to stay with a young child is most welcome at Insight Private Hospital.

To assist you in what to bring and what to expect please see below.

Hours – Insight is open from 7am until 7pm Monday to Thursday and Friday 8.00am to 4.30pm

Building Lock down – Please note that at 7pm each night the hospital is locked down and you cannot leave until 7am the following morning.

Car Parking – Day time parking is restricted to 2 hours where signed, however, you can park in the 2 hour park between 5.30pm and 7am. You must move your car at 7am to another 2 hour park or off the premises. This is a building requirement, which we have no authority to change and is closely monitored by building security.

Restricted ward areas – Pre-op and Post-op – We encourage a parent to be with their child in these areas, however, this can only be one parent and no siblings/ children will be allowed in these areas. All family members will be welcome once the child is back in their ward room, please note the visiting hours are 10am – 12MD and 2pm – 7pm.

Smokers – If you are a smoker, please note this is a "no smoking building" and that there is no option to leave the building to smoke from 7pm and 7am the following day as the building is securely locked down between these times.

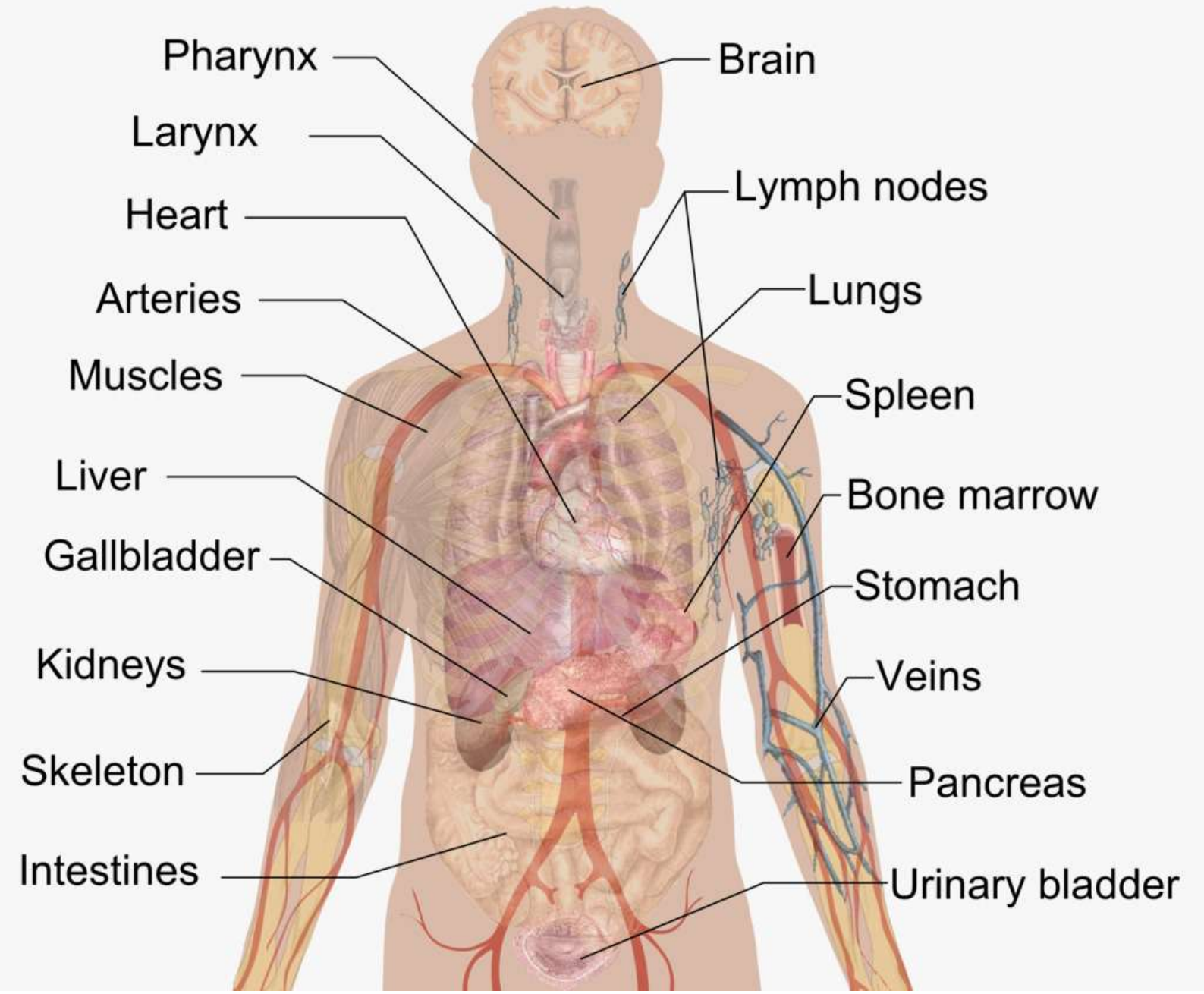
Parents Meals / Information – Insight will provide you with a bed and breakfast, please ensure you fill out the menu on arrival. Please note that the kitchen is not available to visitors, however, the kitchen staff will offer you tea and coffee throughout the day. Should you wish to leave for a break and or a meal at any time between 7am and 7pm there are several cafés in close proximity to Insight, including the café on the ground floor which is open until 5.30pm.

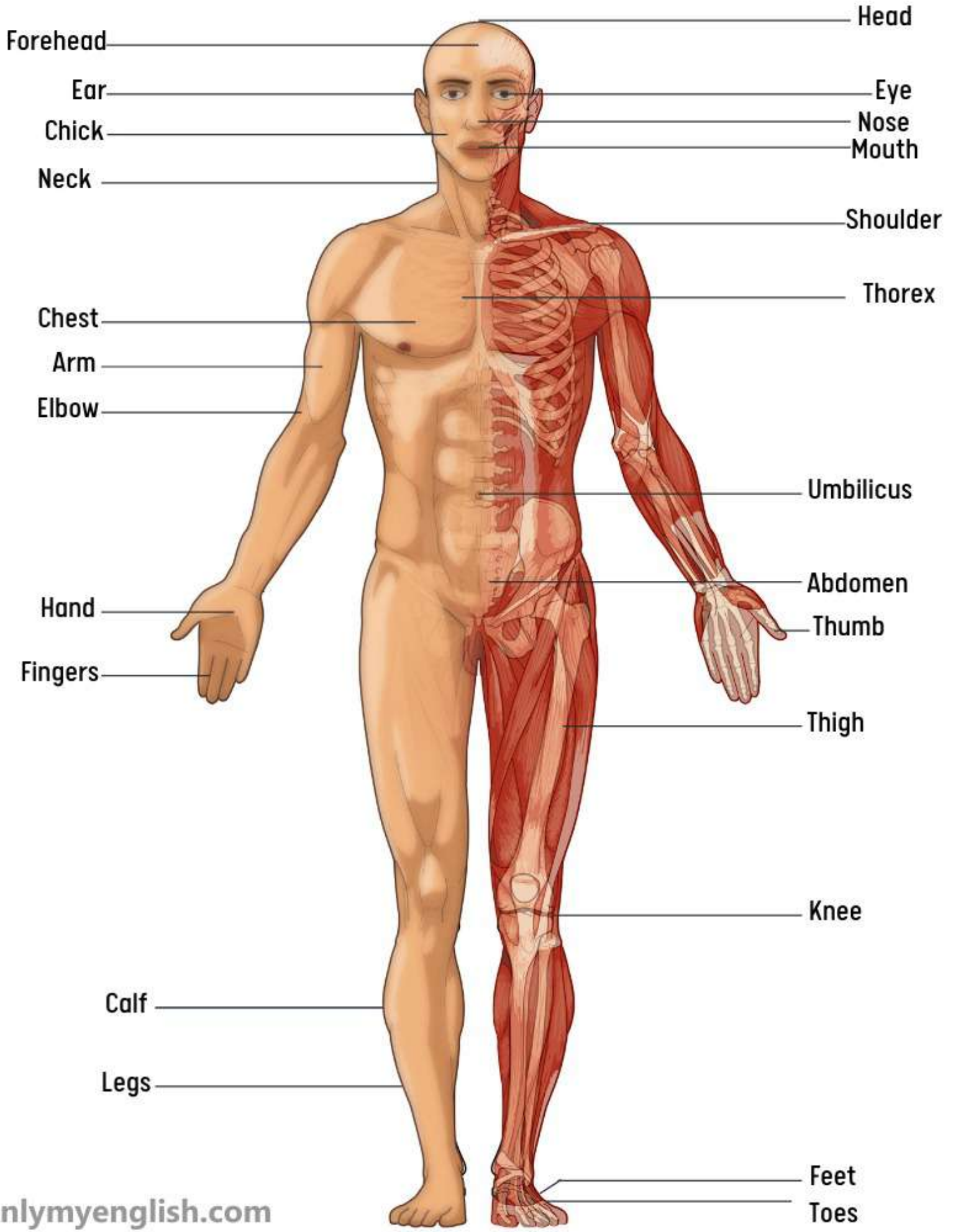
Menu – The children's menu is light, we are flexible with the menu for the children. Food is available for children at any time. We do cater for food intolerances.

Optional items to bring – Your child might have a favorite toy, pillow, blanket etc and may bring along for comfort. It is also a good idea to bring some books, movies or games that they might like to play.
Insight Private Hospital has a DVD player and some "G" rated movies.

If you have any questions please do not hesitate to contact us on 02 6058 0800.

Internal organs





Hartford Hospital
A Hartford HealthCare Partner

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PATIENT PRE-ADMISSION QUESTIONNAIRE

Name:_____ **D.O.B.**___/___/___ **Date of Procedure:** ___/___/___

☎ **Phone #:** _____ **Height:** _____ **Weight:** _____

Proposed Procedure: _____
Surgeon: _____
Family Doctor: _____

- Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, foods, etc? ..... ❒ YES ❒ NO
  If **YES**, to what? _____
  What type of reaction?:
  ☐ RASH ☐ HIVES ☐ NAUSEA ☐ SWELLING ☐ TROUBLE BREATHING
- Do you take any medicines every day? (Including Aspirin, Birth Control Pills, Maalox.) . ***If yes, Please list below and bring to the hospital:*** ❒ YES ❒ NO

  _____
  _____
  _____
- Do you take any herbal products, diet pills, over-the-counter products?..... ❒ YES ❒ NO
  If **YES**, what? _____

NOTE: If you currently are taking herbal / diet remedies, we recommend they be stopped 2 weeks prior to your procedure date.

- Could you be pregnant? ..... ❒ YES ❒ NO
- Have you ever smoked cigarettes? ..... ❒ YES ❒ NO
  a. How many a day? _____ b. For how long? _____ c. Do you smoke now? _____
- Do you drink alcohol? ..... ❒ YES ❒ NO
  a. How often? _____ b. What kind? _____ c. How much? _____
- Have you ever had an operation before? ..... ❒ YES ❒ NO
  a. If **YES**, what kind and when? _____
  b. Do you remember what type of anesthesia you had? ..... ❒ YES ❒ NO
  ☐ General ☐ Spinal ☐ Epidural ☐ Local
  c. Did you ever have a problem with anesthesia? ..... ❒ YES ❒ NO
  If YES, what? _____
  d. Has anyone in your family ever had a problem with anesthesia? ..... ❒ YES ❒ NO
  If YES, what? _____

- Have you ever had a : heart attack? ..... ❒ YES ❒ NO
  heart condition? ..... ❒ YES ❒ NO

Have you ever experienced:
- chest pain (angina)? ..... ❒ YES ❒ NO
- high blood pressure? ..... ❒ YES ❒ NO
- shortness of breath? ..... ❒ YES ❒ NO
- pressure in your chest? ..... ❒ YES ❒ NO
- palpitations or irregular heart beat? ..... ❒ YES ❒ NO
- abnormal electrocardiogram? ..... ❒ YES ❒ NO

Hartford Hospital
A Hartford HealthCare Partner

484

PATIENT PRE-ADMISSION QUESTIONNAIRE

Name:_____ **D.O.B.**___/___/___ **Date of Procedure:** ___/___/___

☎ **Phone #:** _____ **Height:** _____ **Weight:** _____

Proposed Procedure: _____
Surgeon: _____
Family Doctor: _____

- Do you have any allergies or sensitivities to drugs, dyes, any kind of tape, latex products, foods, etc? ..... ❒ YES ❒ NO
  If **YES**, to what? _____
  What type of reaction?:
  ☐ RASH ☐ HIVES ☐ NAUSEA ☐ SWELLING ☐ TROUBLE BREATHING
- Do you take any medicines every day? (Including Aspirin, Birth Control Pills, Maalox.) . ***If yes, Please list below and bring to the hospital:*** ❒ YES ❒ NO

  _____
  _____
  _____
- Do you take any herbal products, diet pills, over-the-counter products?..... ❒ YES ❒ NO
  If **YES**, what? _____

NOTE: If you currently are taking herbal / diet remedies, we recommend they be stopped 2 weeks prior to your procedure date.

- Could you be pregnant? ..... ❒ YES ❒ NO
- Have you ever smoked cigarettes? ..... ❒ YES ❒ NO
  a. How many a day? _____ b. For how long? _____ c. Do you smoke now? _____
- Do you drink alcohol? ..... ❒ YES ❒ NO
  a. How often? _____ b. What kind? _____ c. How much? _____
- Have you ever had an operation before? ..... ❒ YES ❒ NO
  a. If **YES**, what kind and when? _____
  b. Do you remember what type of anesthesia you had? ..... ❒ YES ❒ NO
  ☐ General ☐ Spinal ☐ Epidural ☐ Local
  c. Did you ever have a problem with anesthesia? ..... ❒ YES ❒ NO
  If YES, what? _____
  d. Has anyone in your family ever had a problem with anesthesia? ..... ❒ YES ❒ NO
  If YES, what? _____

- Have you ever had a : heart attack? ..... ❒ YES ❒ NO
  heart condition? ..... ❒ YES ❒ NO

Have you ever experienced:
- chest pain (angina)? ..... ❒ YES ❒ NO
- high blood pressure? ..... ❒ YES ❒ NO
- shortness of breath? ..... ❒ YES ❒ NO
- pressure in your chest? ..... ❒ YES ❒ NO
- palpitations or irregular heart beat? ..... ❒ YES ❒ NO
- abnormal electrocardiogram? ..... ❒ YES ❒ NO

CALVARY HOSPITAL
Where Life Continues

Patient Name: _____

SS #: _____

Date: _____

Section D

CURRENT MEDICATIONS:

NOTE: PLEASE FAX A PRINT OUT OF THE MEDEX, IF AVAILABLE.

(Please attach Medication Listing, Physician Orders and Wound Care orders with application)

_____

_____

_____

_____

_____

_____

_____

_____

COMMUNICATION NEEDS: _____

Patient and/or Family is in agreement with Calvary Hospital Scope of Care (Symptom Management/Basic Life Support)

□ Yes □ No (indicate reason) _____

_____

DNR □ Yes (Please Provide a Copy) □ No **HCP** □ Yes (Please Provide a Copy) □ No

Family Issues _____

_____

_____

Patient lives with _____

Application Completed by: Signature: _____ **Print:** _____ **Date/Time:** _____

Application for Acute Inpatient Care for Symptom Management
Related to Advanced Cancer, Home Care, Hospice at Home and Outpatient Clinic Services

1. **Complete application as soon as possible and fax to the Calvary Outreach Department at (718-518-2670), Monday to Friday 8:30 a.m. to 5:00 p.m.**
   - **The *entire* application must be completed for all referrals.**
2. **Complete insurance information is appreciated to offset delays due to precertification requirements. If known, please provide us with the MCO Case Manager's name and telephone number.**
3. **Patient/Families need to understand that resuscitation is limited to basic CPR. If a patient or family requests or expects additional life support measures, we will call 911 and transfer the patient to the nearest emergency department.**

CALVARY HOSPITAL

Where Life Continues

COMMUNITY OUTREACH SERVICES
1740 Eastchester Road, Bronx, NY 10461
Phone (718) 518-2300 Fax (718) 518-2670

ADMISSION: (Please check one)
Today □ **Tomorrow** □ ***Hold/Backup** □
REHAB □ **ANTIBIOTIC TX** □
WOUND CARE SERVICE □
Interim Home Services □ **Yes** □ **No**
Copy of Advance Directives Provided □ **Yes** □ **No**
DNR □ **Yes (Attach Copy)** □ **No**
HCP □ **Yes (Attach Copy)** □ **No**

Application for: (*Check where applicable):*
ACUTE INPATIENT ADMISSION
□ **Bronx Campus** □ **Brooklyn Campus**

CALVARY @ HOME:
□ **Hospice at Home** □ **Home Care**
Tentative Discharge Date ___/___/___

Ambulatory Services:
□ **Outpatient Services** □ **Center for Palliative Wound Care**

Section A

PATIENT NAME_____
First Name **Last Name**

Address:_____ Apt. # City State Zip

Phone: (___) Age Birth Date: / / Sex Race Rel Marital Status

SS#___-___-___ Medicare Medicaid

Ins. Co. Policy #

Other Insurance Information **Medicaid Office Phone #**

Section B

#1 Contact Name_____ Relationship □ HCP □ POA □ Advance Directives
First Name Last Name

Address:_____ Apt. # City State Zip

Home Phone: (___) Cell Phone: (___) Work Phone: (___)

#2 Contact Name_____ Relationship □ HCP □ POA □ Advance Directives
First Name Last Name

Home Phone: (___) Cell Phone: (___) Work Phone: (___)

PHYSICIAN NAME:_____
Physician Agrees with Transfer to Calvary Hospital? □ Yes □ No

Physician Address: City State Zip

Phone: (___) Fax: (___) Beeper: (___) Cell: (___)

SW/CM/DCP NAME: Beeper: (___) #

Phone: (___) Ext: Fax: (___) Nursing Unit Phone: (___)

Facility/Program: **Patient Admit Date:** ___/___/___

Completed by: SIGNATURE: **PRINT:** **DATE/TIME:**

Section C **PLEASE FAX MEDICATION RECONCILIATION LIST**

DIAGNOSIS:_____

/ALLERGIES:_____

Mets: □ Lung □ Liver □ Brain □ Bone □ **Other**: **DNR** □Yes (attach a copy) □No

Current Medical Issues/Intensity of Service

□ PCA
□ Oxygen □ Shortness of Breath
□ BIPAP/ Settings: _____
□ Nausea/Vomiting
□ Diarrhea □ Constipation
□ Restraints
□ Seizure
□ Pathological Fracture
□ TPN/PPN
□ Cord Compression
□ Hemorrhage/Bleeding_____
□ Infection Type of Infection_____
□ Isolation Type of Isolation_____
□ Cardiac Arrhythmias
□ Psychiatric Dx_____
□ History of Wandering
□ History of Falls
□ Pain Control
□ Drains/Tubes/Central Lines/Port
□ Anxiety □ Agitation □ Confusion
□ Complex Wound Care □ Fistula
□ Endocrine Disorders
□ Inadequate PO/IV Fluids Therapy
□ Fluid and Electrolyte Disorder
□Chemo/Radiation Therapy (Current/Past)
□ Radiation Implant (Current/Past)
□ Active/Curative Treatment

OTHER:_____

***REASON FOR HOLD\B/U:**_____

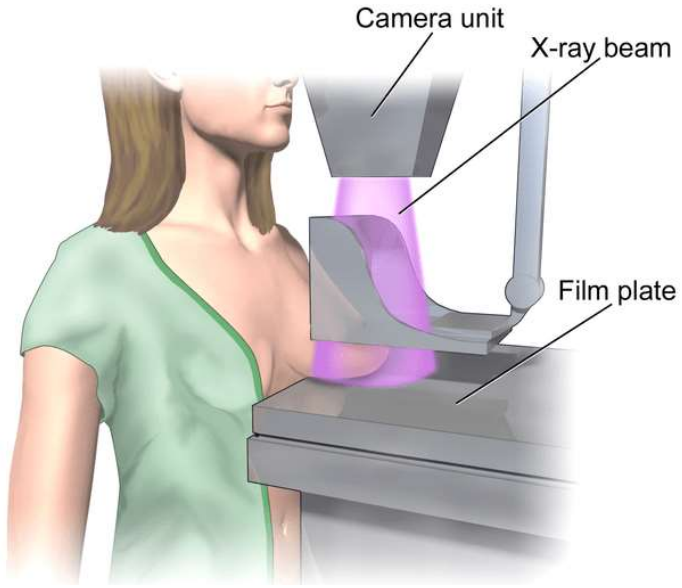
THE MEDICAL DEPARTMENT IN HOSPITAL

Accident and Emergency (A&E)

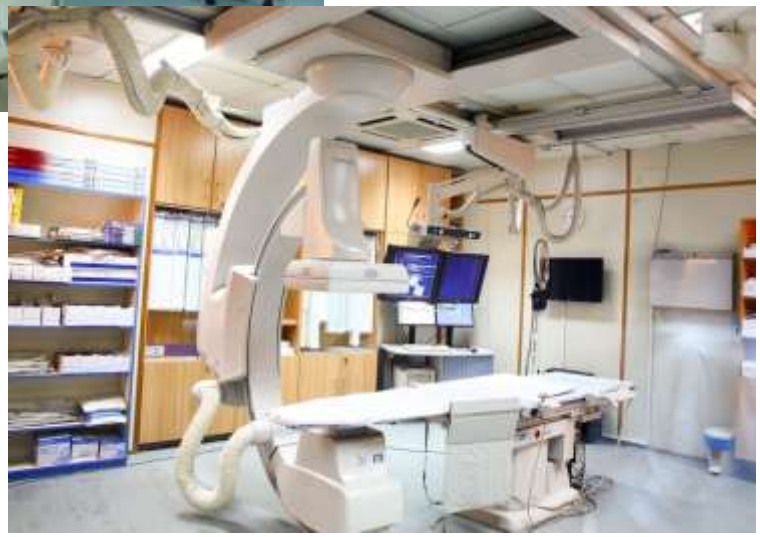
Anaesthetics Department

Breast Screening Department

Breast Screening Department



Cardiology Department



Chaplaincy Department

Critical Care Department or Intensive Care Unit (ICU)

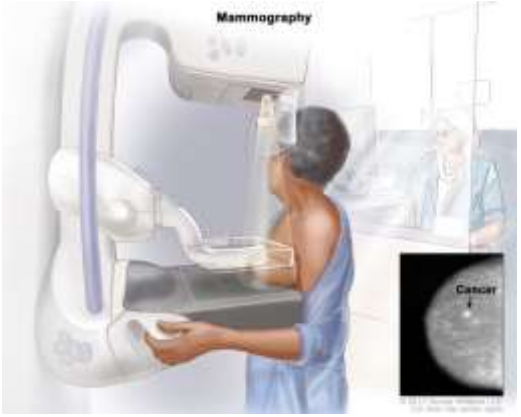
Diagnostic Imaging Department (X-ray)

X-ray Scans

Scans for A&E, Interventional radiology, CT scanning, MRI scanning

Ultrasound scans.

Mammography (breast scans).



Diagnostic Imaging Department (X-ray)

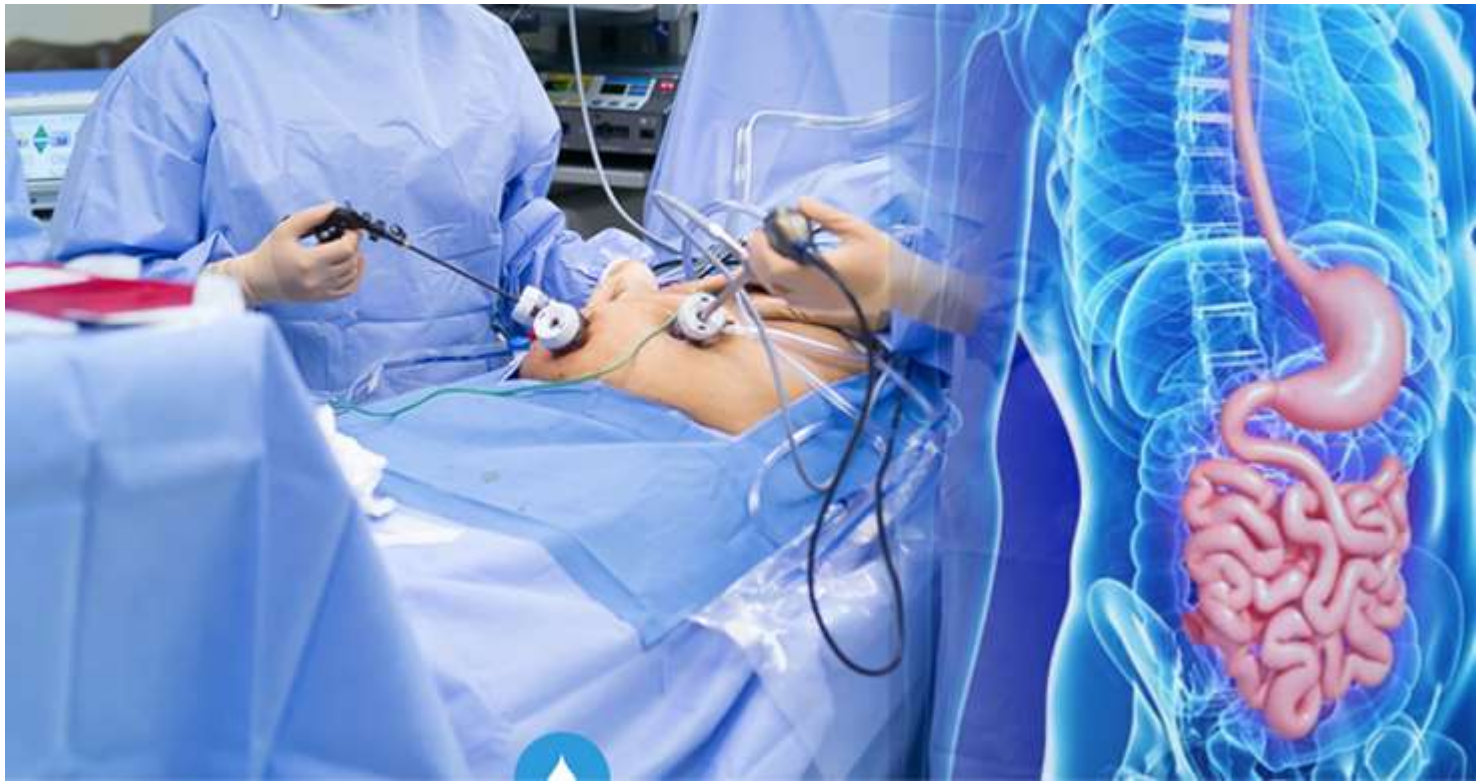
Angiography (X-ray of blood vessels)

Discharge Lounge Department

Ear nose and throat (ENT) Department

Elderly Services Department

Gastroenterology Department



General Surgery Department

Gynaecology Department

Hematology Department

Maternity Department

Maternity Department

Neonatal Unit

Microbology Department

Nephrology Department

Nephrology Department

Nutrition and Dietetics Department

Obstetrics and Gynecology Units

Occupational Therapy Department

Occupational Therapy Department

Ophthalmology Department

Orthopaedics Department

Pain Management Clinics

Pharmacy Department

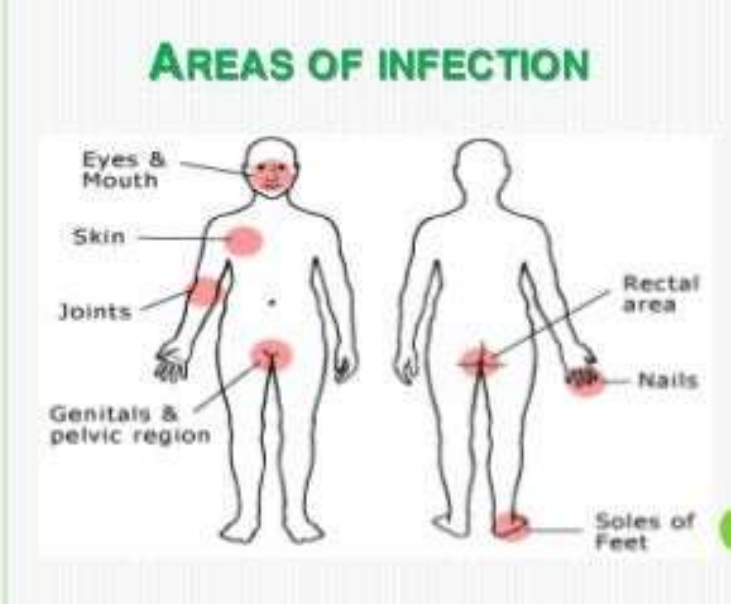
Physiotherapy Department

Radiotherapy Department

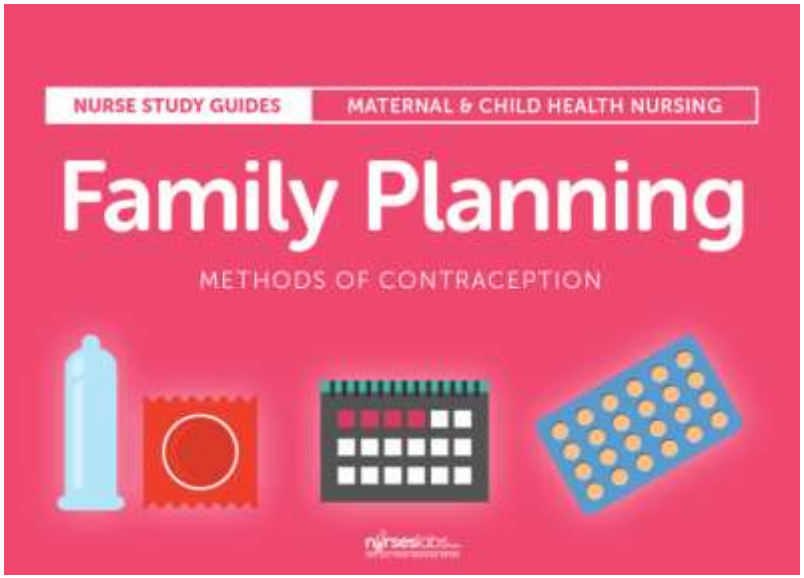
Renal Unit

The Sexual Health Department

Advice, testing and treatment for all sexually transmitted infections (STIs)



Family planning care (including emergency contraception and free condoms)

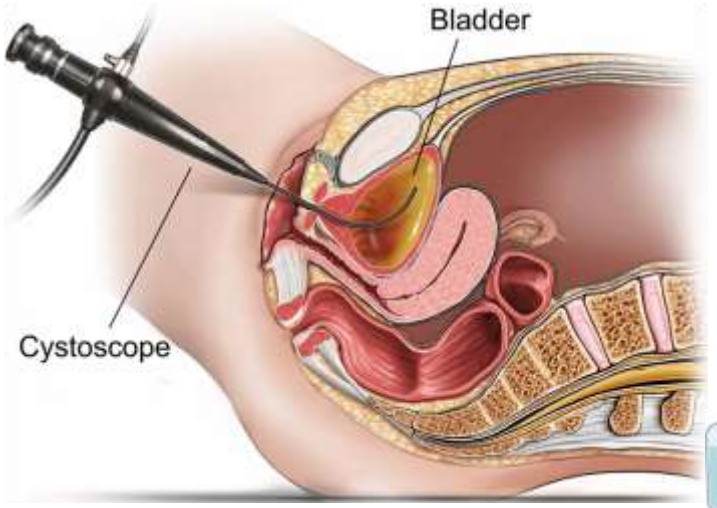


The Sexual Health Department

Pregnancy testing and advice

Urology Department

Flexible cystoscopy bladder checks



Urodynamic studies (eg for incontinence)

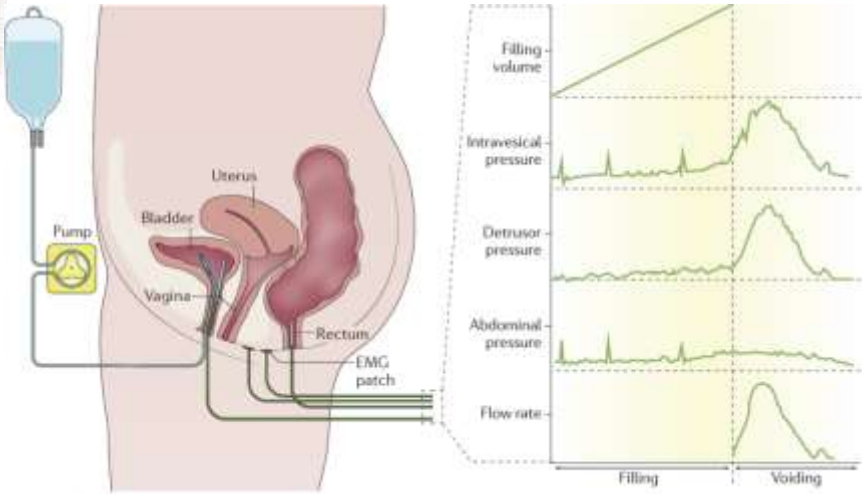
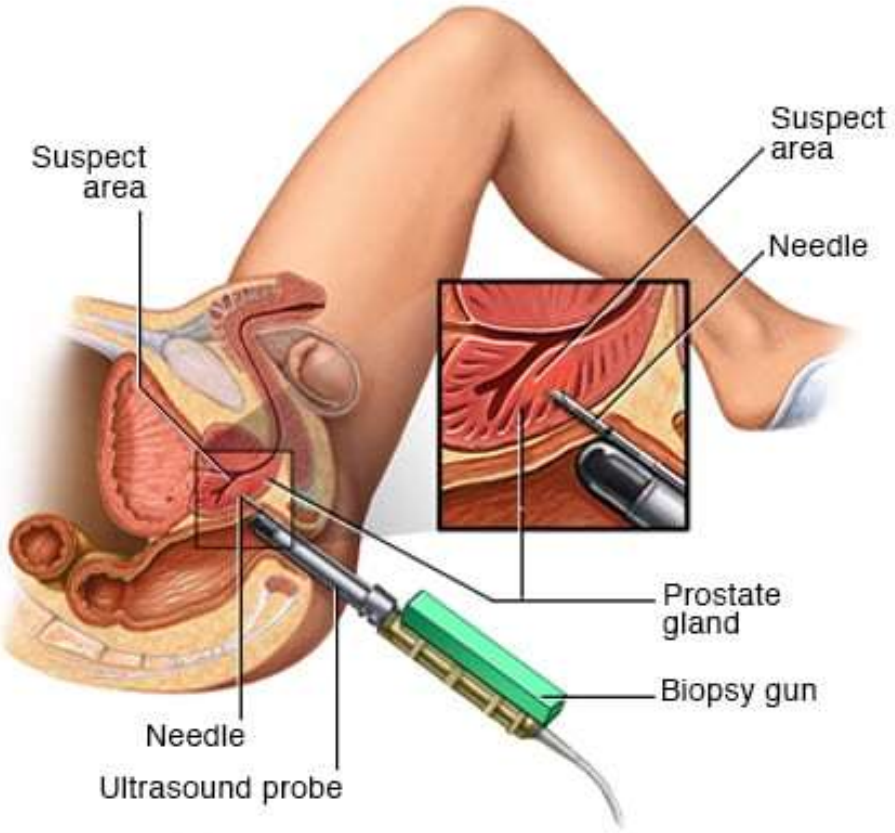


Figure 7 | **Multichannel urodynamic testing.** Invasive (catheterized) pressure measurements during urodynamic studies

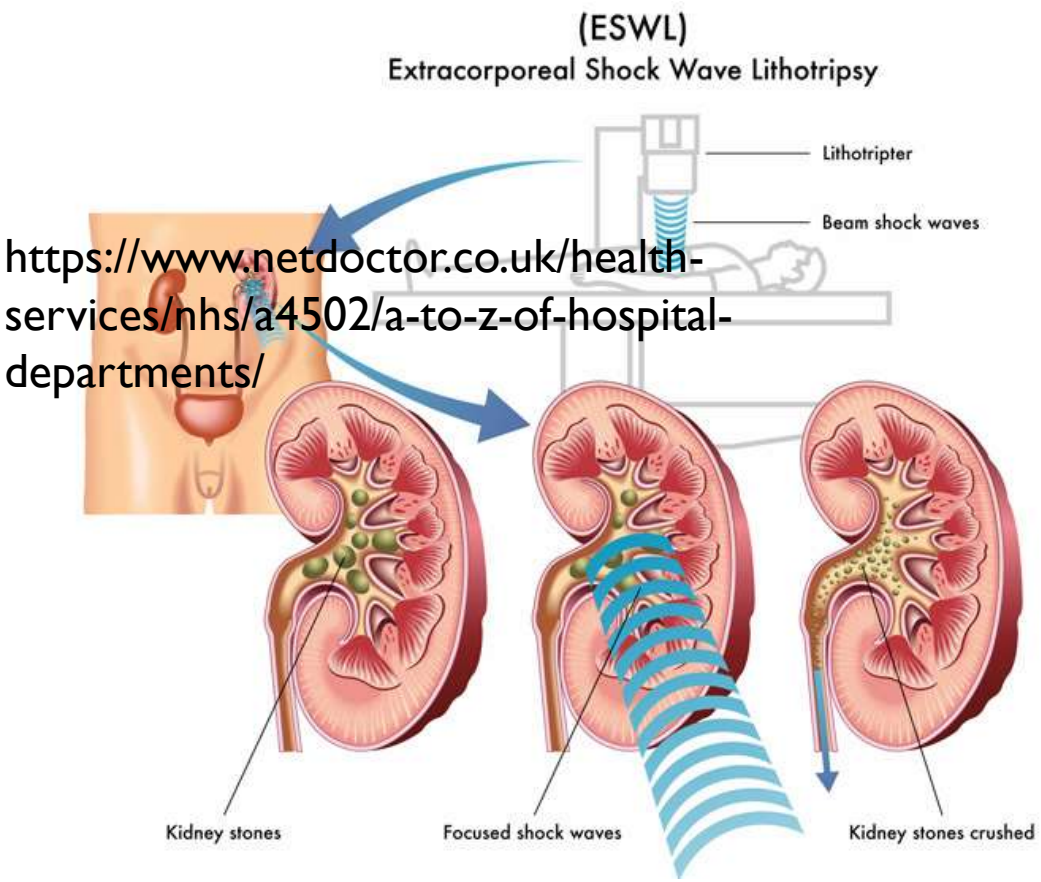
Urology Department

Prostate assessments and biopsies



Urology Department

Shockwave lithotripsy to break up kidney stones



https://www.netdoctor.co.uk/health-services/nhs/a4502/a-to-z-of-hospital-departments/

MEDICAL INSTRUMENTS USED FOR MEASURING VITAL SIGNS

(Body Temperature, Pulse Rate, Respiration Rate, Blood Pressure)

WHAT ARE VITAL SIGNS?

Vital signs are measurements of the body's most basic functions.

Vital signs are useful in detecting or monitoring medical problems. Vital signs can be measured in a medical setting, at home, at the site of a medical emergency, or elsewhere.

THE FOUR MAIN VITAL SIGNS

1. BODY TEMPERATURE
2. PULSE RATE
3. RESPIRATION RATE
4. BLOOD PRESSURE

BODY TEMPERATURE

The normal body temperature of a person varies depending on gender, recent activity, food and fluid consumption, time of day, and, in women, the stage of the menstrual cycle. Normal body temperature can range from 97.8 degrees F (or Fahrenheit, equivalent to 36.5 degrees C, or Celsius) to 99 degrees F (37.2 degrees C) for a healthy adult. A person's body temperature can be taken in any of the following ways:

A PERSON'S BODY TEMPERATURE CAN BE TAKEN IN ANY OF THE FOLLOWING WAYS:

1. **ORALLY**

   Temperature can be taken by mouth using either the classic glass thermometer, or the more modern digital thermometers that use an electronic probe to measure body temperature.

Classic Glass Thermometer

modern digital thermometer

A PERSON'S BODY TEMPERATURE CAN BE TAKEN IN ANY OF THE FOLLOWING WAYS:

2. **Rectally.**

   Temperatures taken rectally (using a glass or digital thermometer) tend to be 0.5 to 0.7 degrees F higher than when taken by mouth.


Classic Glass Thermometer

modern digital thermometer

A PERSON'S BODY TEMPERATURE CAN BE TAKEN IN ANY OF THE FOLLOWING WAYS:

3. **Axillary**

   Temperatures can be taken under the arm using a glass or digital thermometer. Temperatures taken by this route tend to be 0.3 to 0.4 degrees F lower than those temperatures taken by mouth.

Classic Glass Thermometer

modern digital thermometer

A PERSON'S BODY TEMPERATURE CAN BE TAKEN IN ANY OF THE FOLLOWING WAYS:

4. **By ear**

   A special thermometer can quickly measure the temperature of the ear drum, which reflects the body's core temperature (the temperature of the internal organs).

A Tympanic Digital Thermometer

A PERSON'S BODY TEMPERATURE CAN BE TAKEN IN ANY OF THE FOLLOWING WAYS:

5. **By skin**

   A special thermometer can quickly measure the temperature of the skin on the forehead.

Infrared Thermometer

PULSE RATE

The pulse rate is a measurement of the heart rate, or the number of times the heart beats per minute. As the heart pushes blood through the arteries, the arteries expand and contract with the flow of the blood. Taking a pulse not only measures the heart rate, but also can indicate the following:

TAKING A PULSE NOT ONLY MEASURES THE HEART RATE, BUT ALSO CAN INDICATE THE FOLLOWING:

1. Heart rhythm
2. Strength of the pulse

HOW TO CHECK YOUR PULSE

For most people, it is easiest to take the pulse at the wrist. If you use the lower neck, be sure not to press too hard, and never press on the pulses on both sides of the lower neck at the same time to prevent blocking blood flow to the brain. When taking your pulse:

1. Using the first and second fingertips, press firmly but gently on the arteries until you feel a pulse.
2. Begin counting the pulse when the clock's second hand is on the 12.
3. Count your pulse for 60 seconds (or for 15 seconds and then multiply by four to calculate beats per minute).
4. When counting, do not watch the clock continuously, but concentrate on the beats of the pulse.
5. If unsure about your results, ask another person to count for you.

RESPIRATION RATE

The respiration rate is the number of breaths a person takes per minute. The rate is usually measured when a person is at rest and simply involves counting the number of breaths for one minute by counting how many times the chest rises. Respiration rates may increase with fever, illness, and other medical conditions. When checking respiration, it is important to also note whether a person has any difficulty breathing.

BLOOD PRESSURE

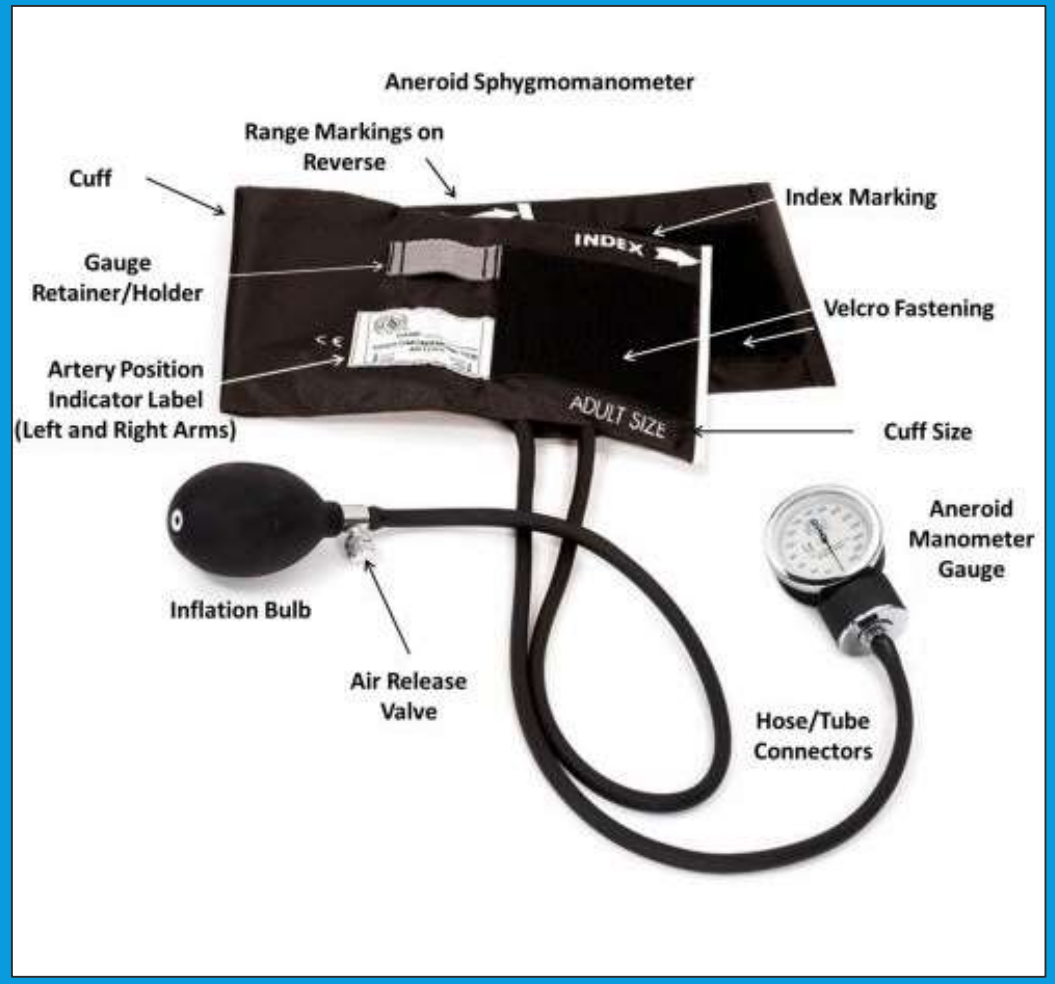
High blood pressure, or hypertension, directly increases the risk of heart attack, heart failure, and stroke. With high blood pressure, the arteries may have an increased resistance against the flow of blood, causing the heart to pump harder to circulate the blood.

Blood Pressure Monitor

Sphygmomanometer

Stethoscope

SPHYGMOMANOMETER



MEDICAL INSTRUMENTS USED FOR MEASURING VITAL SIGNS

REFERENCE

Johns Hopkins Medicine. (n.d). *Vital Signs (Body Temperature, Pulse Rate, Respiration Rate, Blood Pressure)*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/vital-signs-body-temperature-pulse-rate-respiration-rate-blood-pressure

The name of profession in the hospital:

1. Patient : Pasien
2. Doctor : Dokter
3. Nurse : Perawat
4. Oculist : Dokter Mata
5. Ophtalmologist : Dokter mata
6. Pediatrician : Dokter Anak
7. Aurist : Dokter telinga
8. Pharmacist : Apoteker
9. Psychiatrist : Psikiater
10. Surgeon : Ahli Bedah
11. General Practitioner : Dokter Praktek Umum
12. Midwife : Bidan
13. Allergist : Ahli alergi
14. Anesthesiologist : Ahli anestesi / obat bius
15. Cardiologist : Ahli jantung
16. Dietician : Ahli gizi
17. Dentist : Dokter gigi
18. Gastroenterologist : Ahli organ pencernaan
19. Gynecologist : Ahli kandungan
20. Inpatient : Pasien yang menginap di rumah sakit
21. Internist : Ahli organ dalam
22. Lung specialist : Ahli paru-paru
23. Pulmonologist : Ahli paru-paru
24. Psychologist : Ahli ilmu jiwa
25. Medical technician : Teknisi medis
26. Neurologist : Ahli saraf
27. Outpatient : Pasien yang tidak bermalam di rumah sakit
28. Podiatrist : Ahli penyakit kaki
29. Physician : Dokter
30. Radiologist : Ahli radiologi (seperti X-ray dan semacamnya)
31. Security guard : Satpam
32. Specialist : Spesialis
33. Visitor : Pengunjung / penjenguk
34. Corpse : Jenazah
35. Pediatric : Spesialis Anak
36. Andrologist : Spesialis Andrologi (Reproduksi Laki-laki)
37. Orthodontist : Spesialis Orthodonti (meratakan gigi)
38. Surgeon : Spesialis Bedah Umum
39. Oncologist : Spesialis Kanker
40. Pediatric Surgeon : Spesialis Bedah Anak
41. Orthopedic : Spesialis Bedah Tulang
42. Plastic Surgeon : Spesialis Bedah Plastik
43. Neurosurgeon : Spesialis Bedah Syaraf
44. Urologist : Spesialis Bedah Saluran Kemih
45. Family Doctor : Spesialis Dokter Famili (Keluarga)
46. Cardiologist : Spesialis Jantung dan Pembuluh Darah
47. Psychiatrist : Psikiater (Kesehatan Jiwa)
48. Dermatologist : Spesialis Penyakit Kulit dan Kelamin
49. Ophthalmologist : Spesialis Mata
50. Obstetrician : Spesialis Kebidanan dan Kandungan
51. Pulmonologist : Spesialis Paru
52. Radiologist : Spesialis Radiologi

53. Neurologist : Spesialis Syaraf
54. ENT Specialist : Dokter THT
55. Oral Surgeon : Spesialis Bedah Mulut
56. Digestive Surgeon : Spesialis Bedah Saluran Pencernaan
57. Nefrologist : Ahli Penyakit Ginjal
58. Internist : Spesialis Penyakit Dalam
59. Audiologist : Spesialis Telinga
60. Vet : Dokter Hewan

Addressing a Patient:

Asking expression	**Response**
Can you please confirm your name?	Yes, My name is ……..
It's Mr./Miss/Mrs. …, isn't it?	Yes, I am ……
How would you like me to address you?	You can call me ……
May I know your name, please?	Sure, my name is ……
What is your name, sir/mom/miss?	My name is …….

UNIVERSITAS PAHLAWAN TUANKU TAMBUSAI
PROGRAM STUDI D III KEPERAWATAN
TAHUN AJARAN 2022/2023

DAFTAR NILAI

Mata Kuliah : **Bahasa Inggris III**
Semester : **Semester V**
Dosen : **Hannisa Haris M.Pd**
Angkatan :

NO	NIM	NAMA	NILAI		KETERANGAN
			MUTU	LAMBANG	
1	2014401022	AFRI YOLANDA SARI	4	A	
2	2014401001	AISYAH ROSADI	4	A	
3	2014401027	AMAL RISKY	4	A	
4	2014401009	AMALIYA MAYUS	4	A	
5	2014401026	ANDI SAPUTRA	3,7	A-	
6	2014401023	CINDY PUSPITA AYU	4	A	
7	2014401010	DESY RATNA	4	A	
8	2014401020	DEWI SARTIKA	4	A	
9	2014401011	DINDA ZALIANTI BASRI	4	A	
10	2014401003	DONI HERMAWAN	3,7	A-	
11	2014401012	ELSA BERLIANA PUTRI	4	A	
12	2014401004	FIKRI RIJA PRIANSYAH	3,3	B+	
13	2014401013	GILANG AR RACHMANSYAH	4	A	
14	2014401052	JULITA CICILIA	4	A	
15	2014401031	M. ZIKRIL FAJAR ADITIA	4	A	
16	2014401042	MAULANA MHD ZIKRI	3,3	B	
17	2014401029	MELLY SUSANA	3,3	B	
18	2014401021	MELSY HAFIZAH	4	A	
19	2014401006	MUHAMMAD AFRI YANSYAH	3,3	B-	
20	2014401015	MUHAMMAD RADITO MAULANA	4	A	
21	2014401028	PUTRI INDRIANI MIRAZA	4	A	
22	2014401032	RENI INDAH OKTARI	4	A	
23	2014401016	SAPURA	4	A	
24	2014401017	SASMI AMALIAH	4	A	
25	2014401033	SISKA AMELIA PUTRI	4	A	
26	2014401018	SYAHRIZA	4	A	
27	2014401019	WESTAMA NAORIANDI	4	A	
28	2014401053	WIDIA UTAMI	4	A	
29	2014401024	YESI PRATAMA	4	A	

Keterangan Nilai :

Nilai Absolut	Nilai Mutu	Kategori
85 - 100	4	A
80 - 84	3,7	A-
75 - 79	3,3	B+
70 - 74	3, 0	B
65 - 69	2,7	B-
60 - 64	2,3	C+
55 - 59	2, 0	C
45 - 54	1, 0	D
< 45	0	E

Bangkinang, 21 Januari 2023
Ketua Prodi D III Keperawatan

Dosen Pengajar

(Hannisa Haris M.Pd)

(Ns. RIDHA HIDAYAT, M. Kep)