CLEMENTI HOSPITAL

INTEGRATED NURSING RECORD

UNIT	WARD	BED
Surgical	21	5

LEE HO YIN
S3925683C
Blk 648, Clementi Ave 4,
#03-723 S 650648

INSTRUCTIONS

1 The Registered Nurse is responsible to ensure that baseline assessment is done within 4 hours and full assessment and plan of care are done within 24 hours of patient's admission.

2 The Integrated Nursing Record shall be used to assess and plan the appropriate nursing care for all patients.

3 The plan of care is based on Abdellah's Model of 21 Nursing Problems and patient care is planned using the nursing process of assessment, planning, implementation and evaluation

4 For sections where boxes are used, place a tick ☑ the where applicable.

ORIENTATION : To be completed by PCA and above

PERSON TO CONTACT IN EMERGENCY

NAME	RELATIONSHIP	CONTACT NUMBERS	LANGUAGE SPOKEN
Spokesperson 1 Teo Hock Seng	Son	(Res) 67442196 (Off) 65607311 (HP) 81541719	English Mandarin
Spokesperson 2 Teo Pow Ann	Daughter	(Res) 65489157 (Off) 67201234 (HP) 98951433	English Mandarin
Caregiver 1		(Res) (Off) (HP)	
Caregiver 2		(Res) (Off) (HP)	

2 ADMISSION DATA

Police Case ☑ No ☐ Yes Industrial Accident No ☑ ☐ Yes

Time of arrival 11:30 hrs Doctor informed 11:30 hrs Seen by doctor 11:50 hrs

From ☑ A&E ☐ SC ☐ Others

On ☑ Wheelchair ☐ Trolley ☐ Walk in

With ☐ Friend ☑ Family ☐ Others

Preferred Spoken Language:

☐ English ☑ Mandarin ☐ Malay ☐ Tamil

☐ Dialect/Others(specify):

3 PREVIOUS ADMISSION ☑ New case of CH

☐ Old case of CH Trace casenotes on

4 REASON FOR ADMISSION

Epigastric Pain & Vomiting

5 PATIENT ORIENTATION CHECKLIST

Orientation Given To: ☑ Patient ☑ Family member ☐ Others: (Please Specify): _____

☑ Ward Layout
- Bed number & side-rails
- Use of call bell
- Emergency exits
- Location of light switches
- Bathroom & toilets

} not applicable for ICU and HD

☑ Ward Routine
- Ward rounds by doctors
- Medication times
- Meal times

☑ Hospital Routine
- Permission before leaving ward
- To remain in hospital till discharge
- Visiting hours
- Hospital check-out time

☑ Patient Facilities
- Day room
- Telephone
- Television
- Air-conditioning

☑ Personal Belongings
- Responsibility for valuables
- Toiletries

☐ Others *(Please specify)*: _____

6 PERSONAL ITEMS *(Personal Items kept in ward for use at own risk)*

☑ No *(If no, go to point 7)*

☐ Yes

☑ Vision aid	◉ Glasses ○ Contact lens, specify _____	☒ Wrist watch
☒ Hearing aid	○ Specify _____	☑ Handphone
☑ Denture	○ Specify upper & lower (full set)	☐ Others _____
☑ Walking device	With patient ☑ Wheelchair ☐ Quad stick ☐ Walking stick ☐ Others (specify) _____	

SAFEKEEPING OF PERSONAL PROPERTIES

☑ No Identity Card or property received

☐ RECEIVED property for safekeeping, document in PROPERTY FORM

DECLARATION

I have been orientated through the details above and understand the information provided by the attending nurse.

I understand that if I / the patient choose to keep any valuables or cash with me / him / her during hospitalisation, I shall not hold CLEMENTI Hospital responsible in any way in the event of loss or damage to the valuables / cash.

	Name	Signature	Relationship / Designation
Advice given to :	HENG DAN YUI		/
Advice given by :	AMY CHUA		EN

8 Section A assessed by:

	Designation	Name	Signature	Date	Time
CA and EN	EN	AMY CHUA			11:35
N	RN	MATCH Tan			11:40

SECTION A: Complete within 4 hours of admission by EN and above

9 COGNITION / PERCEPTION PATTERN

a) Level of consciousness: ☑ Alert ☐ Confused ☐ Drowsy ☐ Unresponsive ☐ Disorientated

Orientated to : ☑ Day ☐ Time ☑ Person ☑ Place

b) Sensory: ☑ Asymptomatic ☐ Dizziness ☐ Headache ☐ Numbness ☐ Paralysis ☐ Tingling ☐ Tremors

c) Hearing: Right ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

Left ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

d) Vision: Right ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

Left ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

Remarks _____

10 RESPIRATION

Breathing pattern: ☑ Regular ☐ Irregular

Presence of symptoms: ☐ Nil ☑ Dyspnoea ☐ Cough ○ Productive ○ Haemoptysis ○ Non productive

Remarks: slight SOB Respiration rate: 28-30/min. SPO2 (RA) 94%.

11 CIRCULATION

Pulse: ☐ Regular ☑ Irregular

Presence of symptoms: ☐ Nil ☐ Chest pain ☐ Chest tightness ☐ Giddiness ☑ Oedema

Extremities: ☐ Warm ☑ Cold ☐ Clammy ☐ Cyanosed

Remarks _____

12 PAIN / COMFORT

Presence of Pain

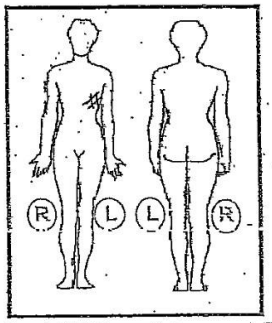
☐ No *(If no, go to Item 13)*

☐ No, pain resolved after treatment at A&E. Complete pain assessment

☑ Yes. Complete pain assessment

☐ Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients"

Mark a cross (X) or shade the affected areas on the body diagram below:



Pain Assessment

a. Location of Pain: Where does it hurt? Epigastric region

b. PAIN SEVERITY SCORE : How bad is the pain? Use only ONE pain scale 7

c. Tick scale used ☑ VNP ☐ SPD ☐ FPR

d. Duration : How long have you had this pain? (hours / days / months / years)

e. Quality : Is the pain constant, dull, sharp, burning or on and off ?

constant & dull

f. Does your pain affect your usual daily routine?

☐ No ☐ Yes

○ Performs ADL with discomfort

☑ Interferes with ADL and sleep

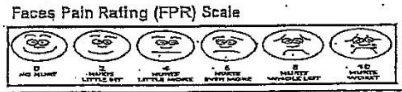
○ Others

Verbal Numerical Pain (VNP) Scale

Simple Pain Descriptive (SPD) Scale

Score	
No pain	0
Mild pain	2
Moderate pain	5
Severe pain	8

Faces Pain Rating (FPR) Scale



13 Section A assessed by :

EN: EN (Designation) — AMY CHUA (Name) — Signature — / / — 11:35 (Time)

SN: RN (Designation) — Macy Tan (Name) — Signature — / / (Date) — 11:48 (Time)

LEE HO YIN
S2315479I
Blk 648, Clementi Ave 4,
#03-723 S 650648

SECTION B: Complete within 24 hours of admission by RN

14 ASSESSMENT OF DIABETES WD 21 BED 5

Questions	Response	Score
a History of diabetes	☐ No *(go to item 15)*	0
	☑ Yes	
b Newly diagnosed diabetes	☑ No	0
	☐ Yes	4
c On oral diabetes medication or INSULIN therapy	☑ No	0
	☐ Yes, please specify : ○ Tablet	1
	○ Insulin(with or without tablets)	4
d Previous or current problem with FEET	☑ No	0
	☐ General complaints (numbness, tingling sensation/pin and needles)	1
	☐ Active ulcers / Previous amputation	4
e Patient is admitted for Hypoglycaemia	☑ No	0
	☐ Yes	4
	Total Score	0

☐ IF TOTAL SCORE IS ≥ 4 :

a) Fax "Assessment of Diabetes" section to Diabetes Nurse

b) For ICU or HD patients, fax "Assessment of Diabetes" section on day of transfer to general ward

Remarks _____

15 NUTRITIONAL SCREENING *(Complete the screening by ticking as appropriate)*

Nutritional Indicator	Status	Yes	No
Food intake	Decreased persistently over the past 3 months due to loss of appetite, digestive problems e.g. vomitting, chewing or	☑	☑
Mode of feeding	Tube feed	☐	☑
Weight loss	Unintentional weight loss greater than 3kg (6.6lbs) during last 3 months	☑	☐
Diet-related condition *(may tick more than one)*	Wounds / pressure sores	☐	☑
	Multiple trauma or multiple fractures	☐	☑
	Signs of muscle wasting / cachexia	☑	☐
	Pre / post major surgery eg. Abdominal, ENT surgery and others	☐	☑
	Sepsis / infection	☐	☑
	Cancer	☐	☑
	Gastrointestinal disease	☑	☐
	Therapeutic diet *e.g DM, low salt, low cholesterol*	☑	☐

Number of yes 5

If :
☐ on tube feed
OR ☐ ≥ 2 yes
} Refer dietitian on _____

Remarks _____

EN Amy Chua

16 FOOD ALLERGY

Any food allergy ☑ No ☐ Yes, specify _____ *(Indicate in the Nursing Organiser & e-diet)*

SECTION A: Complete within 4 hours of admission by EN and above

9 COGNITION / PERCEPTION PATTERN

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Orientated to : ☑ Day ☑ Time ☑ Person ☑ Place

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Left ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

d) Vision: Right ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess
Left ☑ Normal ☐ Impaired (specify)_____ ☐ Unable to assess

Remarks _____

10 RESPIRATION

Breathing pattern: ☑ Regular ☐ Irregular

Presence of symptoms: ☐ Nil ☑ Dyspnoea ☐ Cough ○ Productive ○ Haemoptysis ○ Non productive

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Remarks _____

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Presence of Pain

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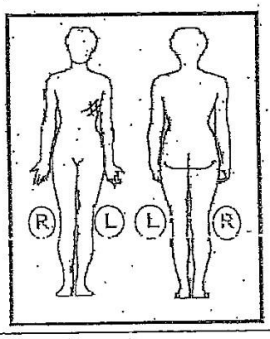
☐ No, pain resolved after treatment at A&E. Complete pain assessment
☑ Yes. Complete pain assessment
☐ Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients"

Mark a cross (X) or shade the affected areas on the body diagram below:



Pain Assessment

a Location of Pain: Where does it hurt? Epigastric region

b PAIN SEVERITY SCORE : How bad is the pain? Use only ONE pain scale : 7

c Tick scale used ☑ VNP ☐ SPD ☐ FPR

d Duration : How long have you had this pain? (hours / days / months / years) 0

e Quality : Is the pain constant, dull, sharp, burning or on and off ?
constant & dull

f Does your pain affect your usual daily routine?
☐ No ☐ Yes
○ Performs ADL with discomfort
☑ Interferes with ADL and sleep
○ Others
_____
_____

Verbal Numerical Pain (VNP) Scale

Simple Pain Descriptive (SPD) Scale

Score	
No pain	0
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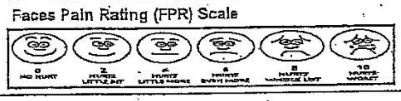
Severe pain	8

Faces Pain Rating (FPR) Scale



13 Section A assessed by :

	Designation	Name	Signature	Date	Time
EN	EN	AMY CHUA			11:31
SN	RN	Macy Tan			11:40

17 ORAL CAVITY

Mouth / Tongue: ☐ Moist ☑ Dry ☐ Coated ☐ Ulcer

Teeth: ☐ Intact ☐ Loose (specify) _____ ☑ Dentures ☑ Upper ☑ Lower

Presence of: ☐ Nil ☑ Nausea ☑ Vomiting ☐ Difficulty in swallowing

Remarks _____

18 SKIN

Colour: ☐ Normal ☐ Flushed ☐ Jaundiced ☑ Pale ☐ Others (Specify): _____

Integrity: ☑ Intact ☐ Impaired

Description	Site(s) (Specify)
☐ Blister	
☐ Superficial broken skin	
☐ Bruises	
☐ Rashes	
☐ Redness	
☐ Others (specify)	

Body Temperature
☑ Normal
☐ Subnormal body temperature
☐ Raised body temperature

Remarks _____

PRESSURE ULCER RISK ASSESSMENT : BRADEN SCALE

Braden scale criteria	Descriptors				Score
Sensory perception	1. Completely limited	2. Very limited	3. Slightly limited	4. No impairment	3
Moisture	1. Constantly moist	2. Moist	3. Occasionally moist	4. Rarely moist	3
Activity	1. Bed bound	2. Chair bound	3. Walk Occasionally	4. Walk frequently	3
Mobility	1. Immobile	2. Very limited	3. Slightly limited	4. No limitation	3
Nutrition	1. Very poor	2. Probably adequate	3. Adequate	4. Excellent	2 EN.
Friction and sheer	1. Problem	2. Potential problem	3. No apparent problem		3 Amy Chua
				Total score	16 ~~18~~ 17 EN

IF SCORE IS ≤16 → ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care)

Amy Chua

Remarks _____

19 ELIMINATION

a Urinary

Appearance: ☑ Clear ☐ Cloudy ☐ Haematuria ☐ Tea coloured

Presence of: ☐ Dribbling ☐ Frequency ☐ Incontinence ☐ Urgency ☐ Burning sensation ☐ Retention ☐ Others (specify) _____

Adaptive aids: ☑ Nil ☐ Diapers ☐ Indwelling catheter ☐ Urosheath ☐ Others (specify): _____

Remarks _____

b Bowel

Usual bowel pattern (specify) 1x per 2-3 days

Problem of: ☐ Nil ☑ Constipation ☐ Diarrhoea ☐ Incontinence ☐ Malaena

Remarks BNO for 4 days.

20. FUNCTIONAL STATUS

✓ *tick on the appropriate box*

New onset difficulty with the following :	No	Yes	If yes, automatic referral (except for ICU & HD cases, spinal injuries, trauma and RTA cases)
Ambulation	✓		Physiotherapist on _____
Toileting / Bathing	✓		Occupational Therapist on _____
Dressing / Grooming	✓		
Transfer	✓		
Feeding	✓		
Speaking	✓		Speech Therapist on _____
Swallowing	✓		

Remarks _____

ASSESS IN GENERAL WARD : Date Assessed _____

21 FALL RISK ASSESSMENT ☐ (For Unconscious patient, proceed to Item No. 22 Sleep Pattern)

Item	Morse Scale Criteria		Score (*circle the number*)
1	History of fall (include current admission and last 12 months)		(No) 0 Yes 25
2	Has a secondary diagnosis e.g with comorbidities, polypharmacy (If more than 1 medical diagnosis is listed)		No 0 (Yes) 15
3	Receive : IV therapy / heparin Lock		No 0 (Yes) 20
4	Use Ambulatory Aid:	• None / bedrest / nurse assist	(0)
		• Crutches / stick / umbrella / quadstick / frame	15
		• Holds on to furniture	30
5	Gait is :	• Normal / bedrest / Wheelchair	(0)
		• Weak	10
		• Impaired	20
6.	Mental Status	• Orientated to own ability	(0)
		• Overestimated / forgets limitations	15
		Total Score	35

IF SCORE IS ≥ 45 → ☐ Implement fall precautions and document in Risk Assessment for Falls and Inpatient Clinical Notes (Nursing Notes and Plan of Care)

Remarks _____

22 SLEEP PATTERN

Sleep Problem ☐ No ☐ Yes ✓ Interrupted ○ Insomnia ○ Others, specify _____

Remarks _____

23 PSYCHOLOGICAL REACTION

No apparent problem

Reaction ☐ Calm

Problem

☑ Anxious / Nervous ☐ Frequent crying / Tearful ☐ Withdrawn ☐ Irritable ☐ Sad

☐ Aggressive ☐ Violent ☐ Angry

Expressed

☐ Guilt ☐ Shame ☐ Negative feeling about self ☑ Feeling tired at all times

☐ Difficulty in concentrating, remembering things or decision making

☐ Others (specify) _____

If ≥ 1 tick, inform doctor and document in Inpatient Clinical Notes (Nursing Notes and Plan of Care)

Remarks _____

24 SPIRITUAL / CULTURAL

Religion

☑ Buddhism ☐ Hinduism ☐ Sikhism ☐ Roman Catholic

☐ Free thinker ☐ Islam ☐ Christianity ☐ Others _____

Any concern related to diet

☐ No ☑ Yes, specify Poor Appetite

Any other concern

☑ No ☐ Yes, specify _____

Remarks rapid weight loss 15kg in 3 month's time

25 ECONOMIC & FINANCIAL SUPPORT

☐ Employer ☐ Self ☐ Spouse ☐ Parents ☑ Children

☐ Public Assistance ☐ Relatives ☐ Friends ☐ Others _____

Remarks _____

26 SOCIAL HISTORY

a Accommodation: ☑ With family, specify Son ☐ Live alone ☐ Others (specify) _____

b Type of housing: ☐ Private ☐ Condominium ☑ HDB ☐ Others _____

c Toilet: (if applicable) ☑ Sitting ☐ Squatting

d Lift landing at: (if applicable) ☑ Same level ☐ Different level

Remarks _____

27 IDENTIFIED DISCHARGE PLANNING CONCERN *(if applicable)*

(i) Is patient caring for him/her self ☑ Yes ☐ No

(a) Does the patient has a primary caregiver?

☐ No ☐ Yes, specify _____

(b) Alone at home?

☑ No ☐ Yes (_____ hours)

(ii) Any discharge planning concerns? ☑ No ☐ Yes →

☐ Financial ☐ No carer

☐ Home placement ☐ Pain management

☐ Specify _____

} Document in Inpatient Clinical Notes (Nursing Notes and Plan of Care)

REFER ☐ MSW ☐ Community hospital ☐ Nursing home

☐ Pain service (Referral at doctor's discretion) ☐ Others _____

Remarks _____

28 Section B assessed by:

RN	RN	Maicy Tan			11:40
	Designation	Name	Signature	Date	Time

23 PSYCHOLOGICAL REACTION

No apparent problem

Reaction ☐ Calm

Problem

☑ Anxious / Nervous ☐ Frequent crying / Tearful ☐ Withdrawn ☐ Irritable ☐ Sad

☐ Aggressive ☐ Violent ☐ Angry

Expressed

☐ Guilt ☐ Shame ☐ Negative feeling about self ☑ Feeling tired at all times

☐ Difficulty in concentrating, remembering things or decision making

☐ Others (specify) _____

If ≥ 1 tick, inform doctor and document in Inpatient Clinical Notes (Nursing Notes and Plan of Care)

Remarks _____

24 SPIRITUAL / CULTURAL

Religion

☑ Buddhism ☐ Hinduism ☐ Sikhism ☐ Roman Catholic

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☐ Employer ☐ Self ☐ Spouse ☐ Parents ☑ Children

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Remarks _____

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a Accommodation: ☑ With family, specify Son ☐ Live alone ☐ Others (specify) _____

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c Toilet: (if applicable) ☑ Sitting ☐ Squatting

d Lift landing at: (if applicable) ☑ Same level ☐ Different level

Remarks _____

27 IDENTIFIED DISCHARGE PLANNING CONCERN *(if applicable)*

(i) Is patient caring for him/her self ☑ Yes ☐ No

(a) Does the patient has a primary caregiver?

☐ No ☐ Yes, specify _____

(b) Alone at home?

☑ No ☐ Yes (_____ hours)

(ii) Any discharge planning concerns? ☑ No ☐ Yes →

☐ Financial ☐ No carer

☐ Home placement ☐ Pain management

☐ Specify _____

} Document in Inpatient Clinical Notes (Nursing Notes and Plan of Care)

REFER ☐ MSW ☐ Community hospital ☐ Nursing home

☐ Pain service (Referral at doctor's discretion) ☐ Others _____

Remarks _____

28 Section B assessed by:

RN	RN	Maicy Tan			11:40
	Designation	Name	Signature	Date	Time

DISCHARGE CHECKLIST

Instructions: To be completed on day of discharge

Date of discharge _____ Time _____

Discharge to:

☐ Home ☐ Community Hospital ☐ AMKH ☐ Bright Vision ☐ SACH ☐ St Lukes

☐ Nursing Home Specify _____ ☐ Others, specify _____

Mode of discharge:

☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Others _____

Removal of :

☐ IV cannula

☐ Drain(s)

☐ Catheter

☐ Identification band

☐ Others _____

Checked and returned:

☐ Property

☐ Own medications

☐ Appliances, specify _____

☐ Private X-rays _____ (no. of films)

☐ Others, specify. _____

☐ Discharge Medical Certificate Number _____

☐ Discharge Memorandum (*2 copies if patient is for STO / Dressing at Polyclinic*)

STO date : _____

Types of dressing and date due : _____

☐ Follow-up appointment (Doctors/ Therapists/ Dietitian / Others)

TCU	Name	Designation	Date	Time	Memo given	
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No
					☐ Yes	☐ No

☐ Special Instructions: _____

☐ Referrals: OPS/ HNF / Hospice / Others _____

☐ Medications given / counselled by ○ Pharmacist ○ Nurse

☐ Medik Awas application form if applicable

Advice on: ☐ Wound care ☐ Head injury advice ☐ Fall precaution advice ☐ Pain Management

☐ Other discharge teaching / instructions, specify _____

I have understood the above discharge advice explained to me

_____ _____

Name of patient / relative-relationship Signature

Discharged by : _____ _____

Name of nurse Signature