P = Patient Perspective
C = Clinician Assessment
A = Action/Plan
R = Response of the Patient
E = Evaluation by Clinician

CLINICAL NOTES

PERSONAL HEALTH INFORMATION (PHI) LABEL

Date and Time	Focus	Notes

P = Patient Perspective
C = Clinician Assessment
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CLINICAL NOTES

PERSONAL HEALTH INFORMATION (PHI) LABEL

Date and Time	Focus	Notes

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

Inpatient Nursing Documentation Form

PERSONAL HEALTH INFORMATION (PHI) LABEL

DATE

dd/mm/yyyy

PLEASE DOCUMENT IN BLACK OR BLUE PEN ONLY

NURSE SIGNATURE LOG

Print Name + Designation	Initials	Print Name + Designation	Initials

	DAY	NIGHT
Patient Out on Pass Complete only if applicable	Patient Out on Pass ☐ See Clinical Notes	Patient Out on Pass ☐ See Clinical Notes

NURSING SHIFT REPORT AT THE BEDSIDE (NSRB)

Initials = Completed **No*** = No (Requires Clinical Note)	DAY	NIGHT
NSRB Received		
Safety Check Completed (Incoming Nurse to Initial)		

PREVENTION INTERVENTIONS

DOCUMENTATION TO BE COMPLETED AT END OF SHIFT

Yes = Completed **No** = No (Document Exceptions Below)	DAY	NIGHT
All Pressure Injury Prevention Interventions Implemented as per Care Plan		
All Falls Prevention Interventions Implemented as per Care Plan		
Exceptions What elements of the Care Plans above were you unable to complete and specify why.		

7221

DATE _____

LEGEND
* = See Clinical Notes
U/A = Unable to Assess*

DAY ASSESSMENT

TIME of Assessment _____ **TIME** of Documentation _____ **NURSE** Initials _____

NIGHT ASSESSMENT

TIME of Assessment _____ **TIME** of Documentation _____ **NURSE** Initials _____

BEHAVIOURAL

Responsive Behaviour

- ○ Yes* ○ No

PAIN

Pain Score

- ☐ No Pain

Location	At Rest	With Activity
	___/10*	___/10*
	___/10*	___/10*
	___/10*	___/10*

NEUROLOGICAL

- ☐ Refer to Neurological Vital Signs — If **not** selected, complete below

Level of Consciousness (LOC)
- ○ Alert ○ Altered LOC*

Oriented to Person, Place and Time
- ○ Yes ○ No
- Specify _____

Moves all limbs spontaneously with equal strength
- ○ Yes ○ No
- Specify _____

RESPIRATORY

Respirations Regular
- ○ Yes ○ No*

Shortness of Breath (SOB)
- ☐ None ☐ At Rest ☐ On Exertion

Breath Sounds
- ☐ Equal
- ☐ Decreased
- ☐ Absent
- Location _____

Adventitious Sounds
In = Inspiration
Ex = Expiration

	Location/Description	On
☐ None		
☐ Crackles		In Ex
☐ Wheezes		In Ex
☐ _____		In Ex

Cough
Specify = Pain, Sputum Colour, Sputum Consistency, etc.
- ○ None ○ NonProductive ○ Productive
- Specify _____

CARDIOVASCULAR

Capillary refill less than 3 seconds
- ○ Yes ○ No

Peripheral Pulses Present
RAx2 = Radial Arterial
DP/PTx2 = Dorsalis Pedis/Posterior Tibial
Other _____

○ Palpable	○ Doppler Used	○ Absent*
○ Palpable	○ Doppler Used	○ Absent*
○ Palpable	○ Doppler Used	○ Absent*

Edema
- ☐ None — Location or Generalized/Characteristics
- ☐ 1+ _____
- ☐ 2+ _____
- ☐ 3+ _____
- ☐ 4+ _____
- ☐ Non-Pitting _____

Telemetry
- ○ Yes ○ No
- ☐ Lead Placement Verified/Battery Checked

DATE _____

LEGEND
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DAY ASSESSMENT

TIME of Assessment _____ **TIME** of Documentation _____ **NURSE** Initials _____

NIGHT ASSESSMENT

TIME of Assessment _____ **TIME** of Documentation _____ **NURSE** Initials _____

GASTROINTESTINAL (GI)

Abdomen
- ☐ Soft ☐ Non-Tender
- ☐ Firm
- ☐ Tender Location _____
- ☐ Distended Location _____

Bowel Sounds Audible
Reg = Regular
Hypo = Hypoactive
Hyper = Hyperactive

RLQ	○ Reg	○ Hypo	○ Hyper	○ Inaudible*
RUQ	○ Reg	○ Hypo	○ Hyper	○ Inaudible*
LUQ	○ Reg	○ Hypo	○ Hyper	○ Inaudible*
LLQ	○ Reg	○ Hypo	○ Hyper	○ Inaudible*

Nausea/Vomiting
- ☐ None ☐ Nausea* ☐ Vomiting*

Bowel Movements (BM)

Hard
- Separate hard lumps, like nuts (hard to pass)
- Sausage-shaped but lumpy

Formed
- Like a sausage but with cracks on surface
- Like a sausage or snake, smooth, and soft
- Soft blobs with clear-cut edges (passed easily)

Loose
- Fluffy pieces with ragged edges, a mushy stool

Watery
- Watery, no solid pieces. Entirely liquid

S = Small (Less than 100ml)
M = Medium (100 to 250ml)
Lg = Large (Greater than 250ml)

SR = Self Reported (Patient or Family/Caregiver)
PSW = Personal Support Worker (Reported)

ONGOING ASSESSMENT
- ☐ No BM This Shift ☐ Incontinent ☐ GI Device

Time	Consistency	Colour/Pain	Quantity	SR	PSW
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐
			S M Lg	☐	☐

GENITOURINARY (GU)

Voiding
- ☐ Spontaneous ☐ Incontinent
- ☐ Anuria ☐ GU Device

Clear/Amber Urine
- ○ Yes ○ No
- Colour _____
- ☐ Hematuria ☐ Foul Smell ☐ Sediment
- ☐ Clots ☐ Dysuria
- ☐ Self Reported (Patient or Family/Caregiver)

EDUCATION

ONGOING ASSESSMENT
- ☐ No Education Provided This Shift
- ☐ Patient Declined ☐ Use of Interpreter

Patient and Family/Caregiver Education

Resources Given
Medication Information, Supplies, Educational Material, etc.

Teach-Back
Return demonstration of skill or knowledge

Time _____
Learner ☐ Patient ☐ Family/Caregiver
Topic/Skill _____
Resources _____
Outcome ☐ Teach-Back ☐ Needs Reinforcement

DATE _____

LEGEND
* = See Clinical Notes
U/A = Unable to Assess*

DAY ASSESSMENT

NURSE INITIALS _____

NIGHT ASSESSMENT

NURSE INITIALS _____

ACTIVITIES OF DAILY LIVING

Mobility — Level Of Assistance
ONGOING ASSESSMENT
- ☐ Independent
- ☐ Supervised ☐ Assist x ___
- ☐ Bedrest ☐ Bedbound

Mobility Aid
- ☐ None ☐ Cane ☐ Geri Chair
- ☐ Patient Lift ☐ Walker ☐ Wheelchair
- ☐ Other _____

Mobility Activity
- ☐ No Mobility Activity
- ☐ Patient Ambulating Independently

If **not** selected above, complete below
- **Time** _____ **Duration** _____
- **Type of Activity** _____
- **Assisted by** _____
- **Patient Tolerance** _____

Bathing
- ☐ No Bed Bath/Shower

If **not** selected above, complete below

Level Of Assistance
- ○ Independent
- ○ Supervised ○ Assist x ___

PSW = Personal Support Worker (Assisted)

Type
- ☐ Bed Bath Time _____ ☐ PSW
- ☐ Shower Time _____ ☐ PSW
- ☐ Chlorhexidine Used

Toileting/Peri Care — Level Of Assistance
- ○ Independent
- ○ Supervised ○ Assist x ___

Type
- ☐ Up to Bathroom ☐ Urinal
- ☐ Bed Pan ☐ Commode
- ☐ Brief/Pad Change x ___

Feeding — Level Of Assistance
- ○ Independent
- ○ Supervised ○ Assisted
- ☐ Eating ☐ Tray Setup

Type
- ☐ By Mouth/Oral ☐ Nothing by Mouth
- ☐ Enteral Nutrition ☐ Parenteral Nutrition

If **By Mouth/Oral** is selected, complete below

% Of Meal Consumed Of Entire Tray

Breakfast	___ %	☐ PSW	☐ Up to Chair
Lunch	___ %	☐ PSW	☐ Up to Chair
Dinner	___ %	☐ PSW	☐ Up to Chair

Oral Care — Level Of Assistance
- ○ Independent
- ○ Supervised ○ Assisted

If **Independent** is selected, the section below is optional

Time
- Time _____ ☐ PSW
- ☐ Denture Care

Sleep
- ☐ No Sleep Concerns ☐ Sleep Concerns*
- ☐ CPAP