

# Wayne-Finger Lakes BOCES

## Practical Nursing Program

### Chart Analysis

Directions: Select a chart. Locate the forms listed below. They may not be in the primary chart.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician's Order Sheet    | <input type="checkbox"/> MOLST form           | <input type="checkbox"/> Progress notes           |
| <input type="checkbox"/> Admission sheet            | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory sheet         |
| <input type="checkbox"/> Medication record (MAR)    | <input type="checkbox"/> Vital signs record   | <input type="checkbox"/> Nursing Admission sheet  |
| <input type="checkbox"/> Xray reports               | <input type="checkbox"/> Consultation report  | <input type="checkbox"/> Recovery room report     |
| <input type="checkbox"/> Social Work notes          | <input type="checkbox"/> Dietary notes        | <input type="checkbox"/> Therapy notes (PT,OT,ST) |
| <input type="checkbox"/> Respiratory notes          | <input type="checkbox"/> Care plan            | <input type="checkbox"/> Kardex                   |
| <input type="checkbox"/> Treatment book             | <input type="checkbox"/> BM record            | <input type="checkbox"/> Weights                  |
| <input type="checkbox"/> Nursing observation record |   |   |

Gather the following information from the chart. Type up and hand in.

1. Patient initials, age, date of admission, allergies, code status
2. History of present illness (HPI): included admitting diagnosis, pathophysiology of diagnosis, course of illness, course of hospital or LTC stay, any consultations.
3. Past medical history (PMH): any co-morbidities or diagnoses the patient had prior to admission and the pathophysiology of these.
4. Psychosocial history: family, support systems, education, occupation.
5. Nursing care and treatments: as described on Kardex, clinical pathways, care plan. Include treatments ordered by MD or NP. Describe functional capabilities of patient.
6. Therapies prescribed: including Physical therapy, Occupational therapy, Speech therapy, Respiratory therapy. Discuss the reasons for these therapies, and patient progress.
7. Medical tests and the reason for these: including imaging, lab tests and other diagnostic tests. Discuss results and how the results relate to the diagnoses.
8. Medications: list all medications, include classification of the drug, action of the drug, major side effects, nursing implications, reason drug is given, and the dosage, route and frequency.
9. Discharge plan