



1600

Document Hygiene:**Time:** 0730**Bath:****Complete/Partial/Self/Shower****Shampoo Hair:****Yes/No****Heels Floated:** Yes/No**Turn & Reposition :** Yes Q2h**Shave:** Not applicable.

Nurse Narrative Note: The patient is a 76 year-old female, admitted on 5-25-19 with a postoperative wound infection of the right hip. She is alert and oriented to person, place, time and situation. She reports no pain and 0 on a 0-10 pain scale. She states, "it only hurts to move my right foot and leg it aches every time I move it or add pressure." Heels are elevated and achy pain noted on right foot around heel. No edema noted on right foot. Baseline vital signs are: respirations-16, blood pressure 179/77, pulse ox- 92% with a blood sugar reading of 121. She is on 2L of oxygen via nasal cannula and slowly weaning off. Ortho came in to change her right hip dressing at 0730. It is covered with an ABD. She had a picc line placed in the upper right brachium at 1630. She will be discharging to therapy with the antibiotics prescribed with her. She has her SCD's on and urine output total is 600mL from 0700-1600. She voids in a brief with purewick provided. No ambulation during shift. She is on a 1800 diabetic diet, she ate 100% of her breakfast and 25% of her lunch. She has been using the incentive spirometer Q2h. She is cooperative and very pleasant.



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