

Swelling
(Peripheral and Pulmonary Edema)

Subjective Data:

Allergies: _____

Chief complaint: _____

Location: _____ Size: _____ Pain Scale: (0-10) _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Res _____ Temp. _____ Wt _____ O2 sats: _____

Offender on anticoagulants (warfarin, aspirin, heparin etc.), diuretic, cardiac medication. Yes No

| Heart Rhythm | Respiration | Lung Sounds | Skin | Swelling | Pulse |
|--|--|---|--|---|---|
| <input type="checkbox"/> Sinus rhythm <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Even <input type="checkbox"/> Uneven <input type="checkbox"/> Labored <input type="checkbox"/> Unlabored <input type="checkbox"/> Shallow <input type="checkbox"/> Rapid <input type="checkbox"/> Dyspnea <input type="checkbox"/> Air Hunger <input type="checkbox"/> Use of accessory muscles | <input type="checkbox"/> Clear <input type="checkbox"/> Rhonchi <input type="checkbox"/> Wheezes <input type="checkbox"/> Diminished <input type="checkbox"/> Rales | <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Pink <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic <input type="checkbox"/> Mottled | <input type="checkbox"/> Tongue <input type="checkbox"/> Throat <input type="checkbox"/> Facial <input type="checkbox"/> Extremities <input type="checkbox"/> Abdomen <input type="checkbox"/> Generalized | Location: _____ <input type="checkbox"/> Able to palpate <input type="checkbox"/> Unable to palpate |

| Capillary Refill | Edema | Neurological (sensation) | Movement | Appearance |
|---|--|--|--|--|
| <input type="checkbox"/> Brisk - < 2 seconds <input type="checkbox"/> Sluggish - > 2 seconds | <input type="checkbox"/> Non - Pitting <input type="checkbox"/> Pitting (scale) <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> +4 Location: _____ | <input type="checkbox"/> Sensation Present <input type="checkbox"/> Sensation Absent Location: _____ <input type="checkbox"/> Lethargy <input type="checkbox"/> Disoriented | <input type="checkbox"/> No Limitation <input type="checkbox"/> Limit Movement Describe: _____ | <input type="checkbox"/> No distress <input type="checkbox"/> Mild distress <input type="checkbox"/> Moderate distress <input type="checkbox"/> Severe distress |

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

- Shortness of breath, abnormal breaths sounds and/or tachycardia
- Impaired neurological (lethargy, disorientation)/vascular status

Refer to Medical Provider If:

- Marked edema is present
- Edema is accompanied by blurry vision, severe headache, tingling or numbness
- Active infection - cellulitis
- Condition not responding to intervention

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alteration in skin integrity and comfort related to: excess fluid volume - edema

Impaired gas exchange related to: excess fluid in lungs

Plan:

Nursing Intervention Routine:

| Peripheral Edema | Pulmonary Edema |
|---|---|
| <input type="checkbox"/> Protect the affected area. <input type="checkbox"/> Raise the legs several times per day to improve circulation. Elevate head if facial. <input type="checkbox"/> Apply ice to the affected area to reduce swelling 24 to 48 hours <input type="checkbox"/> Elevate the affected area anytime sitting or lying down. <input type="checkbox"/> Cut down salt consumption. <input type="checkbox"/> Avoid sitting for long periods of time. <input type="checkbox"/> Monitor I & O <input type="checkbox"/> Assess fit of shoes and slippers to avoid risk of pressure and skin breakdown. <input type="checkbox"/> Consider crutches if lower extremity. <input type="checkbox"/> Medical lay-in/Restrictions. | <input type="checkbox"/> Reassure offender, provide calm, quiet environment <input type="checkbox"/> Place offender in semi-fowler position or reclining position <input type="checkbox"/> Place pulse oximeter <input type="checkbox"/> Administer Oxygen at 2L minute via nasal cannula to maintain oxygen saturation above 90% (requires provider order) <input type="checkbox"/> Monitor blood pressure, cardiac rate and rhythm <input type="checkbox"/> Monitor breath sounds and be alert for crackles (Rales), heart tones and peripheral pulses <input type="checkbox"/> Monitor skin color, moisture, temperature and capillary refill time <input type="checkbox"/> Monitor for a new non-productive cough <input type="checkbox"/> Monitor for signs of hypoxia: restlessness, confusion, headache <input type="checkbox"/> Assess for distended neck and peripheral vessels <input type="checkbox"/> Schedule offender for daily weights <input type="checkbox"/> Instruct offender to take slow deep breaths <input type="checkbox"/> Monitor I & O |

Progress Note: _____

Offender Education:

- Instructed signs and symptoms to warrant further treatment (loss of sensation, increase swelling, decrease ROM, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

QHCP/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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