Your Hospital's Logo Here

CRITICAL CARE FLOW SHEET

PATIENT IDENTIFICATION

START DATE:	STOP DATE:

SIGNATURE / TITLE / INITIALS	SIGNATURE / TITLE / INITIALS

WT Today: / WT Yesterday:	KG / LBS	HT:
PAST 24° Intake / Output		BALANCE 24°

TYPE:	PA Catheter	Arterial Line	Central Line	Central Line	Sheath	Other
Insertion Date						
Insertion Site						
Removal Date						

LAB DATA

LABWORK	RESULTS					LABWORK	RESULTS				
TIME						Time					
BS						Albumin					
BUN						WBC					
Cr						Hgb					
Na						Hct					
K						PT					
Cl						INR					
CO2						PTT					
Ca						Platelets					
Phos						CPK					
Magnesium						CK - MB					
Cholesterol						CPK Index					
Total Bili						Troponin					
Alk. Phos						Lactic Acid					
SGOT						NH_4					
SGPT						Pre-Albumin					
Total Protein						Digoxin					

TIME	STAT MEDS	INITIALS	TIME	STAT MEDS	INITIALS

ISOLATION	☐ YES ☐ NO	ISOLATION TYPE:	NEGATIVE FLOW MAINTAINED:	☐ YES ☐ NO	☐ N/A ☐ HEPAFILTER
PATHWAY	☐ NO	☐ YES; If "YES", SPECIFY:			
CODE STATUS	☐ FULL CODE	☐ DNR	☐ OTHER:		

PART OF THE MEDICAL RECORD

Critical Care Vital Sign Flow Sheet

HOUR 07 - 07	
MINUTE :00 - :59	

● PULSE

V/Λ BP

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 0

BP Method
A = A-Line
C = Cuff
D = Doppler

TEMP	
Respirations	
BP Method	
MAP	
CVP	
PAS	
PAD	
PCWP	
CO/CI	
SVR	
Pulse Ox	
Accu-Check	

PULSES		
	Radial R / L	
	Dorsalis Pedal R / L	
	R / L	

PULSES (Code): **O = Absent** **D = Doppler** **1+ = Intermittent** **2+ = Weak** **3+ = Strong**

Hematoma	
Sandbag	

INVASIVE LINE CARE

PERIPHERAL	CHECK WHEN CHANGED		CENTRAL	CHECK WHEN CHANGED	U	P	SWAN GANZ	CHECK WHEN CHANGED	U	P	A LINE OTHER	CHECK WHEN CHANGED	U	P
	#1 DATE			CORDIS TUBING				DRESSING				DRESSING		
	SITE			PROX. TUBING				PRESSURE TUBING				PRESSURE TUBING		
	#2 DATE			MEDIAL TUBING				FLUSH BAG				FLUSH BAG		
	SITE			DISTAL TUBING				CO SET TUBING				TUBING		
	#3 DATE			DRESSING										
	SITE													

PART OF THE MEDICAL RECORD

DRUG DOSAGE (mcg/kg/min., mcg/min., etc.) **DRIP WEIGHT:___________(KG)**

INTRAVENOUS	07	08	09	10	11	12	13	14	8 Hour Total	15	16	17	18	19	20	21	22	8 Hour Total	23	24	01	02	03	04	05	06	8 Hour Total	24 Hour Total
mcg or mg / ml																												
mcg or mg / ml																												
mcg or mg / ml																												
mcg or mg / ml																												
mcg or mg / ml																												
mcg or mg / ml																												
☐ PPN ☐ TPN																												
INTRALIPIDS																												
BLOOD PRODUCTS																												
I.V. MEDS																												
CO INJECTATE																												
TUBE FEEDING																												
NG MEDS																												
PO FLUIDS / FREE H_2O																												
																										TOTAL INTAKE			

	07	08	09	10	11	12	13	14	8 Hour Total	15	16	17	18	19	20	21	22	8 Hour Total	23	24	01	02	03	04	05	06	8 Hour Total	24 Hour Total
URINE																												
HEMODIALYSIS FLUID REMOVAL																												
NG																												
STOOL																												
DRAINS																												
IV SITE CHECKS Q 2 Hrs																												
POSITION △ R / L / B / C																												
																										TOTAL OUTPUT			

R = Right Side *B = Back*
L = Left Side *C = Chair*

DIET INTAKE	ALL	≥ 1/2	< 1/2	DIET INTAKE	ALL	≥ 1/2	< 1/2	DIET INTAKE	ALL	≥ 1/2	< 1/2
Breakfast				Lunch				Dinner			

PART OF THE MEDICAL RECORD

NEUROLOGICAL ASSESSMENT

TIME																																	
INITIALS																																	B = Brisk S = Sluggish - = No Reaction C = Eye Closed
PUPILS Right Size																																	
PUPILS Right Reaction																																	
PUPILS Left Size																																	
PUPILS Left Reaction																																	

•1 •2 •3 •4 •5 •6 Please use numbers scale

COMA SCALE																																		
Eyes open	Spontaneously=4 To sound=3 To pain =2 None=1																																Eyes closed by swelling = C
Best verbal response	Oriented=5 Confused=4 inappropriate words=3 Incomprehensible sounds=2 None=1																																Endotracheal tube or tracheostomy = T
Best motor response	Obey commands=6 Localize pain=5 Withdraws=4 Flexion to pain=3 Exten. To pain=2 None=1																																Record best limb response
GLASCOW COMA SCALE TOTAL																																	

EXTREMITY																									
LEFT	Hand																								
LEFT	Leg																								
RIGHT	Hand																								
RIGHT	Leg																								
Consciousness																									
Seizure Activity																									
Speech																									

Consciousness

- A = alert
- L = lethargic / drowsy
- R = restless
- C = confused
- CT = comatose
- S = stuporous / obtunded

Extremities

- S = strong or normal
- W = weak
- M = slight movement
- A = absent or paralyzed

FALL PREVENTION STANDARD

	N	D	E
Fall Standard in Use			
Yellow ID band on Patient			
Yellow Card on Door			
Call Light in Reach			
Bed Low & Locked			
Bed Alarm On			
Side Rails Up ☐X2 ☐X4			

PART ONE: RESTRAINT INTERVENTION

☐ **N/A** If initial order, document time restraints applied: ____________ MILITARY TIME

1 Indication for use of restraints:
- ☐ Interference with medical treatment
- ☐ Risk of Falls

2 Alternative intervention(s) attempted prior to restraint applications
- ☐ Nursing interventions - i.e., securing tubing, dressing
- ☐ Diversional activity - i.e., music, puzzles, etc.
- ☐ Spend more time with patients
- ☐ Family / significant other involvement
- ☐ Environment change
- ☐ Reduce stimuli
- ☐ Reality orientation
- ☐ Bed alarm

3 Alternative measures effective: ☐ Yes ☐ No

4 Education
- **a.** Patient / significant other educated on restraint alternatives + reason(s) for restraint use: ☐ Yes ☐ No
- **b.** Patient / significant other verbalized understanding ☐ Yes ☐ No
  - ☐ Not understood by patient; significant other unavailable

5 Type & location of restraint(s) in use: ____________

6
- **a.** Restraint Standard for Acute Care Setting in use: ☐ Yes ☐ No
- **b.** Acute Confusional State Standard in use: ☐ Yes ☐ No

Indicate Time(s) Patient OUT OF RESTRAINTS

N		
D		
E		

PART TWO: OBSERVATION SHEET

Directions: Document every 2 hours (MST / CCT may complete)

TIME	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600
Hydration / Nutrition												
Toilet / Comfort												
Skin Checked												
ROM												
Circulation Checked												
LOC / Mental / Emotional												
Staff Initials												

ROUTINES & SAFETY

SHIFT	U	P
Back Care		
Bath		
Oral Hygiene		
Foley Catheter		
Ted / SCD / Plexiplus		
Lines Zeroed		
Activity (BR, BRP, Chair, Ambulatory)		

ROUTINES & SAFETY

SHIFT	U	P
Bed Surface **M** = Maxifloat **S** = Softcare **O** = Other / Specialty Bed (Specify)		

PART OF THE MEDICAL RECORD

RESPIRATORY

										TRACH / ET TUBE				ABGS					
TIME	Equipment	Oxygen % FiO2 / LPM	Tidal Volume	Spontaneous TV	Vent Mode	Vent Rate / Spont.	PEEP / PS	Peak / Mean Press Insp	PC / IE	Size	Position (R = Right, M = Middle, L = Left)	CM Mark	HOB 30°	**TIME**	pH	paCO2	paO2	HCO3	O2 SAT

TIME								
INITIALS								
CARDIOVASCULAR: RHYTHM								
HEART SOUNDS: S1 S2								
HEART SOUNDS: Gallop								
HEART SOUNDS: Murmur								
HEART SOUNDS: Fx Rub								
SKIN								
COLOR								
JVD								
EDEMA / LOCATION								
CAPILLARY REFILL R / L								
PACEMAKER: MODE								
PACEMAKER: TYPE								
PACEMAKER: RATE / MA								
RESPIRATORY: RESPIRATIONS								
BREATH SOUNDS: R U L								
BREATH SOUNDS: R M L								
BREATH SOUNDS: R L L								
BREATH SOUNDS: L U L								
BREATH SOUNDS: L L L								
SUCTION								
SECR. COLOR AMT.								
CHEST TUBES: SITE								
CHEST TUBES: DRAINAGE / (Describe)								
CHEST TUBES: H2O SEAL / Bubbling +/-								
CHEST TUBES: SUCTION / (CmH2O)								
GI: ABDOMEN								
GI: BOWEL SOUNDS								
GI: STOOL: description								
GI: NG: description								
GI:								
GU: URINE: (color, char.)								
GU: Method of output								
GU:								

COMMENTS:

CODES

HEART SOUNDS
- + = PRESENT
- ↓ = DECREASED

GALLOP
- S_4 S_1 S_2 S_3
- S_3
- S_4

MURMUR/FRICTION RUB
- + / - = PRESENT / ABSENT

SKIN
- W = WARM
- CL = COOL
- CD = COLD
- H = HOT
- DI = DIAPHORETIC
- CLA = CLAMMY
- M = MOIST
- DR = DRY

COLOR
- F = FLUSHED
- N = NORMAL / PINK
- P = PALE
- C = CYANOTIC
- J = JAUNDICED
- D = DUSKY
- M = MOTTLED

JVD
- + / - = PRESENT / ABSENT

EDEMA
- N = NONE
- G = GENERALIZED
- P = PITTING
- NP = NON-PITTING
- T = TRACE
- 1+ = 2 MM PITTING
- 2+ = 4 MM PITTING
- 3+ = 6 MM PITTING
- 4+ = 8 MM PITTING

RESPIRATIONS
- R = REGULAR
- I = IRREGULAR
- S = SHALLOW
- L = LABORED
- H = HYPERVENTILATION (↑ RATE & ↑ DEPTH)
- 0* = OTHER (Asterisk & Describe)

BREATH SOUNDS
- CL = CLEAR
- RA = RALES / CRACKLES
- RH = RHONCHI
- WZ = WHEEZE
- E = EXPIRATORY
- I = INSPIRATORY
- ↓ = DECREASED
- O = ABSENT
- BR = BRONCHIAL

ABDOMEN
- FL = FLAT
- D = DISTENDED
- L = LARGE
- T = TENDER
- S = SOFT
- F = FIRM
- R = RIGID

BOWEL SOUNDS
- + = PRESENT
- ▼ = HYPOACTIVE
- ▲ = HYPERACTIVE
- O = ABSENT

PART OF THE MEDICAL RECORD

PAIN MANAGEMENT

COMFORT GOAL:

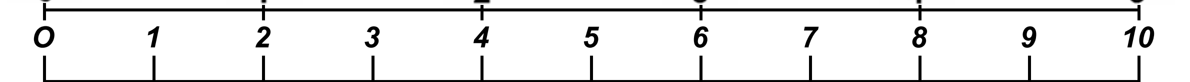
RATING SCALE:

TIME	PAIN LOCATION	SEDATION RATING	PAIN RATING	INTERVENTION	INITIALS	EVALUATION TIME/PAIN #	INITIALS

PAIN SCALES:

WONG-BAKER: *(Faces)*

0-10 VISUAL: *(Numeric)*



VERBAL: No Hurt · Hurts Little Bit · Hurts Little More · Hurts Even More · Hurts Whole Lot · Worst Pain

NON-COGNITIVE: *(FLACC Scale)*

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

SEDATION SCALE:

S = NORMAL SLEEP, EASY TO AROUSE, ORIENTED WHEN AWAKENED, APPROPRIATE COGNITIVE BEHAVIOR
1 = WIDE AWAKE - ALERT (OR AT BASELINE), ORIENTED, INITIATES CONVERSATION
2 = DROWSY, EASY TO AROUSE, BUT ORIENTED AND DEMONSTRATES APPROPRIATE COGNITIVE BEHAVIOR WHEN AWAKE
3 = DROWSY, SOMEWHAT DIFFICULT TO AROUSE, BUT ORIENTED WHEN AWAKE
4 = DIFFICULT TO AROUSE, CONFUSED, NOT ORIENTED
5 = UNAROUSABLE

INTERVENTION:

1 = DISCUSS PAIN MANAGEMENT PLAN WITH PHYSICIAN
2 = PHARMACOLOGICAL (See MED KARDEX)
3 = NON-PHARMACOLOGICAL **A.** Position Changed **B.** Relaxation Technique
C. Splinting **D.** Imagery **E.** Music **F.** Education
G. Other: ______________________________

FLACC PAIN SCALE:

1. Sum of FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY Scores = FLACC Score
2. Record FLACC Score using the 0-10 VISUAL (NUMERIC) Scale above

_____ **= FACE Score**
0 = No particular expression or smile
1 = Occasional grimace or frown, withdrawn, disinterested
2 = Frequent to constant frown, clenched jaw, quivering chin

_____ **= LEGS Score**
0 = Normal position, or relaxed
1 = Uneasy, restless, tense
2 = Kicking, or legs drawn up

_____ **= ACTIVITY Score**
0 = Lying quietly, normal position, moves easily
1 = Squirming, shifting back & forth, tense
2 = Arched, rigid, or jerking

_____ **= CRY Score**
0 = No crying (asleep or awake)
1 = Moans or whimpers, occasional complaint
2 = Crying steadily, screams or sobs, frequent complaints

_____ **= CONSOLABILITY Score**
0 = Content, relaxed
1 = Reassured by touching, hugging, talking to, distractable
2 = Difficult to console or comfort

PRESSURE SORE RISK ASSESSMENT: TO BE COMPLETED EVERY 24 HRS

SENSORY PERCEPTION	MOISTURE	ACTIVITY	MOBILITY	NUTRITION	FRICTION & SHEAR
1. TOTALLY LIMITED	1. TOTALLY MOIST	1. BEDREST	1. TOTALLY IMMOBILE	1. VERY POOR	1. PROBLEM
2. VERY LIMITED	2. VERY MOIST	2. CHAIRFAST	2. VERY LIMITED	2. PROBABLY INADEQUATE	2. POTENTIAL PROBLEM
3. SLIGHTLY LIMITED	3. OCCASIONALLY MOIST	3. WALKS OCCASIONALLY	3. SLIGHTLY LIMITED	3. ADEQUATE	3. NO APPARENT PROBLEM
4. NO IMPAIRMENT	4. RARELY MOIST	4. WALKS FREQUENTLY	4. NO LIMITATIONS	4. EXCELLENT	
SCORE:					

IF TOTAL SCORE ≤ 17, PATIENT IS AT HIGH RISK FOR PRESSURE ULCER
IMPLEMENT PRESSURE ULCER PREVENTION PROTOCOL IMMEDIATELY

SERUM ALBUMIN _________

TOTAL SCORE: ______________________

COMPLETED BY: ______________________

WOUND CARE: On ADMISSION + every THURSDAY

STAGE:
I = Reddened area (intact skin)
II = Blister, skin break
III = Skin break exposing subcutaneous tissue
IV = Skin break exposing muscle and / or bone

PERI-WOUND TISSUE:
WNL = Within Normal Limits
R = Reddened
D = Darkened
M = Macerated

Right Left · Right Left · Left Right · Right Left · Left Foot · Right Foot · Outer · Outer · Right Left · Left Right · Right Left

APPEARANCE: P = Pink / Clean S = Slough E = Eschar

ODOR: O = None M = Mild F = Foul

DRAINAGE: O = None S = Serous SG = Sero-sanguinous P = Purulent

☐ **NA** **ADDITIONAL DRESSING CHANGES DOCUMENT IN PROGRESS NOTES** **If more than 5 wounds, use OVERLAY**

(Legend)
TYPE
Venous Stasis
Pressure Ulcer
Traumatic Wound

SHIFT:	☐ U	☐ P	☐ U	☐ P	☐ U	☐ P	☐ U	☐ P	☐ U	☐ P
LOCATION:	WOUND #:		WOUND #:		WOUND #:		WOUND #:		WOUND #:	
TYPE (Legend):	TYPE:		TYPE:		TYPE:		TYPE:		TYPE:	
Stage:										
Appearance:										
Drainage:										
Odor:										
Peri-Wound Tissue:										
Size [L x W x D]# cm:										
Undermining [Y / N]:										
Nurse's Initials:										
Irrigation:										
Treatment:										
Time / Initials:										

PART OF THE MEDICAL RECORD