

HACKETTSTOWN REGIONAL MEDICAL CENTER

ICU
(Scope)

TITLE: ICU 24-Hour Nursing Flow Sheet Guideline

PURPOSE:	To establish guidelines for completing documentation using the Critical Care 24-Hour Nursing Flow Sheet.
NATURE OF FORM:	Permanent
TARGETED POPULATION:	All inpatients admitted to ICU and as the downtime form for PCU
PERSON RESPONSIBLE:	RN
PLACEMENT:	In the Nurses' Notes section of the chart.

CONTENT:

1. Enter current date and bed number of patient. Current date is reflective at 0700.
2. Isolation Precautions: if applicable write in type of "special" isolation. If no specific isolation ordered then write in "standard".
3. Yesterday's Weight: Enter previous day's weight in kilograms.
4. Today's Weight: Enter current's date's weight. All patients are weighed daily.
5. Yesterday's intake/Output: Enter yesterday's total 24-hour intake and 24hour output.

Vital Signs:

6. Enter time of vital signs in military time.
7. Enter temperature in degrees Fahrenheit.
8. Heart Rate (HR): enter HR value.
9. Rhythm: Enter ECG rhythm interpretations under appropriate time frame of the print out you are measuring.
10. Blood Pressure (BP): Enter BP under appropriate device used to obtain reading. Enter value under "Art" if the BP was obtained from an arterial line; enter value under "Cuff" if the BP was obtained from a cuff pressure. MAP: enter mean arterial blood pressure here.
11. Respirations (resp): Enter respirations.
12. Pulse oximetry: Enter pulse oximetry reading.
13. Pulmonary Artery Systolic and Diastolic Pressures (PAS/PAD): If patient has pulmonary artery catheter enter PAS in top section of split box and PAD in bottom section of split box. If patient does not have PA catheter, leave this section blank.
14. Central Venous Pressure/Pulmonary Capillary Wedge Pressure (CVP/PCWP): If monitoring CVP, enter value in top section of split box, if monitoring PCWP, enter value in bottom section of split box. If not monitoring these values, leave blank.

Pain

15. Pain Location: If a patient complains of pain write in location of pain, to include site and laterality if applicable.
16. Intensity/Scale: Enter the numeric value of the pain level as per patient. Using the key on the bottom of the form, enter the scale used to obtain the value. (as per hospital policy)
17. Description: Use key code to enter in patient's description of pain.
18. Intervention: Using the key code, enter the intervention used for patient's pain management. If further explanation is needed enter a "*" and explain your intervention in nurse's progress note.
19. Initials: Enter nurse's initials for completing time frame of vital signs and pain assessment.

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20. Enter time of page 2 assessments
21. Sedation scale: if patient is on a continuous IV sedative agent, use the sedation scale and write in appropriate corresponding numeric value. Leave blank if not on continuous sedation.
22. Accuchecks: Accucheck results completed in this section. Chart result in appropriate time frame. This is used to monitor patient' s accuchecks if on an insulin drip, where hourly accuchecks are required. All other accuchecks (Q4, Q6, and AC/HS with subcutaneous coverage) will continue to be charted on accucheck MAR.

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23. Comments/STAT events: Open narrative area for any comments such as physician calls, name/dosage/route of stat medication given at that time, name/dosage/route of pain medication or prn medications given at that time.
Intake
24. Medication Concentration: Enter the IV medication concentration in this area and or IV solution. Use one column per IV. Use first five columns for IV medications and last 3 for IV fluids/with or without additives.
Example: Dopamine 400mg/250 ml D5W or 1000cc NS
Also on this line enter how the medication and/or IV fluid should be running.
Example: For Dopamine: mcg/kg/min or for IV fluids ml/hr.
25. Enter medication dosage in top section of split box and the volume of that dosage in the bottom section of the split box.
Example: For Nitroglycerine drip: 10mcg/3ml. It is running at 10mcg/min at 3ml/hr. Already stated in box above that Nitro would run at mcg/min, so no need to rewrite in this box. In the bottom section of the split box the IV pump is running at 3 ml/hr for this dosage, so write in 3. This will make adding the intake easier. At any time a new bag of the solution/medication is hung, place an ↑ next to the rate. This will indicate a new bag went up at that time.
26. IV meds: Enter total volume of any IV medications administered in that time frame
27. Blood Products; Enter total volume of any blood products that infused in that time frame.
28. PO/Tube Feeding/Irrigation: Enter the volume of any po intake, tube feeding intake and irrigation for the appropriate hour.
29. Running IV Total Intake: Add all the intakes from that time frame and enter the total volume in the top section of the box. Add hourly intake to previous intake to obtain running total number. Enter this number in the bottom portion of the box.
30. Initials: enter nurse's initials information documented on that row for specific time frame.
31. 12 hour total: Enter the total volume for each column of intake at the end of your shift. Circle the total 12 hour for each. Then add each column across and write in total in the total intake column. Adding columns across at 12 hour and adding the total running column together should give you the same numbers. This is done at the end of each 12-hour shift. Circle final 12 hour value.
32. The night shift at 7am is responsible for adding the two 12 hour shifts' intake recording and entering the value under 24 total section. Transcribe this 24-hour total record to the new 24-hour flowsheet.

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33. Output: Enter total volume for any output under the appropriate time frame in which it was measured and the under the appropriate source.
34. Extra columns: Enter source of output that is not listed. Enter volume under appropriate time frame.
35. Running Total output: add all the outputs for that time frame across and enter the total output from all sources in that column. Add hourly output and enter new total by adding current volume to previous total.
36. 12 hours: add each column of output source and enter value in the 12-hour section for each. Then add together each total source and enter the grand total value in the "total output" box under the 12-hour row. This number should equal the number if you added the total output column up.
37. Each shift completes a 12-hour total. The night shift at 7am is responsible for adding the two 12 columns of output. Enter the value under 24 total section. Transcribe this 24-hour total record to the new 24-hour flowsheet.
38. GCS section: Glasgow Coma Scale: Using the codes on the page enter corresponding assessment in appropriate time frame and assessment column. Enter total value for Glasgow coma scale assessment.
39. Neurological Data: If applicable document the pupil size and reaction using the codes. Assess arms and legs and use code key.
40. Initials: enter nurse's initials information documented on that row for specific time frame.

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Respiratory Data

41. If any areas are not applicable, check off NA box. Or enter the time of the assessment.
42. Enter O2 appliance. This would be Nasal Cannula (NC), Non rebreather mask (NRB), Venturi mask (VM), face mask (FM) or Ventilator (use type of vent, servo I). If patient is on none, enter "None".
43. If patient on a ventilator enter size of endotracheal tube, and the level at which the ETT meet the patient's lip.
44. If patient on a ventilator enter the mode of the ventilator.
45. Enter the amount of O2 the patient is receiving. (Liters for NC, % for other appliances). If the patient is on none, enter "RA" for room air.
46. Rate: if patient is on a ventilator enter the ventilator setting and patient's rate. 20/24
47. Volume: if patient is on a ventilator enter the ventilator setting and patient's volume. 600/650.
48. Peak pressure: enter this value if patient is on a ventilator.

- 49. Pressure support/PEEP: enter these setting if patient is on a ventilator and the physician has ordered these settings.
- 50. ETCO2: Enter end tidal CO2 value if applicable.
- 51. Initials: enter nurse's initials information documented on that row for specific time frame.

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- 52. Suction: If patient is orally or endotracheal or tracheal suctioned enter time of suctioning, enter amount and color of secretions. If not applicable, check off box.
- 53. Incentive Spirometry: if IS is ordered enter the time patient used the IS and number of breaths they took and the average volume of each breath.
- 54. Initials: enter nurse's initials information documented on that row for specific time frame.

Diet

- 55. For each meal, enter the patient's diet or NPO status
- 56. If eating enter the percentage of food taken. If patient is NPO then leave blank.
- 57. Enter the level of assistance patient requires for meals.
- 58. Enter nurse's initials for completing each section of the meals.
- 59. If patient is on tube feeding, enter type of feeding and rate. If there are residuals, chart in nurse's notes.
- 60. Enter nurse's initials for completing tube feeding section.

Lines

- 61. Enter the site location of pulmonary artery catheter. Enter the original insertion date. This date is to be carried over to the next day's flow sheet and everyday there after as long as the catheter remains in the same site. If no PA line, leave blank.
- 62. Using the IV codes enter the description of the access site per hospital policy.
- 63. Enter the site location of the arterial line. Follow steps 61 and 62 as above. If no arterial line, leave blank.
- 64. If an arterial line or PA line is in use, check off the appropriate time column when system was calibrated and flushed.
- 65. Enter Central line type and location. Follow steps 61 and 62 above.
- 66. Enter one peripheral intravenous site location per line. Enter size and insertion date for each. This date is to be carried over to the next day's flow sheet and everyday there after as long as the catheter remains in the same site. Follow hospital policy for expiration of peripheral sites.
- 67. Initials: Enter your initials for each time frame an IV access assessment was completed.

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Assessment

- 68. Neuro: enter an orientation assessment under the appropriate time frame when the assessment occurred. Write in Aox3 for the alert and orientated to time, person and place. If an abnormal alertness and orientation is assessed write an "*" in the box, complete a narrative note. Note a positive or negative gag, swallow and cough reflex if applicable. Note a positive or negative corneal and babinski for right and left if applicable. If assessments are not applicable, then fill in NA or leave blank.
- 69. Respiratory: In appropriate time column, enter the quality of respirations by entering the underlined section of the word that describes the assessment. Check off breath sounds that are auscultated and write in which side has that assessment. Enter a chest tube assessment if applicable. If not check off the NA box.
- 70. Cardiovascular: Enter audibility of S1S2 by using the underline part of the word in the key.
- 71. Enter the skin color, temperature and turgor assessment by entering the underlined section of the word that describes the assessment. Document this under appropriate time column.
- 72. JVD: enter whether the patient has jugular venous distention using the key code.
- 73. If patient has a pacemaker, describe the type and fill in the settings. Then under time column enter "no change in settings" or enter new settings.
- 74. Edema: Location will be in the top section of the box and the assessment of edema will be in the bottom section of the box. Describe type of edema under the time column by using code key and write in location.
- 75. Capillary refill: enter normal or sluggish.
- 76. Pulses: for each pulse under appropriate time column enter quality of pulses both right and left by using key code. If a pulse is not assessed leave blank.
- 77. AV fistula: If present write in location. In time column box enter assessment findings using key code.
- 78. Gastro: Enter bowel sound and abdominal character assessment finding under time column using key code. Enter abdominal girth if applicable. If patient has Nasogastric tube (NGT) enter what type of suction and describe the color of the drainage. When Placement is verified enter a check in the box under the time column it was done and how it was verified. Enter A= air verification, XR= x-ray verification. If irrigated enter a check in the box under the time column it

was done. Enter the volume of retained irrigant in the intake section. Enter * in any box that a progress note was written referring to this assessment. If patient has other tubes enter type of tube in box under time frame column.

79. GU: enter "catheter" or Voiding in the time column box to describe method of elimination. If catheter enter size. Describe color and clarity in appropriate box.
80. Initials: Initials this box at the end of time column that an assessment was charted.

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Braden Scale , Pressure Ulcers/incision DVT and Fall Risk Assessment

Braden Scale

81. The Braden Scale will be used to assess all patients for pressure ulcer risk. This assessment will be done daily. Circle appropriate risk points, add the point together and enter this number on the total Score line. If less than 16 follow the instructions.
82. After completing the pressure ulcer risk assessment, enter the time it was completed and initials.
83. Check off yes or no as to whether the pressure ulcer prevention is implemented.
84. For each shift check off any intervention that were implemented. If none leave blank.
85. Initials: Initials this box at the end of time column that an assessment was charted.

Ulcer and incision assessments

86. Enter a location for each individual pressure ulcer, wound or incision that patient has.
87. Measure the ulcer/wound weekly in centimeters and enter the measurements. Do not remove a dressing to do measurements. Measure when applicable with dressing changes.
88. If the patient has a pressure ulcer, stage it. Use the key on the side of the flow sheet.
89. List any intervention or treatments for each ulcer/wound.
90. Enter description of wound using the key code.
91. Time and initial your assessment.
92. Mark location of pressure ulcers, wounds, or incisions on the diagram.
93. List all incisions and wounds and follow steps 86- 92. Do NOT stage wounds or incision, leave blank.

DVT

94. Check off yes or no if the screening was completed that day (date of the flow sheet). Check the appropriate risk level as a result of the screening. Check off what interventions are in place of that no orders are in place, or measures are contraindicated for the patient. DVT assessment: Initial and time daily assessment. If patient has already been assessed and there are no changes, write in "already screened" and complete the rest of the section.

Fall Assessment

95. Circle appropriate risk point for the patient. In each category. Add total score, time and initial when assessment was completed.
96. If intervention for fall assessment are required check off all appropriate interventions done during the appropriate shift. Initial under appropriate shift.

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Hygiene/Skin/Activity/Safety

97. Place check marks in all boxes that are appropriate and under appropriate time column. Only care rendered and devices/treatments that are on the patient will be checked off. All NA boxes will be left blank. (Under bath, enter C=Complete, P=Partial, and S=Self)
98. Initials: Enter initials for time column that you made check marks in.

Nurses Notes

99. Enter all narrative notes here. Enter time frame in military time and sign all entries.
100. Initial and corresponding signature for each nurse that documented on the flowsheet for current 24 hours.

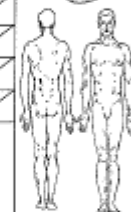
PUPIL SIZE (mm)		Reaction: (S) Sluggish (F) Fixed (B) Brisk (C) Swollen Closed (X) Not Round										INITIALS				
TIME	OUTPUT						GCS (38)				NEUROLOGICAL DATA (39)				INITIALS (40)	
	URINE	NGT	CHEST TUBE	STOOL	TOTAL OUTPUT	EYES OPENING	VERBAL	MOTOR	GCS TOTAL	PUPILS		ARMS		LEGS		
										L	R	L	R	L		R
07		(33)			(34)											
08																
09																
10																
11																
12																
13																
14																
15																
16																
17																
18																
12 HOUR TOTAL		(36)														
19																
20																
21																
22																
23																
00																
01																
02																
03																
04																
05																
06																
12 HOUR TOTAL																
24 HOUR TOTAL		(37)														

Name: _____

RESPIRATORY DATA													
TIME	VENT SETTINGS <input type="checkbox"/> NA										SUCTION <input type="checkbox"/> NA		
	APPLIANCE	SIZE/cm Mark	MODE	FIO2/LPM	RATE SET/PT RATE	TIDAL VOLUME SET/PT	PEAK PRESSURE	PRESSURE SUPPORT/PEEP	ETCO2	INITIALS	TIME	AMOUNT AND COLOR	INCENTIVE SPIROMETRY # OF BREATHS/ VOLUME
(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)	(49)	(50)	(51)	(52)	(53)	(54)
DIET													
Breakfast			Lunch			Dinner			Snacks				
Diet Ordered <input type="checkbox"/> NPO or (55)			<input type="checkbox"/> NPO or			<input type="checkbox"/> NPO or			<input type="checkbox"/> Given/Time				
% Meal Taken (56) %			% (57) %			% (58) %			<input type="checkbox"/> NA				
Meal Assist <input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed (59)			<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed (60)			<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed			<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed				
Tube Feeding: Full Strength Type: (61)			Rate: (62)			Initials: (63)							
Full Strength Type: (64)			Rate: (65)			Initials: (66)							
LINES													
PA Line Site:	Insertion Date:	08	10	12	14	16	18	20	22	00	02	04	06
(67)	(68)												
A Line Site:	Insertion Date:												
(69)	(70)												
Transducer Levited and Zeroed: (71)													
Central Line:	Site	Insertion Date:											
(72)	(73)	(74)											
PIV Site:		Size	Insertion Date:										
(75)	(76)	(77)	(78)										
Initials:		(79)											
IV Codes: WNL=Site is unremarkable, dressing dry and intact; D/C=Line Removed; *=Comments in nurses notes; TLC=Triple Lumen Catheter; PC=Port-a-Cath; PICC=Peripherally Inserted Central Catheter; Drsg Chg=Dressing Changed													

		NURSING ASSESSMENT													
		08	10	12	14	16	18	20	22	00	02	04	06		
NEURO	Mental Status: ✓ Y (awake, alert, orient x3)	(08)													
	Gag/Swallow/Cough														
	Corneal R/L														
	Babinski R/L														
	Respirations: Easy, Unlabored, Tachy Dyspneic, Regular, Labored														
	Breath: Clear														
	Sounds: Rales														
	Right Left Rhonchi														
	Blaseral Wheeze														
	Throughout Diminished														
Bases															
Chest Location															
Tube Water Seal															
Suction															
Air Leak															
Crepitus															
Cough: NP=Nonprod. P=Productive															
Sputum: Th=Thick Tn=Thin Color															
Heart Sounds: S1 S2 Clear, Distant or Muffled	(10)														
Skin Color: Normal, Blue, Pale, Dusky, Cyanotic, Jaundice, Ashen															
Temp: Warm, Cold, Cool, Hot, Dry, Diaphoretic	(11)														
Turgor: Normal, Decreased	(12)														
JVD: Present = + Absent = -	(13)														
Pacemaker Type: _____ Rate Mode _____ MA / Sensitivity	(14)														
Edema Location/Assessment: None=0 Nonpitting=0 Pitting: 1+ 2+ 3+ Anasarca	(15)														
Capillary Refill: N=<3 sec S=>3 sec	(16)														
Pulses: Brachial R/L	(17)														
0=Absent Radial R/L															
D=Doppler Femoral R/L															
1+=Weak/Thready Popliteal R/L															
2+=Normal Post. Tib R/L															
3+=Bounding D.Pedal R/L															
AV Fistula: Location: Thrill + or - Bruit + or - <input type="checkbox"/> NA	(18)														
Bowel Sounds: Present + Absent - Hypoactive, Hyperactive															
Abdominal Character: Soft, Non-Tender, Tender, Firm, Distended															
Tube Type: Nasogastric <input type="checkbox"/> NA Feeding G-Tube, J-Tube															
NGT Suction: Low Continuous Suction Clamped Low Intermittent Suction Gravity															
NGT Color															
Placement Verified/Method															
Irrigated:															
Ostomy: Chart in Notes, Type, Site and Assessment															
Catheter / Void / Incontinence															
Catheter Size: 16F. / Other	(19)														
Color: Yellow, Amber, Bloody, Dark															
Clarity: Clear, Cloudy	(20)														
INITIALS	(21)														

Name: _____

NURSING ASSESSMENT							
All patients must be assessed for pressure ulcer risk according to the pressure ulcer protocol. Circle the appropriate risk points for the patient in each category. Total all the categories and enter to the right. Time and initial assessment. Any patient with a score of 16 points or less must be placed on pressure prevention. Please note this assessment is completed based on the patient's current status.							
BRADEN SCALE	Sensory Perception	Moisture	Activity	Mobility (81)	Nutrition	Friction and Shear	DAILY Assess risk and total. TOTAL = (82) Time/Initials:
	1 Completely Limited	1 Constantly Moist	1 Bedrest	1 Comp. Inmobile	1 Very Poor	1 Problem	
	2 Very Limited	2 Very Moist	2 Chairrest	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 Problem	
	4 No Impairment	4 Rarely Moist	4 Walks Frequently	4 No Limitation	4 Excellent	4 Excellent	
Protocol Implemented: <input type="checkbox"/> Yes <input type="checkbox"/> No 0700-1900 (83)				If protocol implemented, document interventions once a shift. 1900-0700			
<input type="checkbox"/> Use pillows between bony prominences <input type="checkbox"/> Heel elevators <input type="checkbox"/> Specialty bed <input type="checkbox"/> Lotion dry areas <input type="checkbox"/> Encourage/assist patient to shift body weight frequently (84) <input type="checkbox"/> Nutritional support <input type="checkbox"/> Wound/Ostomy Nurse aware				<input type="checkbox"/> Use pillows between bony prominences <input type="checkbox"/> Heel elevators <input type="checkbox"/> Specialty bed <input type="checkbox"/> Lotion dry areas <input type="checkbox"/> Encourage/assist patient to shift body weight frequently <input type="checkbox"/> Nutritional support <input type="checkbox"/> Wound/Ostomy Nurse aware			
Above interventions carried out throughout the shift (85) Initials:				Above interventions carried out throughout the shift Initials:			
PRESSURE ULCERS / INCISIONS	Location	Measurements Length x Width x Depth in cm	Stage (if pressure ulcer)	Treatment Interventions	Description of Wound Bed and Drainage	Time and Initials	Use red pen to mark 
	(86)	(87)	(88)	(89)	(90)	(91)	
Treatment/Interventions 1. Dressing per Physician Order 4. Seating Cushion 2. Dressing Intact 5. Elbow Protectors 3. Vac Therapy per Physician Order 6. Heels elevated				Color of Exudate: Serous, Seroganguinous, Purulent Amount of Exudate: Minimal Moisture Moderate Exude Light Exude Heavy Exude			
Stages: I: Reddened area/skin intact II: Blister/break in skin, superficial III: Skin break exposing subcut. tissue/slough IV: Skin break involving muscle or bone E: Eschar DTI: Deep Tissue Injury Wound Bed: Intact Skin: "Red" Partial Thickness: "Pink/Red" Granulation: "Beefy Red" Epithelialization: "Pearly Pink" Slough: Soft, Yellow or Gray" Eschar: "Leathery, Black or Brown"							
DVT	Screening Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Risk Level: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Highest						
	Measures Implemented: <input type="checkbox"/> TEDS <input type="checkbox"/> SCD <input type="checkbox"/> Medications _____ <input type="checkbox"/> Contraindicated <input type="checkbox"/> No Measures Ordered Time: _____ Initials: _____						
FALL RISK ASSESSMENT	Risk Factor (Variables)	0700-1900	1900-0700	Intervention 0700-1900	Intervention 1900-0700		
	History of falling	No=0 Yes=25	No=0 Yes=25	<input type="checkbox"/> Bed in low position	<input type="checkbox"/> Bed in low position		
	Secondary Diagnosis (see estimator)	No=0 Yes=15	No=0 Yes=15	<input type="checkbox"/> Yellow band	<input type="checkbox"/> Yellow band (96)		
	Ambulatory Aid Nonweightbearing assist=0 Couches/chair/walker=15 Furniture=30	0 15 30	0 15 30	<input type="checkbox"/> Night light	<input type="checkbox"/> Night light		
	IV or IV Access	No=0 Yes=20	No=0 Yes=20	<input type="checkbox"/> Fall bed alarm on / TABS (highest risk)	<input type="checkbox"/> Fall bed alarm on / TABS (highest risk)		
Gait Normal/bedrest/wheelchair=0 Walker=10 Impaired=20	0 10 20	0 10 20	<input type="checkbox"/> Bedpan/urinal within reach	<input type="checkbox"/> Bedpan/urinal within reach			
Mental Status Oriented to own ability=0 Overestimated/forget limitations=15	0 15	0 15	<input type="checkbox"/> Star outside room	<input type="checkbox"/> Star outside room			
Patient's Total Score Risk Assessment Completed Time/Initials				<input type="checkbox"/> Yellow blanket (highest risk, OOB and transporting) <input type="checkbox"/> Yellow socks / antielectrolyte <input type="checkbox"/> Fall sticker on chart <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initials: _____	<input type="checkbox"/> Yellow blanket (highest risk, OOB and transporting) <input type="checkbox"/> Yellow socks / antielectrolyte <input type="checkbox"/> Fall sticker on chart <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initials: _____		
Normal/low risk 0-24 Moderate risk 25-44 High risk 45 or above. Prevention Program in place for moderate to high risk patients.							

ROUTINE NURSING CARE												
	08	10	12	14	16	18	20	22	00	02	04	06
HYGIENE / SKIN / ACTIVITY	Bath C – P – S											
	Oral Care											
	Oral Care/Intubated Protocol											
	Trach Care											
	Urinary Cath. Care / Incont. Care											
	Teds / Compression Boots											
	Cooling / Warming Blanket											
	HOB 30 Degress											
	Turn: R=Right L=Left B=Back S=Self											
	Bed Rest											
	OOB to Chair											
	OOB Ambulating											
	Assistance for OOB Need: Y / N											
	If Yes # of Staff Needed											
	ROM A=Active P=Passive											
	Sleeping											
SAFETY	Alarm on Audible / Functioning											
	Call Bell within Reach											
	Side Rails: 2 3 4											
	ID Band On											
	Other Bands:											
	Initials: (18)											
TIME	NURSES' PROGRESS NOTES											
	99											

Name: _____

