GUIDELINE

TITLE: PATIENT CARE FLOW SHEET

PURPOSE: To outline the steps for completing the Patient Care Flow Sheet

NATURE OF FORM: Permanent Form

DEFINITIONS: N/A

POPULATION: For use on all medical/surgical patients.

RESPONSIBLE PERSONS: N/A

PLACEMENT: It is placed sequentially in the “Nurses’ Notes” section and remains a permanent part of the patient’s medical record.

DETAILED INSTRUCTIONS:

A. The Medical Surgical Flow Sheet provides a 24-hour record for documentation of pertinent and concise patient assessments, interventions, and patient response.

B. Serves as a basis for planning, evaluating, and assuring continuity of patient care.

C. Provides a legal document to protect the interests of the patient, hospital, and responsible practitioners.

D. A complete system assessment, in addition to emotional status, is performed and documented on each patient by an RN every eight (8) hours. The RN will review the plan of care with patient/family and record initials. If patient is not a candidate for or family is not available for review of plan of care, check box to indicate this.

E. Any change in a patient’s condition requires a re-assessment by an RN. Once the RN completes an assessment, the LPN can collect patient data and document findings. Any changes must be reported to an RN for re-assessment.

F. Documentation is completed at the same time assessments, observation, and data collection are completed, or as procedures/treatments are initiated/completed.

G. The Flow Sheet is initiated after completion of Admission Data Base. A new flow record is implemented at 0700. The unit secretary or Nurse on the evening shift will stamp flow sheets for the following day.

H. **Only** the RN and LPN may document on the Medical Surgical Flow Sheet.

I. Any nurse documenting on the flow sheet indicates her/his initials in the space provided and then identifies initials on the “Signature Sheet”.

J. An asterisk (*) and initials entered anywhere on the flow sheet indicates to see the Focus Notes for more information.

K. Slashed boxes indicate two pieces of information may be documented. The top box coincides with the first identified criterium; the bottom box, the second criterium.

L. If criteria does not apply to patient write in NA for non-applicable to show that it was addressed.

M. A focus note is used to document additional assessments/procedures specific to a particular patient.

N. If detailed system data is needed or more frequent than every four hours, utilize appropriate flow sheet.

I. CARE PLAN

A. The registered nurse is responsible for all care plans which will be initiated on the admission shift and updated daily on all shifts.

B. The RN will place a check mark in the box provided to refer to the Clinical Guideline when appropriate. The title of the clinical guideline will then be documented in the area provided. When this takes place, the clinical care plan page does not require any further documentation unless other nursing diagnoses are identified which are not on the Clinical Guideline.

C. Document the date in the area provided.

D. Using a priority system, choose the actual or potential problems.

E. Document the reason for the nursing diagnosis chosen. For ex. if the diagnosis reads "Alt in comfort" then the RN will add "related to. . . ." as appropriate.

F. Identify the expected outcome and add any defining terms as needed in the area provided when appropriate.

G. Once the appropriate nursing diagnoses are chosen, the RN will then initial in the box next to the diagnosis.

H. If the patient has been in the hospital for one or more days, the RN must review the care plan from the previous day and address all diagnoses identified on that day. The RN may also add to the plan of care as needed.

I. When the outcome is achieved, the RN will place a check mark in the "Yes" box. Documentation **must** reflect the outcome achieved. When this occurs, you no longer need to address this problem on the following day because it is now resolved.

J. An RN that identifies a potential or actual problem that has not already been identified the RN may add this problem to the care plan at any time of the day. A signature at the bottom of the page along with the time is required when doing so.

K. Input from other members of the health care team should be included when appropriate.

L. The RN will complete this plan of care based on a systems assessment and chart review in order to identify priorities properly. The RN will then initial, sign the bottom of the form in the area provided.

M. If the patient is a renal/dialysis patient, the interdisciplinary Renal Care Plan will be utilized. The flow sheet care plan will be stamped "See Dialysis Care Plan"

II. GENERAL INSTRUCTIONS

A. Assessments are documented when performed. Write the time, and your initials in the boxes of the appropriate assessment criteria.

B. Patient Assessment Sections:

1. The RN completes the assessment every eight (8) hours, at 0800, 1600 and 0001. Re-assessment should be done if patient's condition changes, and results entered in Focus Notes.

2. Routine assessment criteria are presented for each body system, with those criteria highlighted that denote "normal". If all highlighted criteria apply to the patient, place initials in the box labeled "WNL" (within normal limits). If, however, one or more of the highlighted criteria is not applicable, asterisk and initial the "WNL" box and write a focus note or fill out appropriate flow sheet. Some systems have additional assessment criteria not directly related to normal/abnormal, (i.e. chest tubes/trach). Place a circle (❍) and initials in a box, which indicates see admission database. This reflects normal for patient (i.e. Left sided weakness from previous CVA).

3. **The Respiratory System** requires use of a code to document the method O_2 is being delivered. This code is presented with the type and is identified with a "#". Other criteria require an entry to define the criteria specifically for the patient, i.e. type of airway, 0_2%

4. When using flow sheet to indicate D=Data or A = Action, which necessitates a R=Response, place an (*) asterisk and initials and then document R=Response in focus notes.

5. **Integumentary:**

   The "Wound/Skin Observation and Treatment" form is used to document more detailed data. Check the box in front of "See Wound/Skin Observations and Treatments" to indicate use of this. This form is used to document pressure ulcers and severe skin problems. Use picture of body to show location. If additional areas are needed for wound documentation, check box and use an additional wound skin observation and treatment form.

6. **Genitourinary System:**

   If patient has an indwelling foley catheter, write in size and initial appropriate box if urine is clean and color yellow. Asterisk (*) along with initials required in focus notes.

   RN or LPN completes assessment as needed if condition changes. Document in Focus Notes as to change in condition.

7. **Patient Teaching:**

   Complete information requested. Check box if patient is not a candidate for teaching.

8. **Pain:**

   a. Document location of patient's pain. Using scale of "O = No Pain - 10 = worst pain imaginable; A=Asleep", based on the patient's rating of his/her pain, indicate pain severity. If patient is unable to use a numerical scale, verbal indicators, i.e. "severe", may be used - following pain protocol #8620.034b.

   b. Document any pharmacologic/non-pharmacologic (heat/cold, positioning, massage, etc.) intervention performed to relieve pain. If this intervention is a medication or PCA, etc.., simply write its name, since this documents the intervention. It is not the official documentation of the medication. Medications, including dosages, must be documented on the Patient Medication Record or if PCA, document on PCA Flow Sheet.

   c. Document time and patient's response to intervention in the "Response" section, using the same scale of "O = No Pain - 10 = Worst Pain Imaginable: A = asleep." Initial box.

   d. Comments: Document any comments relating to pain assessment/intervention/response.

   e. If patient denies pain: chart time and document under this section.

9. **Risk to Fall Assessment:**

   Circle each applicable risk point to identify patients who are at high or moderate risk for falls. Place a check mark in the appropriate box in the "Fall Risk Score Area." Place your initials in the area provided.

   *Fall prevention program is implemented for any patient with a score of 5 or more.

10. **Nutrition:**

    a. Record type of diet on the line that says, "breakfast." If diet is not changed, it doesn't have to be recorded again.

    b. Place code under correct shift to indicate what % of meal patient ate or % of snack taken.

c. Record number of cc's ordered for force fluids if applicable.

d. Record number of fluid in cc's if restricted.

e. Circle either Continuous or Intermittent for tube feeding. Record type of tube feeding and circle if it's pump or gravity. Place initials under correct shift if placement checked and record amount of residual obtained, if any in cc's.

f. If criteria does not apply, circle NA for non-applicable to show that it was addressed. If the item does apply, put a line through NA and your initials.

11. **Hygiene:**

a. Use key to record how bath was done under appropriate shift. Also use key to record mode of how care was completed, then initial.

b. Circle if patient has dentures and initial if mouth care was done.

c. If special mouth care is done, record how often and what method is being used.

d. Place initials under appropriate shift if cath care was done.

e. TEDS - Circle all that apply. Write in box on or off under appropriate shift and initial.

f. Heel protectors/elbow protectors - circle all that apply. Write in box on or off under appropriate shift and initial.

g. If criteria does not apply, circle NA for non-applicable to show that it was addressed. If the item does apply, put a line through NA and your initials.

12. **Activity:**

a. Use appropriate number to indicate activity level and record under shift and initial.

b. Record any ambulation device that is used.

c. If specialty bed in use initial box.

d. Record distance ambulated in feet and initial.

e. If ROM is done, record to what extremities.

f. If patient sleeping initial box.

g. If criteria does not apply, circle NA for non applicable to show that it was addressed. If the item does apply, put a line through NA and your initials.

13. **Safety :**

a. Initial appropriate box. Record number of side rails up. If only 2 side rails up write in T=Top or B=Bottom.

b. Circle appropriate isolation preventive or standard precautions as applicable and initial proper box.

c. Circle ID band as appropriate and initial proper box.

d. If criteria does not apply, circle NA for non-applicable to show that it was addressed. If the item does apply, put a line through NA and your initials.

14. **Wound/Skin Assessment/Daily Patient Care Flow Record**:

Using a Red Pen, the RN/LPN will label the body diagrams provided with numbers beginning with #1. The same number should be used for the same wound each day. Any incisions, wound drains, wounds and/or other skin lesions will be identified on these body diagrams.

1. **Date and Time** - Document the date and the time the observation was made.
2. **Site #** **-** Document the # of the site which corresponds with the # on the diagram.
3. **Wound Code** - Using the key provided, identify which type of wound you are addressing.
4. **Size (cmxcm)** - Document the actual size of the wound using the Disposable Plastic Wound Measuring Grid (see Figure 1).
5. **Appearance** - Using the key provided, document the appearance as observed.
6. **Drainage** - Using the key provided, document the type of drainage noted.
7. **Odor** - Using the key provided, document the type of odor noted.

7. **If Pressure Ulcer**

Depth - Document in cm how deep the pressure ulcer is.

8a. Stage - Document the stage of the pressure ulcer using the key provided.
Undermining - Document cm of weakening tissue.

8. **Description/dressing/change/wound type**

Document what was observed when exposing the wound (if covered). Ex. Staple line clean and dry. If the dressing was not taken down, document only the date and time and that the dressing is Dry and Intact in this area. The RN/LPN will then initial and sign in the area provided at the bottom of the form. If further description necessary document in focus note.

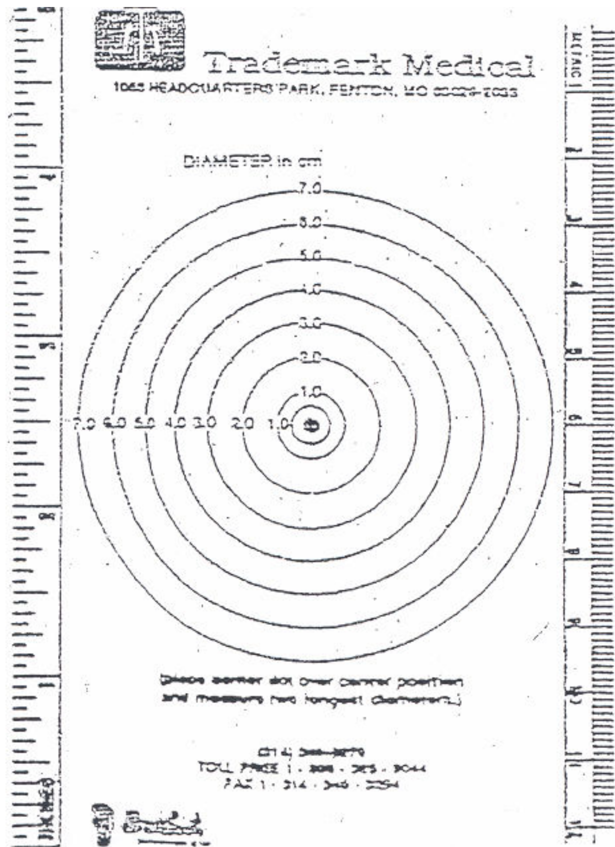
10. Photography of skin breakdown

If skin breakdown is noted upon admission or during hospitalization, obtain consent to photograph and follow PR07 in Administrative Policy book. Tape photographs on multidisciplinary progress note with a description of the wound with Patient Name, Date and Time. (Polaroid camera available on 3 North).

REFERENCES: N/A

APPROVED BY NPC: MAY 2007

FIGURE 1



Hackettstown Regional Medical Center

PATIENT NAME:________________________________ DATE:_______________

WOUND, SKIN OBSERVATIONS AND TREATMENTS

① **DATE & TIME**	② **SITE # (From Diag.)**	③ **WOUND CODE (A)**	④ **Size (cm x cm)**	⑤ **Appearance (B)**	⑥ **DRAINAGE (C)**	⑦ **ODOR (D)**	If Pressure Ulcer ⑧ **DEPTH (CM)**	⑧(a) **STAGE (I,II,III,IV)**	⑨ **Key:** Site # must correspond with number on diagram. **(A) 1** = Surgical Incision 2= Wound Drain 3= Bruise, 4= Pressure ulcer, 5=Burn, 6- Rash, 7= Laceration, 8= Ostomy **(B)** P=Pink/red S= Slough E= Escher G= Granulation I=Inflammation D= Clean/Intact **(C)** 0= Non 1= Serous 2+Serosanguineous 3+ Sanguineous 4=Purulent **(D)** 0= None M= Mild F=Foul **⑨Description Wound Treatment/Dressing Type**	**INITIALS**
				SAMPLE						
2/7/02 (8A)	**#1**	**4**	**2CM**	**I**	**O**	**M**	**1cm**	**II**	**description**	

(8a) Pressure ulcer staging, Stage I – Skin is red but unbroken, **Stage II** – Superficial circulatory and tissue damage, which involves excoriation, vesiculation, or skin break. **Stage III** – Full thickness loss of skin, which may or may not include subcutaneous tissue and produce sarosanguineous drainage – may or may not be necrotic. **Stage IV** – Full thickness loss of skin with invasion of fascia, connective tissue, muscle, or bone. *If escher present, may not be able to stage until debrided.

****MARK BODY USING RED PEN****