### CRITICAL CARE FLOW SHEET

**START DATE:**

**STOP DATE:**

### PATIENT IDENTIFICATION

### SIGNATURE / TITLE / INITIALS

### SIGNATURE / TITLE / INITIALS

---

**WT Today:**

**HT:**

**WT Yesterday:**

**PAST 24h Intake:**

**Output:**

---

**Insertion Date:**

**Insertion Site:**

**Removal Date:**

### LAB DATA

#### LABWORK

<table>
<thead>
<tr>
<th>Labwork</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Time</td>
</tr>
<tr>
<td>BS</td>
<td>Albumin</td>
</tr>
<tr>
<td>BUN</td>
<td>WBC</td>
</tr>
<tr>
<td>Cr</td>
<td>Hgb</td>
</tr>
<tr>
<td>Na</td>
<td>Hct</td>
</tr>
<tr>
<td>K</td>
<td>PT</td>
</tr>
<tr>
<td>Cl</td>
<td>INR</td>
</tr>
<tr>
<td>CO2</td>
<td>PTT</td>
</tr>
<tr>
<td>Ca</td>
<td>Platelets</td>
</tr>
<tr>
<td>Phos</td>
<td>CPK</td>
</tr>
<tr>
<td>Magnesium</td>
<td>CK-MB</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>CPK Index</td>
</tr>
<tr>
<td>Total Bili</td>
<td>Troponin</td>
</tr>
<tr>
<td>Alk. Phos</td>
<td>Lactic Acid</td>
</tr>
<tr>
<td>SGOT</td>
<td>NH₄⁺</td>
</tr>
<tr>
<td>SGPT</td>
<td>Pre-Albumin</td>
</tr>
<tr>
<td>Total Protein</td>
<td>Digoxin</td>
</tr>
</tbody>
</table>

---

#### TIME STAT MEDS

<table>
<thead>
<tr>
<th>Time</th>
<th>Stat Meds</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### ISOLATION

- **YES**
- **NO**

**TYPE:**

- **NEGATIVE FLOW**
- **MAINTAINED:**

**N/A**

**HEPAFILTER**

### PATHWAY

- **YES**
- **NO**

**IF "YES", SPECIFY:**

### CODE STATUS

- **FULL CODE**
- **DNR**
- **OTHER:**

---

PART OF THE MEDICAL RECORD

8850122 Rev. 05/05

Critical Care Flow Sheet_NURSING_CRITICAL CARE

PAGE 1 of 6
## Critical Care Vital Sign Flow Sheet

### Invasive Line Care

<table>
<thead>
<tr>
<th>CHECK WHEN CHANGED</th>
<th>CHECK WHEN CHANGED</th>
<th>U</th>
<th>P</th>
<th>CHECK WHEN CHANGED</th>
<th>U</th>
<th>P</th>
<th>CHECK WHEN CHANGED</th>
<th>U</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 DATE</td>
<td>CORDIS TUBING</td>
<td>S</td>
<td>W</td>
<td>DRESSING</td>
<td>A</td>
<td>L</td>
<td>DRESSING</td>
<td>A</td>
<td>L</td>
</tr>
<tr>
<td>SITE</td>
<td>PROX. TUBING</td>
<td>S</td>
<td>W</td>
<td>PRESSURE TUBING</td>
<td>A</td>
<td>L</td>
<td>PRESSURE TUBING</td>
<td>A</td>
<td>L</td>
</tr>
<tr>
<td>#2 DATE</td>
<td>MEDIAL TUBING</td>
<td>S</td>
<td>W</td>
<td>FLUSH BAG</td>
<td>A</td>
<td>L</td>
<td>FLUSH BAG</td>
<td>A</td>
<td>L</td>
</tr>
<tr>
<td>SITE</td>
<td>DISTAL TUBING</td>
<td>G</td>
<td>N</td>
<td>CO SET TUBING</td>
<td>O</td>
<td>T</td>
<td>TUBING</td>
<td>O</td>
<td>T</td>
</tr>
<tr>
<td>#3 DATE</td>
<td>DRESSING</td>
<td>S</td>
<td>W</td>
<td>GANZ</td>
<td>O</td>
<td>T</td>
<td>OTHER</td>
<td>O</td>
<td>T</td>
</tr>
<tr>
<td>SITE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hematoma

- Sandbag

### Hematoma

- Sandbag

### Pulse Ox

- Accu-Check

### Radial

- R / L

### Dorsalis Pedal

- R / L

### Pulse Ox

- Radial
- Dorsalis Pedal

### BP Method

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

### Hematoma

- Sandbag

### Sandbag

- #1 DATE  CORDIS TUBING  DRESSING  A-LINE
- #2 DATE  MEDIAL TUBING  PRESSURE TUBING
- #3 DATE  DISTAL TUBING  FLUSH BAG
- SITE    3+ = Strong

### Part of the Medical Record

8850122 Rev. 05/05 Critical Care Flow Sheet_NURSING_CRITICAL CARE PAGE 2 of 6
### Critical Care Flow Sheet

**PPN**
- INTRALIPIDS

**TPN**

**INTRAVENOUS**

<table>
<thead>
<tr>
<th>Time</th>
<th>Drug</th>
<th>Dosage</th>
<th>07</th>
<th>08</th>
<th>09</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mcg/kg/min.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>mg/min.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ml/min.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BLOOD PRODUCTS**

**I.V. MEDS**

**CO INJECTATE**

**TUBE FEEDING**

**NG MEDS**

**PO FLUIDS / FREE H₂O**

---

**TOTAL INTAKE**

<table>
<thead>
<tr>
<th>Time</th>
<th>INTRAVENOUS</th>
<th>07</th>
<th>08</th>
<th>09</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**TOTAL OUTPUT**

<table>
<thead>
<tr>
<th>Time</th>
<th>UREINE</th>
<th>07</th>
<th>08</th>
<th>09</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**DIET INTAKE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALL</td>
<td>&gt; 1/2</td>
<td>&lt; 1/2</td>
</tr>
</tbody>
</table>

---

**DRUG DOSAGE (mcg/kg/min., mcg/min., etc.)**

**DRIP WEIGHT:** __________ (KG)

---

**IV SITE CHECKS:** Q 2 Hrs

**POSITION:** R / L / B / C

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

---

**FREE H₂O**

**HEMODIALYSIS**

**FLUID REMOVAL**

---

**PART OF THE MEDICAL RECORD**
### Neurological Assessment

**PUPILS**

<table>
<thead>
<tr>
<th>Right</th>
<th>Size Reaction</th>
<th>Left</th>
<th>Size Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMA SCALE**

- Spontaneously: 4
- To sound: 3
- To pain: 2
- None: 1

**Best verbal response**

- Oriented: 5
- Confused: 4
- Inappropriate words: 2
- Incomprehensible sounds: 1

**Best motor response**

- Obey commands: 6
- Localizes pain: 5
- Withdraws from pain: 4
- Flexion to pain: 3
- Extension to pain: 2
- None: 1

**Consciousness**

- Alert
- Altered
- Lethargic
- Drowsy
- Comatose
- Stuporous

**Extremities**

- Strong
- Weak
- Slight
- Movement
- Absent
- Paralyzed

**GLASGOW COMA SCALE TOTAL**

- Hand
- Leg
- Hand
- Leg

**Seizure Activity**

**Speech**

### Fall Prevention Standard

**PART ONE: RESTRAINT INTERVENTION**

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

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

- Alternative measures effective:
  - Yes
  - No

- Education
  - Patient / significant other educated on restraint
  - Patient / significant other verbalized understanding

**PART TWO: OBSERVATION SHEET**

**TIME**

<table>
<thead>
<tr>
<th>0800</th>
<th>1000</th>
<th>1200</th>
<th>1400</th>
<th>1600</th>
<th>1800</th>
<th>2000</th>
<th>2200</th>
<th>2400</th>
<th>0200</th>
<th>0400</th>
<th>0600</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Hydration / Nutrition
- Toilets / Comfort
- Skin Checked
- ROM
- Circulation Checked
- LOC / Mental / Emotional
- Staff Initiates

## Routines & Safety

**SH I F T**

<table>
<thead>
<tr>
<th>Back Care</th>
<th>Bath</th>
<th>Oral Hygiene</th>
<th>Foley Catheter</th>
<th>Sed / SCD / Plexiplus</th>
<th>Lines Zeroed</th>
<th>Activity (BR, BRP, Chair, Ambulatory)</th>
</tr>
</thead>
</table>

**Bed Surface**

- Maxifloat
- Softcare
- Other / Specialty Bed (Specify)

**PART OF THE MEDICAL RECORD**

8850122 Rev. 05/05 Critical Care Flow Sheet_NURSING_CRITICAL CARE
| Time | Equipment | Oxygen % | FCO2 / LPM | Tidal volume | Spontaneous TV | Vent mode | Vent rate / Spont. | PEEP / PS | Peak / Mean | PC / E | Size | Position | R = Right | M = Middle | L = Left | CM Mark | HOB 30° | TIME | pH | paCO2 | paO2 | HCO3 | O2 Sat |
|------|-----------|----------|------------|--------------|---------------|-----------|-------------------|----------|-------------|-------|------|----------|-----------|-----------|--------|---------|---------|------|-------|-------|-------|

**Respiratory**

**Heart Sounds**
- S1
- S2
- Gallop
- Murmur
- Fx Rub

**Skin**
- Warm (W)
- Cool (CL)
- Cold (CD)
- Hot (H)
- Diaphoretic (DI)
- Clammy (CA)
- Moist (M)
- Dry (DR)
- Hot (H)

**Edema / Location**

**Capillary Refill**
- R/L

**Respirations**
- Bubbling
- SUCTION
- H2O Seal
- DRAINAGE

**Abdomen**
- NG: Description
- Stool: Description

**Urine**
- (Color, char.)

**Method of Output**

**Codes**

**Heart Sounds**
- Present (P)
- Decreased (D)
- Present / Absent (PA)

**Skin**
- Warm (W)
- Cool (CL)
- Cold (CD)
- Hot (H)
- Diaphoretic (DI)
- Clammy (CA)
- Moist (M)
- Dry (DR)

**Edema**
- None (N)
- Generalized (G)
- Pitting (P)
- Non-Pitting (NP)
- Trace (T)
- 1+ to 4+ Pitting

**Respirations**
- Regular (R)
- Irregular (I)
- Shallow (S)
- Labored (L)
- Hyperventilation (H)

**Angina**
- (Rate & Depth)

**Other**
- (Other & Describe)

**Codes**

**Respiratory**

**Heart Sounds**
- Present (P)
- Decreased (D)
- Present / Absent (PA)

**Skin**
- Warm (W)
- Cool (CL)
- Cold (CD)
- Hot (H)
- Diaphoretic (DI)
- Clammy (CA)
- Moist (M)
- Dry (DR)

**Edema**
- None (N)
- Generalized (G)
- Pitting (P)
- Non-Pitting (NP)
- Trace (T)
- 1+ to 4+ Pitting

**Respirations**
- Regular (R)
- Irregular (I)
- Shallow (S)
- Labored (L)
- Hyperventilation (H)

**Angina**
- (Rate & Depth)

**Other**
- (Other & Describe)

**Comments**
**PAIN MANAGEMENT**

**COMFORT GOAL:**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PAIN LOCATION</th>
<th>SEDATION RATING</th>
<th>PAIN RATING</th>
<th>INTERVENTION</th>
<th>INITIALS</th>
<th>EVALUATION TIME/PAIN #</th>
<th>INITIALS</th>
</tr>
</thead>
</table>

**PAIN SCALES:**

**WONG-BAKER:**

<table>
<thead>
<tr>
<th>0-10 VISUAL:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Faces)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Numeric)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VERBAL:**

No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Worst Pain

**NON-COGNITIVE:**

(FLACC Scale)

**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

**PRESSURE SORE RISK ASSESSMENT:**

TO BE COMPLETED EVERY 24 HRS

**SSENTORY PERCEPTION**

<table>
<thead>
<tr>
<th>MOISTURE</th>
<th>ACTIVITY</th>
<th>MOBILITY</th>
<th>NUTRITION</th>
<th>FRICTION &amp; SHEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TOTALLY LIMITED</td>
<td>1. TOTALLY MOIST</td>
<td>1. BEDREST</td>
<td>1. TOTALLY IMMOBILE</td>
<td>1. VERY POOR</td>
</tr>
<tr>
<td>2. VERY LIMITED</td>
<td>2. VERY MOIST</td>
<td>2. CHAIRFAST</td>
<td>2. VERY LIMITED</td>
<td>2. PROBABLY INADEQUATE</td>
</tr>
<tr>
<td>3. SLIGHTLY LIMITED</td>
<td>3. OCCASIONALLY MOIST</td>
<td>3. WALKS OCCASIONALLY</td>
<td>3. SLIGHTLY LIMITED</td>
<td>3. POTENTIAL PROBLEM</td>
</tr>
<tr>
<td>4. NO IMPAIRMENT</td>
<td>4. RARELY MOIST</td>
<td>4. WALKS FREQUENTLY</td>
<td>4. NO LIMITATIONS</td>
<td>4. ADEQUATE</td>
</tr>
<tr>
<td>5 = UNAROUSABLE</td>
<td>5 = UNAROUSABLE</td>
<td>5 = UNAROUSABLE</td>
<td>5 = UNAROUSABLE</td>
<td>5 = UNAROUSABLE</td>
</tr>
</tbody>
</table>

**SCORE:**

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

**PERI-WOUND TISSUE:**

WNL = Within Normal Limits
R = Reddened
D = Darkened
M = Macerated

**DRAINAGE:**

P = Pink / Clean
S = Slough
E = Eschar
O = None
M = Mild
F = Foul

**NA**

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

**TYPE**

(Legend)

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>TYPE</th>
<th>WOUND #</th>
<th>LOCATION</th>
<th>TYPE</th>
<th>WOUND #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SHIFTS:**

(Day of Week)

**LEGEND:**

Venous
Stasis
Pressure
Ulcer
Traumatic

**PART OF THE MEDICAL RECORD**

8850122 Rev. 02/05
Critical Care Flow Sheet_NURSING_CRITICAL CARE