Your Hospital's Logo Here

DATE: ____ / ____ / ____

PATIENT IDENTIFICATION

MEDICAL / SURGICAL NURSING FLOW SHEET

SIGNATURE / TITLE / INITIALS	SIGNATURE / TITLE / INITIALS

INTAKE AND OUTPUT

INTAKE	N	D	E	OUTPUT	N	D	E
IV				Urine			
Oral Liquid				Emesis			
Blood				N/G Tube			
PPN / TPN				Hemovac			
Lipids							
Tube Feeding				Jackson Pratt			
				Chest Tube			
Total 8 Hr.				Total 8H			
Total 24 Hr.				Total 24H			

(MST Completes) DIET

TYPE	TOTAL	> HALF	< HALF
Breakfast			
Lunch			
Dinner			
Supplement Feedings			

ISOLATION: ☐ YES ☐ NO ISOLATION TYPE: ____________

NEGATIVE FLOW MAINTAINED: ☐ YES ☐ NO ☐ N/A ☐ HEPAFILTER

PART OF THE MEDICAL RECORD

USE (√) TO INDICATE PERFORMANCE. USE LARGER SPACE FOR BRIEF COMMENT

	NORMAL		√	N (Init. _______)	√	D (Init. _______)	√	E (Init. _______)
NEUROLOGICAL	Alert, oriented x3,	W / I Normal Limits						
	follows commands,	See Neuro Flow Sheet						
	speech clear and	* Disoriented to:						
	appropriate; motor	* Agitated						
	response; moves	* Lethargic						
	all extremities	* Unresponsive						
		* Restless						
		Speech: None Aphasic						
		Inappropriate						
		Slurred						
		* Motor Deficit / * HOH						
		* Parasthesia / * Impaired Vision						
CARDIOVASCULAR	Heart rhythm regular,	W / I Normal Limits						
	brisk capillary refill,	Abnormal Heart Rate (i.e., Brady, Tachy)						
	no edema, peripheral	Abnormal Heart Rhythm						
	pulses present by	Capillary Refill Time > 3 seconds						
	palpation	Edema Present						
		* Postural Hypotension						
	☐ Graft present	Abnormal Peripheral Pulse						
		Radial		R L		R L		R L
	Location ________	Popliteal						
		Post Tib						
	Bruit: ☐ Y ☐ N	Pedal						
	Thrill: ☐ Y ☐ N	Calf Redness, tenderness, swelling						
		See Neurovascular Assessment Sheet						
PULMONARY	Respirations even,	W / I Normal Limits						
	unlabored; lung	Abnormal Respiratory Rate						
	sounds clear, no	Irregular						
	cough, rate within	Shallow Deep						
	normal limits	Labored						
		Breath Sounds: Diminished Wheeze						
		Absent Rhonchi						
		Crackles						
		Cough: Non-productive						
		Productive						
		Oxygen: Amount / Type						
		Continuous Pulse Oximetry						
		Chest Tube(s) R ___ L ___		Suction Cms Air Leak + / -		Suction Cms Air Leak + / -		Suction Cms Air Leak + / -
		Tracheostomy #						
		Sputum Color:						
		Sputum Consistency:						
G I	Abdomen soft,	W / I Normal Limits						
	non-distended,	Abdomen: Distended						
	nontender, bowel	Tender						
	sounds present	Bowel Sounds: Absent						
	4 quads, no N/V,	Hypoactive						
	diarrhea,	Hyperactive						
	constipation	Nausea Vomiting						
		* Bowel Incontinence						
		Diarrhea						
		Constipation						
		* Colostomy / Ileostomy		☐ COLOS ☐ ILEOS		☐ COLOS ☐ ILEOS		☐ COLOS ☐ ILEOS
		Tubes: GT, NGT, Cantor, Other ________						

*** FALL RISK INDICATORS: If any asterisked item is checked, institute Fall Protocol**

PART OF THE MEDICAL RECORD

USE (√) TO INDICATE PERFORMANCE. USE LARGER SPACE FOR BRIEF COMMENT

	NORMAL		√	N (Init. _______)	√	D (Init. _______)	√	E (Init. _______)
GU	Urine clear,	W / I Normal Limits						
	yellow to amber,	Urine cloudy:						
	No difficulty voiding,	color:						
	No bladder distention	Frequency						
		Burning						
	DIALYSIS DAYS	Dysuria						
	☐ M ☐ TH ☐ SA	* Urinary Incontinence						
	☐ T ☐ F ☐ SU	Foley / Suprapubic / Nephrostomy						
	☐ W	Dialysis						
		Urostomy						
MUSCLOSKEL	Moves all extremities	W / I Normal Limits						
	independently, full /	* Weakness / Location						
	spontaneous ROM;	* Paralysis / Location						
	self care; independent	* Amputation / Type / Location						
	bed mobility, transfers,	* Assistive Device / Type / Prosthesis						
	steady gait; ambulates	Skin Assessment of Immobilized Area						
	without assistive	* Immobilization Device / Type						
	device; absence of	Traction / Type / Location / Wgt						
	joint swelling or tenderness	Joint Pain ____________ Swelling ____________ Erythema						

PAIN MANAGEMENT

COMFORT GOAL:

PAIN RATING SCALE USED:

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

PAIN SCALES:

WONG-BAKER: *(Faces)*	0		1		2		3		4		5
0-10 VISUAL: *(Numeric)*	O	1	2	3	4	5	6	7	8	9	10
VERBAL:	No Hurt		Hurts Little Bit		Hurts Little More		Hurts Even More		Hurts Whole Lot		Worst Pain

NON-COGNITIVE: *Use FLACC Pain 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

PART OF THE MEDICAL RECORD

IV SITE ASSESSMENT

TIME: ☐ N/A	0000		0200		0400		0600		0800		1000		1200		1400		1600		1800		2000		2200	
Initials																								
Venous Access *																								
Location																								
Phlebitis Scale *																								
Dressing Intact (Y/N)																								
Dressing Changes (Y/N)																								
Comment (Progress Note)																								

* PHLEBITIS SCALE CODES

0 = NO PAIN / SWELLING
1 = PAIN AT SITE
2 = PAIN, REDNESS, SWELLING
3 = PAIN, REDNESS, SWELLING (Palpable Cord < 3 inches)
4 = PAIN, REDNESS, SWELLING (Palpable Cord > 3 inches)

VENOUS ACCESS

C = CENTRAL LINE / FEMORAL LINE
P = PERIPHERAL LINE
I = IMPLANTED DEVICE

FALL PREVENTION STANDARD

☐ N/A	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 In Use			
Side Rails Up	☐ X2 ☐ X4	☐ X2 ☐ X4	☐ X2 ☐ X4

PART ONE: RESTRAINT INTERVENTIONS

☐ 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. ☐ Environment change ☐ Reality orientation ☐ Bed alarm
☐ Spend more time with patients ☐ Reduce stimuli ☐ Family / significant other involvement

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 and 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

PART TWO: OBSERVATION FLOWSHEET

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

TIME	0000	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200
Hydration / Nutrition												
Toilet / Comfort												
Skin Checked												
ROM												
Circulation Checked												
LOC / Mental / Emotional Status												
Staff Initials												

Indicate Time(s) Patient OUT OF RESTRAINTS	N:	D:	E:
	N:	D:	E:

PART OF THE MEDICAL RECORD

BRADEN SCORE FOR PREDICTING PRESSURE ULCER RISK: To be Completed every 24 hours					
SENSORY PERCEPTION	**MOISTURE**	**ACTIVITY**	**MOBILITY**	**NUTRITION**	**FRICTION & SHEAR**
1 = Completely limited **2** = Very limited **3** = Slightly limited **4** = No impairment	**1** = Constantly moist **2** = Very moist **3** = Occasionally moist **4** = Rarely moist	**1** = Bedrest **2** = Chairfast **3** = Walks occasionally **4** = Walks often	**1** = Completely **2** = Very limited **3** = Slightly limited **4** = No limitations	**1** = Very poor **2** = Probably inadequate **3** = Adequate **4** = Excellent	**1** = Problem **2** = Potential problem **3** = No apparent problem
SCORE:	SCORE:	SCORE:	SCORE:	SCORE:	SCORE:

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

TOTAL SCORE:
COMPLETED BY:

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

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

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

DRAINAGE
- O = None
- S = Serous
- SG = Sero-sanguineous
- P = Purulent

ODOR
- O = None
- M = Mild
- F = Foul

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

 # NOTE: SIZE IS DOCUMENTED ON ADMISSION & EVERY 7 DAYS (THURSDAYS)

0700 - 1900 ☐ **NA** **Additional Dressing Changes Document in Progress Notes**

(If more then 5 wounds, use Pressure Ulcer Progress Chart Overlay)

LOCATION	WOUND #	WOUND #	WOUND #	WOUND #	WOUND #
TYPE (Venous Stasis, Pressure Ulcer, or Traumatic Wound)					
Stage (Pressure Ulcer ONLY)					
Appearance					
Drainage					
Odor					
Peri-Wound Tissue					
Size - cm (L x W x D)					
Undermining (Y / N)					
Irrigation					
Treatment					
Time / Initials					
Time / Initials					

1900 - 0700 ☐ **NA** **Additional Dressing Changes Document in Progress Notes**

LOCATION	WOUND #	WOUND #	WOUND #	WOUND #	WOUND #
TYPE (Venous Stasis, Pressure Ulcer, or Traumatic Wound)					
Stage (Pressure Ulcer ONLY)					
Appearance					
Drainage					
Odor					
Peri-Wound Tissue					
Size - cm (L x W x D)					
Undermining (Y / N)					
Irrigation					
Treatment					
Time / Initials					
Time / Initials					

PART OF THE MEDICAL RECORD

■ NA POST OPERATIVE WOUND CARE

SITE	N	D	E
Post-Operative Dressing / Incision Assessment			
Post-Operative Wound Drainage Assessment			
Post-Operative Wound Care			
Ice Pack			
Initials			

■ NA TURNING / POSITIONING SCHEDULE

L = Left **R** = Right **B** = Back **CH** = Chair **ST** = Stand **OFF** = OFF Unit **INIT** = Initials

DATE:	0000 INIT	0200 INIT	0400 INIT	0600 INIT	0800 INIT	1000 INIT	1200 INIT	1400 INIT	1600 INIT	1800 INIT	2000 INIT	2200 INIT
POSITION:												

INTERVENTIONS / TREATMENTS

	N	D	E
AM / PM / Care			
Bath (check one): ☐ C ☐ P ☐ S ☐ SH ☐ T			
Peri Care			
Oral Care			
Catheter Care			
Bedrest			
Support Surface			
OOB / Chair			
BRP			
* Ambulated w/ Assist			
Up Ad Lib			
BSC			
Bed Alarm On			
Side Rails Up	☐ X2 ☐ X4	☐ X2 ☐ X4	☐ X2 ☐ X4
Bed Low and Locked			
ROM			
Anti-Embolitic Device / Hose (Remove BID)			
Extremity Skin Assessment			
Trach Care			
Incentive Spirometry			
Suctioning			
Aspiration Precautions			
Seizure Precautions			
Bed Padded			
Airway			
Suction Available			
Visual Observation Q 2 Hrs			
Initials			

PART OF THE MEDICAL RECORD