Today's Date	C.C.day # /	Previous 24H CVVHD Balance	Isolation ☐Yes ☐No Type_____	ID Band On and Name Verified ☐Yes ☐No
Diagnosis		Fluid Restriction ml/24h	Previous ml/24h Intake	Previous ml/24h Output
Date and Type of Surgery/Procedure		Height	Today's Wt	Yesterday Wt	Admission Wt
Physician		Consults		

	TESTS	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CHEM	Na / CL																								
	K																								
	Bun / Creat.																								
	CO_2 / Magnesium																								
	PO_4 / Ca																								
	Glucose enzyll. Ref – 70 - 110 Crit. >60 >500																								
	Insulin - type/amt																								
ENDOC	Stratification Level																								
	Physician Notified																								
	Stratification Model	Level 1: BG > 80 < 150 No action Continue current orders								Level 2: BG < 90 > 150 twice in 24 hr Alert physician for plan adjustment										Level 3: BG < 60 > 300 twice in 24 hr Alert physician for consult					
CBC	HGB / HCT																								
	WBC																								
	PLATELETS																								
	PT / INR																								
	PTT																								
CARDIAC	TROPONIN																								
	MYOGLOBIN																								
	CK-MB / % MB																								
BLOOD GASES ON THERAPY	PH																								
	PCO_2																								
	PAO_2																								
	HCO_3																								
	BE																								
	O_2 SAT																								
	FI O_2 y/a																								
	TV																								
	MODE / RATE																								
	PEEP / P.S.																								
	SPONTANEOUS T.V.																								
Abnormal Results reported to physician																									

IV LINE CARE	Site	Type	Date Inserted	Fluid	C m out	Site Care	Site ✓every 2 hours Pt Protocol AM	PM	Pos/flo / HL Adaptor Changed	Tubing Change Time	Rate Code AM	PM	IJC Site Time

SITE ASSESSMENT RATING CODE

0 patent, no s/s infection
phlebitis or infiltration
1 localized edema
2 tenderness without redness
3 tenderness with redness
4 drainage
N non-patent
*If explanation is needed, place 2 asterisks in appropriate column and document in Notes

CRITICAL CARE FLOW SHEET
UNIVERSITY

Patient Name: _____ MR# _____

Date Time

TEMP
- B-Blood
- R-Rectal
- O-Oral
- Ax-Axillary
- F-Foley

200 180 160 140 120 100 80 60 40

BP mmHg
- ART LINE
- CUFF
- SYSTOLIC
- DIASTOLIC
- IABP

• PULSE

BP CUFF

RESPIRATIONS

SaO_2

SvO_2

HEMODYNAMICS
- PA SYSTOLIC
- PA DIASTOLIC
- PCWP
- SVR
- CO
- CI / SI
- CVP / MAP

Dr. Rounds

INTAKE
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

PO

NG/JT/DHT

OUTPUT
- Chest Output
- Chest Output
- Surgical Drains
- URINE
- NG OUTPUT
- STOOLS
- Misc.

Patient Name: _____ MR# _____

2100 2130 2200 2230 2300 2330 0000 0030 0100 0130 0200 0230 0300 0330 0400 0430 0500 0530

200
180
160
140
120
100
80
60
40

BP
Resp
SaO_2
SVO_2
PAS
PAD
PCWP
SVR
CO
CI
CVP
MAP

Day Nurse | Dr.

1.
2.
3.
4.
5.
6.
7.
8.
9.

PO
N.G.
CTO
CTO
SD
Urine
NGO
Stool
Misc.

IN | OUT

12° DAY

12° NIGHT

24° TOTAL

Night Totals

	Date Time	06	10	12	14	16	18	20	22	24	02	04	0
MOBILITY	Position change (R/L/B)												
	Bed type												
	ROM												
	Heels off bed												
	HOB ↑ / Degree												
	TED's / compression device On-off												
	Ambulate with assist *												
	Skin intact (If not intact, document on Skin/Wound Documentation Record)												
	WOCN referral (for non-healing or worsening wounds or wounds acquired since admission)												
RESPIRATORY	Cough and deep breathe												
	Incentive spirometry volume												
	Trach care												
	ETT tube / tape secure / changed												
	ETT@ ____ cm,												
	Ambu @ bedside												
	Oral care												
NUTRITION	Type of diet / Tube feed												
	% Taken												
	No difficulty swallowing												
	Tube feed residuals												
	Feeding tube verified by x-ray												
SAFETY	SR ↑ X												
	SR entrapment risk assessed												
	SR risk reduction strategies												
	Call bell in reach												
	Nursing rounds every 2 (every 1 hr*)												
	All alarms on, limits set, audible												
FALL PREV	Morse fall scale score												
	Reviewed potential fall risk associated with medication regime												
	Bed low position												
	Bed alert checked and in use												
	Supervise in highly visible area												
	Frequent efforts to reorient												
	Family/Sitter √ S F												

*** Starred items are required for patients on the Fall Prevention Protocol.**

SAFETY/FALL RISK SCREENING MORSE FALL SCALE - 1989

History of Falling
- ☒ No (0)
- ☐ Yes (25)

IV/Lock
- ☐ No (0)
- ☒ Yes (20)

Gait/Transferring
- ☐ Normal/Bedrest/Immobile (0)
- ☒ Weak (10)
- ☐ Impaired (20)

Ambulatory Aid
- ☒ None/BR/WC/Nurse (0)
- ☐ Crutches/Cane/Walker (15)
- ☐ Furniture (30)

Is there a Secondary Diagnosis?
- ☐ No (0)
- ☒ Yes (15)

Mental Status
- ☐ Oriented to own ability (0)
- ☒ Forgets limitations (15)

*Implement Prevention Protocol for score 50 or greater, <5 years old.

Bath	
Linen Changed	
AM Care/ Oral, nares care	/ /
PM Care/ Oral, nares care	/ /

ADDRESSOGRAPH

Initials	Print Name / Title	Initials	Print Name / Title

Initials = Completed * = VIE Note ☐ = N

SKIN RISK	Norton Scale		Physical condition	Mental condition	Activity	Mobility	Incontinent	Total Score	Preventi Protocol Impleme (Score ≤ Note initi
	Shift	Init	Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk//help 3 Chairbound 2 Bed 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasional 3 Usually/urine 2 Doubly 1		
	7A								
	7P								

If score is 14 or less, patient is at risk to develop a pressure ulcer; implement Pressure Ulcer Prevention Protocol.

SURGICAL SITE CARE	Site and Treatment	Wound Color	Drainage Type	Odor	Dressing Changed	Dressing Dry and Intact
	Site#1 _____ Treatment _____					
	Site#2 _____ Treatment _____					
	Site#3 _____ Treatment _____					

Discipline Codes:

N = Nursing		SW = Social Work Services	
MNT = Medical Nutrition Therapy		Rad = Radiology	
PT = Physical Therapy		Card = Cardiology	
OT = Occupational Therapy		Neuro = Neuro diagnostics	
PO = Perioperative		SC = Spiritual Care	
ST = Speech Therapy		PH = Pharmacy	
Rec = Recreational Therapy		CM = Case Manager	
R = Respiratory Therapy			

Note Format:
V=Variation
I=Intervention
E=Evaluation / Outcome

DAILY: Address Each Patient Proble
(All active problems on problem list - docum progress to goals / outcomes identified.)

INTERDISCIPLINARY TEAM PROGRESS NOTES

No adverse effects from medications noted this shift. Monitored medication effectiveness and reviewed patient's perceptions of side effects and efficacy. (Explain variances in VIE note)

7a - 7p: Signature: _____

7p - 7a: Signature: _____

Date and Time	Disc-cipline

Date 03/10/06 Time			07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
NEUROLOGICAL	EYES OPEN	Spontaneously	4																						
		To Speech	3																						
		To Pain	2																						
		None	1																						
	BEST VERBAL RESPONSE	Oriented	5																						
		Confused	4																						
		Inappropriate Words	3																						
		Incomprehensible Sounds	2																						
		None	1																						
	BEST MOTOR RESPONSE	Obeys Commands	6																						
		Localize Pain	5																						
		Withdraws Pain	4																						
		Flexion to Pain	3																						
		Extends to Pain	2																						
		None	1																						
		GCS Total Score*																							
	PUPILS	Right: Size / Reaction																							
		Left: Size / Reaction																							
		LOC																							
	MOTOR ABILITY	Right: Arm / Leg																							
		Left: Arm / Leg																							
	Sedation held for neuro eval.																								
	Train of four																								
	Dial setting																								
CARDIOVASCULAR	HEART SOUNDS	S, S2																							
		Heart Tones:																							
		Rhythm:																							
	SKIN	Skin Temp																							
		Color (Cent/Periph)																							
		EDEMA: Lower Ext.																							
		EDEMA: Upper Ext.																							
		EDEMA: Generalized																							
	PULSES	Radial R/L																							
		Femoral R/L																							
		Post. Tib R/L																							
		Pedal R/L																							
		Femoral Sheath Site assessed per protocol: R / L																							
		Sensation: UE / LE																							
	Allen	Waveform / Circulation																							
	Wires	# Atrial																							
		a Ventricular																							

*** If GSC <5, notify Lifelink 1-800-643-6667**

PUPILS FOR ASSESSMENT

PUPIL SIZES: 2mm, 3mm, 4mm, 5mm, 6mm

PUPIL REACTION
B = brisk
S = sluggish
N = none

LOC
A = alert
L = lethargic
ST = stuporous
C = coma
S = sedated

ABILITY TO MOVE LIMB
0 = no movement
1 = trace or flicker of action
2 = move across bed
3 = lift against gravity
4 = lift against resistance
5 = lift against strong resistance

HEART TONES
D = distant
R = rub
M = murmur
G = gallop

SKIN TEMP
W = warm
CL = cool
CD = cold
H = hot
DI = diaphoretic
CLA = clammy
M = moist
DR = dry

COLOR
F = flushed
N = normal
P = pale
C = cyanotic
J = jaundiced
D = ruddy
R = rash

EDEMA
P = pitting
N = non-pitting
1 = +1
2 = +2
3 = +3
4 = +4

PULSES
A+ = absent
D = doppler
1+ = weak
2+ = normal
3+ = bounding
O = no bruising
BB hemotoma

SENSATION
N = normal
A = absent
T = tingling
NU = numbness

ADDRESSOGRAPH

LETHARGIC = Drowsy but responds to commands
STUPOROUS = Responds only to vigorous and repeated stimulation

Date 03/10/06 Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
RESPIRATORY																							
Respirations																							
BREATH SOUNDS: RUL																							
RML																							
RLL																							
LUL																							
LLL																							
CHEST TUBES: Site:																							
Drain Type:																							
Cm H_2O Suction																							
Air Leak +/-																							
Site:																							
Drain Type:																							
Cm H_2O Suction																							
Air Leak +/-																							
Suction/Hyperoxygenate																							
Amount (Small, Medium, Large)																							
Color																							
GI																							
Abdomen																							
Drains																							
Bowel Sounds/Stomach																							
NG Drainage appearance																							
NG/ Position Verified																							
GU																							
Foley or Voiding																							
Urine (color,clarity)																							
PAIN ASSESSMENT																							
Pain free without intervention																							
Pt / Proxy unable to note or describe pain																							
Non pharm. Intervention used																							
Site 1: Score																							
Type																							
Frequency																							
Site 2: Score																							
Type																							
Frequency																							
Site 3: Score																							
Type																							
Frequency																							

PRN pain med effectiveness documented on PRN MAR

Pain Assessment Frequency:
QS for all patients
More frequently as necessary for:
- Post-op / Post-procedure patients
- Patients who are on pain therapy
- Patients not at desired pain goal

If on PCA / Epidural, see flow sheet for pain data ☐

PAIN ASSESSMENT
Pain Score 0 - 10
0 - none
10 - worst

Pain Type
B = burning
S = sharp
SL = shock Like
Cr = cramping
DO = dull
PR = pressure
O = other (write V/F note)

Pain Frequency
C = constant
I = intermittent

NON PHARMACOLOGIC CODES
1 = TENS
2 = Heat
3 = Cold
4 = Relaxation
5 = Massage
6 = Guided imagery
7 = Distraction
8 = Music
9 = Hypnosis
10 = Position Change
11 = Other _____

CODES FOR ASSESSMENT

Respirations
R = regular
I = irregular
S = shallow
L = labored
V = ventilator

Breath Sounds
C = clear
CR = rhonchi/crackles
Rh = rhonchi
WZ = wheeze
E = expiratory
I = inspiratory
D = decreased
O = absent

Resp. Secretions
Color
Y = yellow
G = green
W = white
T = tan
C = clear
B = bloody

Abdomen
FL = flat
D = distended
L = large
T = tender
S = soft
F = firm
R = rigid

Bowel Sounds
+ = normal
↑ = hypo
↓ = hyper
O = absent

NG Drainage
BL = bloody
CL = clear
B = bile
C = coffee ground

Urine
Y = yellow
A = amber
C = clear
H = hazy
B = bloody

Abbreviations

CRITICAL CARE FLOW SHEET
UNIVERSITY HOSPITAL

34244 (Was UCC170)
459.7 Rev 03/08/05

07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05

MEDICAL RESTRAINTS TREATMENT PLAN

Clinical justification for continued use of restraints (Every 2 hr)	Interference with medical devices, tubes, dressings
	Unsteady gait, attempts to get up without assistance
Type of Restraint (Every 2 hr)	Mitt: R_____L_____
	Soft Wrist: R_____L_____
	Soft Ankle: R_____L_____
	Roll Belt:
	Enclosed Bed
Intervention (Every 2 hr)	Assessed restrained extremities every 2 hours; Warm, palpable pulses and intact skin
	Loosened restraints every 2 hours
	ROM/ repositioned every 2 hours
	Rights, dignity, modesty, visibility to others, comfortable body temp maintained
(Every shift and prn)	Assisted with nourishment
	Provided skin care
Less Restrictive alternatives attempted (Daily)	Close to nurse's station
	Family / Sitter present
	Bed alert
	Diversional activity
	Cover IV sites, PEG, etc
Time Release (Daily)	Results of trial release, including behavior documentation, in VIE note
	Removed
	Reapplied
Restraints Terminated due to	No interference with medical devices, tubes or dressings
	Medical devices, tubes, dressings removed
	Responds to safe limit setting
	Follows verbal commands

☐ Physician order obtained ☐ Family Education Completed

Transfer Discharge Summary **For unmet outcomes, Address on VIE note or discharge sheet.**

CONDITION

Transfer / DC to: Time: Accompanied by:

Reason for transfer / discharge:

Report called to: By:

Transfer / DC VS: See graphic time:

Physical/psychosocial assessment unchanged? ☐Yes ☐No

Progress to outcomes evaluated? ☐Yes ☐No

Pt / family informed of transfer/discharge? ☐Yes ☐No

Physician notified? ☐Yes ☐No

Pt / family understand (reason) for transfer/discharge? ☐Yes ☐No

Skin / Wound Documentation Record complete? ☐Yes ☐No

If discharged, IV line and tele patches removed? ☐Yes ☐No

Initials	Print Name / Title / Shift	Initials	Print Name / Title / Shift	Initials	Print Name / Title / Shift

CRITICAL CARE FLOW SHEET

UNIVERSITY HOSPITAL

ADDRESSOGRAPH