University Medical Center
Respiratory Care Department
Ventilator Flow Sheet

SIGNATURE/CRED	INIT	SIGNATURE/CRED	INIT

DATE																									
TIME																									
INITIALS																									
VENTILATOR SETTINGS	VENTILATOR TYPE																								
	MODE																								
	FIO2																								
	PRESET VE																								
	PRESET BREATHS/MIN																								
	TIDAL VOLUME																								
	SIMV BREATHS/MIN																								
	INSP TIME % / PAUSE TIME %																								
	RISE TIME % / SLOPE TIME (SEC)																								
	INSP / EXP TIME (SEC)																								
	INSP / EXP PRESSURE																								
	FLOW RATE																								
	FLOW PATTERN																								
	PRESSURE CONT / SUPPORT																								
	PEEP / EFFECTIVE PEEP																								
	TERMINATION SENSITIVITY																								
	TRIGGER (FLOW / PRESSURE)																								
	WORKING PRESSURE																								
	ATC (ETT / TRACH)																								
	ATC (TUBE SIZE / % COMP)																								
	HUMIDIFICATION	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20	HME	H20
	EXPIRATORY FILTER (STAR / DISP)																								
ALARMS	UPPER / LOWER VE LIMIT																								
	UPPER / LOWER FIO2 LIMIT																								
	UPPER PRESSURE LIMIT																								
	LOW PRESSURE LIMIT / DELAY																								
	HIGH / LOW RR																								
	LOW PEEP																								
PARAMETERS	BREATHS / MIN																								
	INSPIRATORY VT																								
	EXPIRATORY VT																								
	SPONTANEOUS / PS VT																								
	TOTAL VE																								
	PEAK / PAUSE PRESSURE																								
	MEAN PRESSURE																								
	STATIC COMPLIANCE																								
	AIRWAY RESISTANCE																								
	VITAL CAPACITY / NIF																								
	SPO2 / ETCO2																								
	NO / NO2																								
	TcO2 / TcCO2																								
	TCM TEMPERATURE																								
OTHER	PRE-USE CHECK COMPLETE																								
	CIRCUIT CHANGED																								
	ETT SIZE / PLACEMENT																								
	CUFF PRESSURE																								
	VENT ORDERS VERIFIED																								

COMMENTS

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Respiratory Care Department
Ventilator Flow Sheet

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	CIRCUIT CHANGED																						
	ETT SIZE / PLACEMENT																						
	CUFF PRESSURE																						
	VENT ORDERS VERIFIED																						

COMMENTS

INTAKE (CONT.)	07	08	09	10	11	12	13	14	8 HR TOTAL	15	16	17	18	19	20	21	22	8 HR TOTAL	23	24	01	02	03	04	05	06	8 HR TOTAL	24 HR TOTAL
~~Finger Stick Glucose~~																												
Reference Range: 70-110 mg/dL																												
PO/ENTERAL																												
INTAKE TOTALS YESTERDAY 24 HR TOTAL								8*											16*									

OUTPUT	07	08	09	10	11	12	13	14	8 HR TOTAL	15	16	17	18	19	20	21	22	8 HR TOTAL	23	24	01	02	03	04	05	06	8 HR TOTAL	
METHOD																												
~~GG/NG TUBE~~																												
CHEST TUBE DRAINAGE																												
STOOL/LAST BM_____																												
OUTPUT TOTALS YESTERDAY 24 HR TOTAL								8*																		8*		24*
I & O BALANCE YESTERDAY + OR - WET								8*		RUNNING I & O																8*		

PATIENT NAME: _____

MED. RECORD NO.: _____

DATE: _____

PATIENT NAME: _____ MED. RECORD NO.: _____

CODE FOR NURSING OBSERVATIONS

CARDIAC RHYTHM
- NSR -NORMAL SINUS
- ST -SINUS TACHYCARDIA
- SB -SINUS BRADYCARDIA
- PAC'S -PREMATURE ATRIAL CONTRACTIONS
- SVT -SUPRAVENTRICULAR TACHYCARDIA
- AF -ATRIAL FIBRILLATION
- PVC'S -PREMATURE VENTRICULAR CONTRACTIONS
- VT -VENTRICULAR TACHYCARDIA
- VF -VENTRICULAR FIBRILLATION
- B -BIGEMINY
- HB -HEARTBLOCK
- CA -CARDIAC ARREST
- PM -PACEMAKER

HEART SOUNDS
- N -NORMAL
- Ss,Sd
- M -MURMUR
- R -RUB

SKIN
- W -WARM
- D -DRY
- M -MOIST
- R -RUBOR
- C -CYANOSIS
- P -PALLOR
- M -MOTTLING
- J -JAUNDICE
- K -COOL

CRT:
- < 2 SECONDS (NORMAL)
- > 2 SECONDS

PULSES
(SCALE 0 TO 4+, WHERE 3+ IS NORMAL)

EDEMA
- A -ABSENT
- 1+
- 2+
- 3+

RESPIRATION
- N -NORMAL
- L -LABORED
- CS -CHEYNE-STOKES
- A -APNEA
- PV -PARALYZED ON VENTILATOR
- V -VENTILATOR

CHEST EXPANSION
- R > L
- L > R
- EQUAL

BREATH SOUNDS
- N -NORMAL
- W -WHEEZING
- R -RALES
- RH -RHONCHI
- D -DISTANT
- A -ABSENT
- C -COARSE (NOTE R/L BELOW)
- RU -RIGHT UPPER
- RM -RIGHT MIDDLE
- RL -RIGHT LOWER
- LU -LEFT UPPER
- LL -LEFT LOWER
- B -BILATERAL

MEDICATIONS
- S -SEDATION/TRANQUILIZER
- PL -PARALYTIC
- P -PAIN

SPUTUM
- N -NONE
- S -SMALL
- M -MODERATE
- C -COPIOUS
- T -THIN
- TH -THICK
- F -FOUL
- BT -BLOOD-TINGED
- Y -YELLOW
- W -WHITE

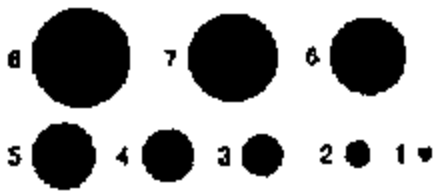
STIMULUS
- 4 -VOICE
- 3 -SHAKE OR SHOUT
- 2 -PERIPHERAL PAIN
- 1 -DEEP PAIN
- 0 -UNRESPONSIVE

ORIENTATION
- 3 -TIME, PLACE, PERSON
- 2 -2 OF THE 3
- 1 -1 OF THE 3
- O -DISORIENTED
- U -UNTESTABLE

PUPIL SHAPE
- R -ROUND
- O -OVAL
- I -IRREGULAR
- U -UNTESTABLE

PUPIL REACTION, CORNEAL, REFLEX AND FACIAL GRIMACE
- 3 -NORMAL
- 2 -DECREASED OR ABNORMAL
- 1 -ABSENT
- U -UNTESTABLE

PUPIL SIZE



EYE OPENING
- 4 -SPONTANEOUSLY
- 3 -TO SPEECH
- 2 -TO PAIN
- 1 -NONE/UNTESTABLE

VERBAL RESPONSE
- 5 -ORIENTED
- 4 -CONFUSED
- 3 -INAPPROPRIATE (WORDS)
- 2 -INCOMPREHENSIBLE (SOUNDS)
- 1 -NONE/UNTESTABLE
- T -INTUBATED

BEST MOTOR RESPONSE
- 6 -OBEYS
- 5 -LOCALIZES
- 4 -WITHDRAWS
- 3 -FLEXES
- 2 -EXTENDS
- 1 -NONE/UNTESTABLE

STRENGTH (R/L)*
- 5 -STRONG
- 4 -MILD WEAKNESS
- 3 -MODERATE WEAKNESS
- 2 -SEVERE WEAKNESS
- 1 -TRACE
- 0 -NONE
- U -UNTESTABLE

CRITERIA FOR RESTRAINTS
- C&D -CONFUSED & DISORIENTED, UNSAFE
- AG -AGITATED, HOSTILE, ABUSIVE
- LOC -LOW LEVEL OF CONSCIOUSNESS
- REM -UNABLE TO REMEMBER INSTRUCTION
- ALT -ALTERNATIVE STRATEGIES UNSUCCESSFUL
- AGE -AGE/DEVELOPMENTAL STAGE
- GRB -GRABS OR PULLS AT OSG OR TUBES

TYPE OF RESTRAINT
- VC -VEST/CHEST
- BW -BELT/WAIST
- WA -WRAP AROUND
- MR -MITTS R
- ML -MITTS L
- MB -MITTS BOTH
- SR -SIDE RAILS
- ANKR -ANKLE R
- ANKL -ANKLE L
- ANKB -ANKLE BOTH
- WR -WRIST R
- WL -WRIST L
- WB -WRIST BOTH

PATIENT BEHAVIOR
- A -ASLEEP
- B -DROWSY
- C -CONFUSED
- D -AGITATED
- E -FREQUENT REDIRECT/REMIND
- F -FOLLOWS DIRECTIONS FOR SHORT TIME
- G -ALERT, DISORIENTED
- H -ALERT AND ORIENTED
- I -CALM AND COOPERATIVE
- J -OTHER (DESCRIBE)

INTERVENTION
- 1 -OUT OF BED TO CHAIR
- 2 -REORIENTATION
- 3 -FAMILY VISIT
- 4 -WOUND/TUBE DISGUISE
- 5 -ACTIVITY/DISTRACTION
- 6 -REDIRECT
- 7 -ADJUST ENVIRONMENT
- 8 -OTHER/REFER TO NOTES

BOWEL SOUNDS
- A -ABSENT
- N -NORMAL
- HYPO -HYPOACTIVE
- HYPER -HYPERACTIVE

ABDOMEN
- F -FLAT
- D -DISTENDED
- T -TENDER
- FR -FORM
- S -SOFT

BRADEN SCALE

SENSORY PERCEPTION
- 1 -COMPLETELY LIMITED
- 2 -VERY LIMITED
- 3 -SLIGHTLY LIMITED
- 4 -NO IMPAIRMENT

MOISTURE
- 1 -CONSTANTLY MOIST
- 2 -MOIST
- 3 -OCCASIONALLY MOIST
- 4 -RARELY MOIST

ACTIVITY
- 1 -BEDFAST
- 2 -CHAIRFAST
- 3 -WALKS OCCASIONALLY
- 4 -WALKS FREQUENTLY

MOBILITY
- 1 -COMPLETELY IMMOBILE
- 2 -VERY LIMITED
- 3 -SLIGHTLY LIMITED
- 4 -NO LIMITATIONS

NUTRITION
- 1 -VERY POOR
- 2 -PROBABLY INADEQUATE
- 3 -ADEQUATE
- 4 -EXCELLENT

FRICTION AND SHEAR
- 1 -PROBLEM
- 2 -POTENTIAL PROBLEM
- 3 -NO APPARENT PROBLEM

* RECORD STRENGTH IF MOTOR RESPONSE 4 OR GREATER
N/A - NOT APPLICABLE

LABEL DISCOLORATIONS, PRESSURE AREAS (STAGE AND SIZE), CASTS, SPLINTS, APPLIANCES, INCISIONS, TUBES *(LABEL ON DIAGRAM)*

SITE/DATE INSERTED
PERIPHERAL IV

_____

_____

A-LINE _____

CVP _____

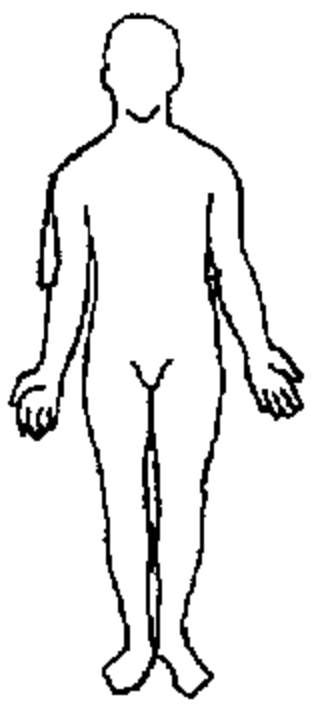
Pa LINE _____

OTHER _____

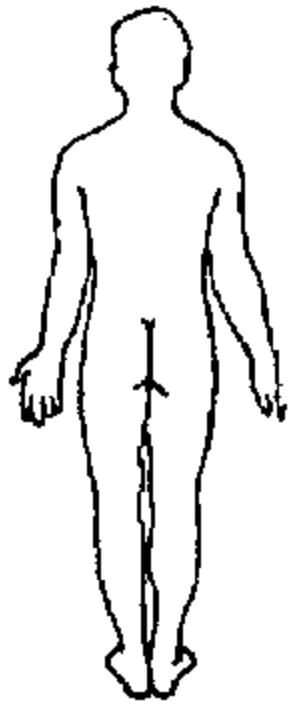
_____

ICP MONITOR

_____



FRONT



BACK

PATIENT NAME: _____ MED. RECORD NO.: _____ DATE: _____

NURSING OBSERVATIONS

	TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CARDIOVASCULAR																									
	CARDIAC RHYTHM																								
	HEART SOUNDS																								
	SKIN																								
	CRT'S																								
	PULSES UE R/L																								
	LE R/L																								
	EDEMA																								
RESPIRATORY																									
	RESPIRATION																								
	CHEST EXPANSION																								
	BREATH SOUNDS RIGHT																								
	BREATH SOUNDS LEFT																								
	SPUTUM CHARACTER																								
	CHEST TUBE DRAINAGE / AIR LEAK																								
NEUROLOGICAL CHECKS q ___																									
	MEDICATIONS																								
	TRAIN OF FOUR																								
	STIMULUS																								
	ORIENTATION																								
	PUPIL SIZE R/L																								
	PUPIL SHAPE R/L																								
	PUPIL REACTION R/L																								
	CORNEALS/BLINK R/L																								
	FACIAL GRIMACE R/L																								
	EYE OPENING																								
	VERBAL RESPONSE																								
	BEST MOTOR RESPONSE																								
	GLASGOW COMA SCALE SCORE																								
	* STRENGTH ARMS R/L																								
	* STRENGTH LEGS R/L																								
	MODE OF SPINAL STABILIZATION																								
	C-SPINE STATUS																								
	SENSATION																								
	SEE SCI FLOWSHEET YES ____ NO ____																								
	OTORRHEA/RHINORRHEA																								
	IVC/LUMBAR DRAINAGE CHARACTER																								
	NUCHEAL RIGIDITY																								
RESTRAINTS	CRITERIA FOR RESTRAINTS / CONTINUED USE																								
	TYPE OF RESTRAINT																								
	PATIENT BEHAVIOR CODE																								
	INTERVENTION CODE																								
	Q 2 Hr CIRCULATION / RESPIRATION																								
	Q 2 Hr REALIGN PATIENT OR RESTRAINTS																								
	Q 2 Hr ✓ SKIN INTEGRITY / OBSERVATION																								
	✓ ROM / RESTRAINT RELEASE PRN																								
	✓ FOOD / FLUID / TOILETING PRN																								

PATIENT NAME: _____ MED. RECORD NO.: _____ DATE: _____

PSYCHOSOCIAL				
	MEMORY			
	JUDGEMENT			
	COMPREHENSION			
	COMMUNICATION			
	MOOD/AFFECT			
	PAIN			
	RANCHOS LOS AMIGOS SCALE			
GI				
	ABDOMEN			
	BOWEL SOUNDS			
	STOOL/FLATUS			
	DRAINAGE CHARACTER			
	DIET TOLERANCE			
	ABDOMINAL GIRTH / PRESSURE			
GU				
	URINE CHARACTER			
SKIN / ORTHO				
	IV SITE CONDITION:			
	WOUND DESCRIPTION:			
BRADEN SCALE	SENSORY PERCEPTION			
	MOISTURE			
	ACTIVITY			
	MOBILITY			
	NUTRITION			
	FRICTION SHEAR			
	BRADEN SCALE SCORE			
	SKIN BREAKDOWN PREVENTION MEASURES			
	TRACTION			
	PIN SITES			
	CALF / THIGH GIRTHS	CALF R _____ L _____ THIGH R _____ L _____		CALF R _____ L _____ THIGH R _____ L _____

PATIENT NAME: _____ MED. RECORD NO.: _____ DATE: _____

CARE DOCUMENTATION

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
HEAD OF BED ELEVATION																								
TURN (DIRECTION)																								
SKIN CARE (AREA)																								
BATH/SHAMPOO																								
NG IRRIGATIONS																								
MOUTH CARE & EYE CARE																								
TRACH CARE																								
FOLEY & PERI CARE																								
LINE CHANGE (SITE)																								
IV DRESSING (SITE)																								
IV TUBING CHANGE (SITE)																								
DRESSING CHANGE:																								
DRESSING CHANGE:																								
CDB/S																								
SUCTION																								
CPT (SITE) Tberg YES/NO																								
CULTURES (WHICH)																								
LAB STUDIES STABLE ☐ UNSTABLE ☐ (WHICH)																								
LAB GOALS:																								
THERAPEUTIC DRUG LEVELS (WHICH)																								
FEVER PACK																								
CV COMPUTE q _____																								
✓ PATIENT ID / ALLERGY/ISOLATION BAND(S) ON																								
✓ PATIENT / FAMILY CARE PLAN																								
D/C TEACHING (DOCUMENT PT/FAMILY ED. SUMMARY)																								
DATA BASE COMPLETED/ADV. DIRECTIVES COMPLETE																								
✓ EMERGENCY EQUIP qs																								
PNEUMATIC COMPRESSION DEVICES																								
✓ IMPACTION q _____																								
ROM																								
PIN CARE q 12°																								
HBO / WHIRLPOOL																								
FAMILY CALLS/VISITS																								
DIAGNOSTIC STUDIES (TYPE)																								
INTERVENTIONS (TYPE)																								

PCT / SHIFT TIME	PCT / SHIFT TIME	PCT / SHIFT TIME
NURSE'S SIGNATURE / SHIFT TIME	NURSE'S SIGNATURE / SHIFT TIME	NURSE'S SIGNATURE / SHIFT TIME

MEDICATIONS - AMOUNT - ROUTE - FREQUENCY • DVT PROPHYLAXIS YES ☐ N/A ☐ • GI PROPHYLAXIS YES ☐ N/A ☐ • BOWEL REGIMEN YES ☐ N/A ☐

PATIENT NAME:

MED. RECORD NO.:

DATE:

NURSING PROGRESS NOTES

TIME	

TIME	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22		23	24	01	02	03	04	05	06	
SEDATION SCORE GOAL RASS _____	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	

RASS -5 Unarousable -4 Deep Sedation -3 Moderate Sedation -2 Light Sedation -1 Drowsy 0 Alert & Calm +1 Restless +2 Agitated +3 Very Agitated +4 Combative

PAIN SCORE (0-10)	/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/		/	/	/	/	/	/	/	/	

CONSULTS		ET NURSE		D/C PLANNING	
PT		SUBSTANCE ABUSE		ID	
OT		PASTORAL CARE		APMS	
SPEECH		SOCIAL WORK		NUTRITION	

PATIENT CARE TECHNICIAN SIGNATURE / SHIFT TIME

NURSE'S SIGNATURE / SHIFT TIME | NURSE'S SIGNATURE / SHIFT TIME | NURSE'S SIGNATURE / SHIFT TIME | COMPLETED BY