UNIVERSITY MEDICAL CENTER

SICU FLOW SHEET

DATE

Dx

OR

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

VITAL SIGNS																HEMODYNAMICS									
Hourly Times	Blood Pressure Key D - Doppler A - A-Line C - Cuff				MAP	ICP / CPP	Apical Rate				Rhythm	Respirations	Temp.	Pain Intensity Scale	Sedation Scale	SPO_2	$ETCO_2$	PAS / PAD	PCWP	CVP	C.O. / C.I.	SVR / SVRI	LVSWI / RVSWI	SVO_2 / O_2ER	DO2I / VO2I
	00	15	30	45			00	15	30	45															
7A																									
8A																									
9A																									
10A																									
11A																									
12N																									
1P																									
2P																									
3P																									
4P																									
5P																									
6P																									
7P																									
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11P																									
12M																									
1A																									
2A																									
3A																									
4A																									
5A																									
6A																									

Signature: _____ Shift: _____ Signature: _____ Shift: _____

Date _____

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RAMSEY SCALE FOR SEDATION

AWAKE LEVELS:

Level 1 Patient anxious and agitated or restless or both

Level 2 Patient cooperative, oriented and tranquil

Level 3 Patient responds to commands only

ASLEEP LEVELS:

Level 4 Patient asleep but responds briskly to light, glabellar tap or loud auditory stimulus

Level 5 Patient asleep with sluggish response to light, glabellar tap or loud auditory stimulus

Level 6 Patient asleep with no response to stimuli

VASCULAR KEY:

P - Palpable

S - Doppler Signal

A - Absent

PULSE QUALITY:

F - Full

D - Diminished

A - Absent

I/O Balance

Yesterday _____

Today _____

Weight: Pre-Op _____ Today _____

Yesterday _____

BSA _____

TITRATED INFUSIONS

00/15	30/45	00/15	30/45	00/15	30/45	00/15	30/45	00/15	30/45	00/15	30/45

PERIPHERAL VASCULAR

Dorsalis Pedis		Posterior Tibial		Radial		Femoral / Popliteal
L	R	L	R	L	R	

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Hendrich Fall Risk Model - Assessment Tool

Score ≥3 Requires Fall Prevention Identification

Risk Factors	Points	Day	Eve.	Nights
Recent History of Falls PT eval/screen	+7	+7	+7	
Depression	+4	+4	+4	
Altered Elimination	+3	+3	+3	
Confusion/Disorientation	+3	+3	+3	

Risk Factors (contd)	Points	Day	Eve.	Nights
Dizziness/Vertigo PT eval/screen	+3	+3	+3	
Poor Judgement	+3	+3	+3	
Poor Mobility/Generalized Weakness	+2	+2	+2	
TOTAL INITIAL RISK SCORE				

KEY	
0 - 2	Normal/Low Risk
3 - 6	Level 1/High Risk
More than 6 PT eval/screen	Level 2/Extremely High Risk

Hourly Times	INTAKE						Blood Products					OUTPUT							
								FFP	PRBC	IV Meds and Cardiac Output	Total Intake	Urine	BM	NG / Residual	Chest Tube				Total Output
7A																			
8A																			
9A																			
10A																			
11A																			
12N																			
1P																			
2P																			
3P																			
4P																			
5P																			
6P																			
12 Hour Totals																			
7P																			
8P																			
9P																			
10P																			
11P																			
12M																			
1A																			
2A																			
3A																			
4A																			
5A																			
6A																			
12 Hour Totals																			
24 Hour Totals																			

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RESPIRATORY DATA

Time	Mode	Rate	Tidal Volume	PEEP	Pressure Support	FiO_2		Time	ARTERIAL BLOOD GASES							
									pH	PCO_2	PO_2	O_2 Sat	HCO_3	Be or BD		

X-RAYS AND PROCEDURES

Time	

LABORATORY DATA

Time	WBC	Hgb	Hct	Plat	PT	INR	PTT	Fib	FSP	BUN	Creat	Na	K	Cl	CO_2	BS

Time	Ca	Mg	PO_4	Amylase	Lipase	Lactate	Osm	Dilantin	Digoxin	CK	CKMB	Troponin	Transferrin	Albumin

BLOOD GLUCOSE MONITORING

Time																
BS																
DOSE																

	Dose Time	Time Drawn	Peak Level	Time Drawn	Trough Level	Time Drawn	Random Level
Vanco							
Gent							
Tobra							

Date _____

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	INITIAL SHIFT ASSESSMENT				SHIFT:
SAFETY		❑ Patient ID Bracelet On	❑ Isolation		
NEUROLOGICAL	LOC/ORIENTATION				
	GAG/SWALLOW/COUGH				
	NEURO DRAINS				
RESPIRATORY	OXYGEN DELIVERY				
		❑ Pulse Oximeter On / Low Alarm Limit Set At ( )			
	CHARACTER OF RESP.				
	BREATH SOUNDS				
	CHEST TUBES	Airleak:		Site:	
		Suction:		Drainage:	
	SECRETIONS				
CARDIOVASCULAR	IV LINES - TYPE	Swan-Ganz /Date		A-Line/Date	
	LOCATION				
	REDNESS/SWELLING?				
	WAVEFORM				DATE
	DRESSING				
	IV LINES - TYPE	TLC DATE	PICC DATE	PIV DATE	PIV DATE / SHILEY
	LOCATION				
	REDNESS/SWELLING?				
	DRESSING				
	EKG				
	CARDIAC INFUSIONS				
	CARDIAC MONITOR	❑ Alarms On / Limits Set At (/)			
	BLOOD PRESSURE	❑ Alarms On / Limits Set At (/)			
GI	BOWEL SOUNDS				
	CHARACTER OF ABD				
	NGT/KEOFEED				
	JT/GT				
	TUBES				
	NUTRITION				
GU	URINATION	Void ____ Foley ____ Date Inserted _____			
	COLOR/CLARITY				
SKIN	TEMP/TURGOR				
	COLOR/EDEMA				
	SKIN INTEGRITY				
	THERAPEUTIC BED				
	DRESSING/INCISIONS				
	TEDS/VENODYNES				

INITIAL PAIN ASSESSMENT

LOCATION OF PAIN: Mark site with letter A or B if more than one site

PAIN SITE:

Location of Pain _____

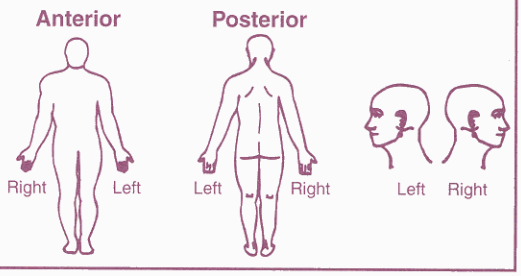
Appearance of Pain Site _____

Pain Intensity _____

Worst Pain Felt (Intensity Score) _____

Least Pain Felt (Intensity Score) _____

Qualities (ache, dull, burn, sharp, etc.) _____



Signature: _____ Shift: _____

Date _____

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INITIAL SHIFT ASSESSMENT SHIFT:	INITIAL SHIFT ASSESSMENT SHIFT:
❑ Patient ID Bracelet On ❑ Isolation	❑ Patient ID Bracelet On ❑ Isolation
❑ Pulse Oximeter On / Low Alarm Limit Set At ( )	❑ Pulse Oximeter On / Low Alarm Limit Set At ( )
Airleak: Site:	Airleak: Site:
Suction: Drainage:	Suction: Drainage:

A-Line/Date	Swan-Ganz /Date	A-Line/Date	Swan-Ganz /Date

TLC DATE	PICC DATE	PIV DATE	PIV DATE	SHILEY DATE	TLC DATE	PICC DATE	PIV DATE	PIV DATE	SHILEY DATE

❑ Alarms On / Limits Set At (/)	❑ Alarms On / Limits Set At (/)
❑ Alarms On / Limits Set At (/)	❑ Alarms On / Limits Set At (/)
Void ____ Foley ____ Date Inserted _____	Void ____ Foley ____ Date Inserted _____

ONSET/DURATION:

When did your pain begin? _____

How long is the pain episode? _____

Is it constant or does it come and go? _____ Does the pain radiate? If yes, where _____

What relieves the pain? (Include medications that relieved pain in past) _____

What causes or increases the pain? _____

What accompanies the pain? (dizziness, nausea, anxiety, etc.) _____

Signature: _____ Shift: _____ Signature: _____ Shift: _____

Date _____

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NEUROLOGIC DATA

GLASGOW COMA SCALE (GCS)

B - BRISK S- SLUGGISH F - FIXED

Pupil Size (mm)

9 8 7 6 5 4 3 2mm

MOTOR FUNCTION

MOTOR STRENGTH:
+ - Strong
O - Weak
A - Absent

MUSCLE TONE:
N - Normal
F - Flaccid
R - Rigid

EYES OPEN
4 Spontaneously
3 To Sound
2 To Pain
1 No Response

BEST VERBAL RESPONSE
5 Oriented
4 Disoriented
3 Inappropriate Words
2 Incomprehensible Sounds
1 No Response

BEST MOTOR RESPONSE
6 Obeys Commands
5 Localizes pain
4 Withdraws to Pain
3 Abnormal Flexion (Decorticate)
2 Abnormal Extension (Decerebrate)
1 No Response

NEURO MUSCULAR BLOCKADE

Evaluating response to TOF Stimulation during maintenance phase in the ICU patient receiving continuous neuromuscular blockade.

Response	Cause	Intervention
TOF = 0	Overparalysis	Decrease dose of neuromuscular blocker or consider holding drug temporarily
TOF = 1 or 2	Adequate level of neuromuscular blockade	None
TOF = 3 or 4	Inadequate or absent neuromuscular blockade	Increase dose of neuromuscular blocker if continued paralytic therapy is desired

Hourly Times	NEUROLOGICAL DATA						MOTOR FUNCTIONS				NEURO MUSCULAR BLOCKADE	
	PUPILS		COMA SCALE				STRENGTH/TONE					
	LEFT SIZE / REACT	RIGHT SIZE / REACT	EYES OPEN	BEST VERBAL RESPONSE	BEST MOTOR RESPONSE	GCS TOTAL	LUE	RUE	LLE	RLE	TOF	INTERVENTION
7A												
8A												
9A												
10A												
11A												
12N												
1P												
2P												
3P												
4P												
5P												
6P												
7P												
8P												
9P												
10P												
11P												
12M												
1A												
2A												
3A												
4A												
5A												
6A												

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Daily Protocol Log

Protocols (check and initial all that apply):			
Shift:	D	E	N
❑ Cardiac Catherization Mgmt.			
❑ Confused Patient Management			
❑ End of Life			
❑ Falls / Injury Prevention			
❑ Generic Diabetes:			
❑ DKA			
❑ Hypoglycemia			
❑ Insulin Infusion			
❑ Insulin Pump (CSII)			
❑ Intravenous Admin. 50% Dextrose			
❑ Genitourinary Management:			
❑ Ileal Conduit Urostomy Mgmt.			
❑ GI Tube Management			
❑ Hygiene Comfort			
❑ Intravenous Therapy Mgmt.: Protocol (Peripheral)			
❑ Central Line Venous Access Device			
❑ Intravenous Therapy Mgmt. (Peripheral)			

Protocols (check and initial all that apply):			
Shift:	D	E	N
❑ Pain Management			
❑ Respiratory Management:			
❑ Chest Tube Management			
❑ Extubation			
❑ Oxygen Management			
❑ Tracheostomy Tube Mgmt.			
❑ Skin and Wound Mgmt.:			
❑ Pressure Ulcer Mgmt.			
❑ Pressure Ulcer Prevention			
❑ Skin Mgmt. for Incontinent Patients			
❑			
❑			
❑			
❑			
❑			
❑			
❑			

SIGNATURES

SIGNATURE	STATUS	INITIALS	SHIFT	SIGNATURE	STATUS	INITIALS	SHIFT