PATIENT CARE RECORD

0700 - 1900
INITIAL / SIGNATURE
PRIMARY NURSE

TIME _____ TO _____
INITIAL / SIGNATURE

TIME _____ TO _____
INITIAL / SIGNATURE

1900 - 0700
INITIAL / SIGNATURE
PRIMARY NURSE

TIME _____ TO _____
INITIAL / SIGNATURE

TIME _____ TO _____
INITIAL / SIGNATURE

KEY	ASSESSMENTS & INTERVENTIONS		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
C - CLEAR / CR - CRACKLES W - WHEEZING / A - ABSENT R - RHONCHI / D - DIMINISHED	BREATH SOUNDS RIGHT UPPER / LOWER	OXYGENATION																									
	LEFT UPPER / LOWER																										
NC - NASAL CANNULA / R - REBREATHER TC - TRACH COLLAR / M - MASK O - OTHER	O2 LITERS / VIA																										
L - LABORED / R - REGULAR U - UNLABORED / I - IRREGULAR	RESPIRATORY PATTERN / RHYTHM																										
P - PRODUCTIVE / A - ABSENT NP - NON-PRODUCTIVE / S - SUCTION	COUGH																										
C - CLEAR / Y - YELLOW / S - SCANT W - WHITE / G - GREEN / M - MODERATE T - TAN / B - BLOODY / C - COPIOUS	SPUTUM COLOR / AMOUNT																										
VOLUME / + INDICATES DONE	INCENTIVE SPIRO / DEEP BREATH																										
W - WARM / D - DRY C - COOL / C - CLAMMY DP - DIAPHORETIC	SKIN TEMP. / SKIN RESPONSE																										
P - PINK / M - MOTTLED PA - PALE / J - JAUNDICED / > 3 SECOND C - CYANOTIC / BL - BLACK / < 3 SECOND	SKIN COLOR / CAPILLARY REFILL																										
R - REGULAR I - IRREGULAR	HEART RHYTHM																										
C - ABSENT DOP - DISCERNABLE ONLY WITH DOPPLER W - WEAK S - STRONG F - SEE NEURO-VASCULAR FLOW SHEET	PERIPHERAL PULSES RADIALS: R / L																										
	DORSALIS PEDIS: R / L																										
+ INDICATES IN PLACE	ANTI EMBOLIC DEVICE TYPE_____																										
C - CARDIAC MONITOR ON																											
#1 _____ #2 _____	PAIN LOCATION	SENSATION																									
0 ----------10 NO PAIN / WORST IMAGINABLE	PAIN LEVEL																										
S - SHARP / C - CONSTANT D - DULL / B - BURNING R - RADIATING / I - INTERMITTENT	CHARACTER																										
M - MEDICATE / P - PROPHYLACTIC CM - COMFORT MEASURE / O - OTHER PCA -	INTERVENTION																										

KEY ASSESSMENTS

MEASURE PCA -

KEY	ASSESSMENTS & INTERVENTIONS		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
C - CONDOM CATH SP - SUPRAPUBIC CATH STC - STRAIGHT CATH V - VOIDING F - FOLEY I - INCONTINENT OS - OSTOMY	URINE	ELIMINATION																									
Y - YELLOW A - AMBER CT - CLOTS CD - CLOUDY C - CLEAR O - OTHER	URINE COLOR																										
S - SOFT F - FIRM D - DISTENDED	ABDOMEN																										
P - PRESENT A - ABSENT HO - HYPOACTIVE N - NORMAL HE - HYPERACTIVE	FLATUS / BOWEL SOUNDS																										
F - FORMED L - LIQUID S - SOFT I - INCONTINENT OS - OSTOMY	BOWEL MOVEMENT / LAST BM _____																										
M - MUCUS B - BLACK BR - BROWN Y - YELLOW G - GREEN BL - BLOODY	COLOR																										
S - SMALL M - MODERATE L - LARGE SC - SCANT	STOOL AMOUNT																										
I - INTACT O - OTHER. SEE SKIN ASSESSMENT	SKIN INTEGRITY	SKIN & TISSUE INTEGRITY																									
D & I - DSG DRY & INTACT A - APPROXIMATED ST - STAPLES / SUTURES T - TRANSPARENT DSG P - PRESSURE DSG SS - STERI-STRIPS PI - PINK S - SEROUS R - REDDENED B - BLOODY PU - PURULENT △ - DSG - △'d	INCISION SITE_____																										
	INCISION SITE_____																										
A - ABSENCE OF PROBLEMS P - PRESENCE OF, SEE IV THERAPY	IV #1 SITE _____ IV #2 SITE _____																										
AD - UP AD LIB BR - BEDREST C - CHAIR R - ROM BSC AR - AMB RM AH - AMB HAL BRP S - STEADY U - UNSTEADY	ACTIVITY / GAIT	ACTIVITY AND REST																									
T - TOLERATES WELL SOB - SHORT OF BREATH D - DIZZY △VS - CHANGE IN VITAL SIGNS O - OTHER	RESPONSE TO ACTIVITY																										
W - WALKER C - CANE CR - CRUTCHES WC - WHEELCHAIR T - TRAPEZE O - OTHER	ASSISTIVE DEVICES / # ASSIST NEEDED																										
S - SITTER	ADDITIONAL INTERVENTIONS																										
+ FEELS RESTED - DOES NOT FEEL RESTED M - MEDICATED CM - COMFORT MEASURE O - OTHER	STATES FEELS RESTED / INTER-VENTIONS																										
B - BACK R - RIGHT SIDE L - LEFT SIDE I - INDEPENDENT	POSITIONING																										
S - SELF A - ASSIST D - DEPENDENT B - BACK M - MOUTH P - PERICARE T - TOTAL SH - SHOWER BA - BATH F - FOOT	HYGIENE / PERSONAL CARE																										
DESTINATION # B - BED WC - WHEELCHAIR G - GURNEY	TRANSPORT / VIA																										
VP - VENIPUNCTURE A - ARTERIAL STICK F - FINGERSTICK # OF STICKS	LAB																										
+ - TOLERATED WELL - - DIDN'T TOLERATE WELL N - NO SPECIMEN OBTAINED INITIALS																											

KEY	ASSESSMENTS & INTERVENTIONS		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
FL - FULL LIQUID CL - CLEAR LIQUID S - SOLID / TYPE TF - TUBE FEEDING PER _____ NPO	DIET TYPE / % TAKEN	NU																									

KEY	ASSESSMENTS & INTERVENTIONS		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
FL - FULL LIQUID CL - CLEAR LIQUID S - SOLID / TYPE TF - TUBE FEEDING PER _____ NPO	DIET TYPE / % TAKEN	NUTRITION																									
P - PRESENT A - ABSENT	NAUSEA / VOMITING	NUTRITION																									
M - MEDICATE CM - COMFORT MEASURE P - PROPHYLACTIC O - OTHER	INTERVENTIONS	NUTRITION																									
		NUTRITION																									
A - ABSENT RUE RLE LUE LLE G - GENERALIZED P - PERIORBITAL S - SACRAL	EDEMA / (1+2+3+4+)	FLUID & ELECTROLYTES																									
I - INTACT M - MOIST P - PINK D - DRY C - CRACKED	MUCOUS MEMBRANES	FLUID & ELECTROLYTES																									
P - PATIENT CL - CLAMPED IS - INTERMITTENT SUCTION C - CONTINUOUS SUCTION G - GRAVITY CO - COMPRESSED	TUBE _____ DESCRIPTION OF OUTPUT _____ TUBE _____ DESCRIPTION OF OUTPUT _____	FLUID & ELECTROLYTES																									
		FLUID & ELECTROLYTES																									
		FLUID & ELECTROLYTES																									
I - INTACT D - DEFICIT - SEE NOTES L & R F - SEE FLOW SHEET	MOTOR FUNCTION UPPER E / LOWER E	NEUROLOGICAL																									
I - INTACT D - DEFICIT - SEE NOTES L & R F - SEE FLOW SHEET	SENSATION UPPER E / LOWER E	NEUROLOGICAL																									
A - ALERT L - LETHARGIC O X 1, 2, OR 3 - ORIENTATION D - DISORIENTED C - COMATOSE	LEVEL OF CONSCIOUSNESS	NEUROLOGICAL																									
		NEUROLOGICAL																									
E - ENCOURAGED VERBALIZATION + VERBALIZES - DOES NOT VERBALIZE	FEELINGS & CONCERNS	SELF CONCEPT MODE																									
C - COOPERATIVE A - ANXIOUS CM - CALM S - SLEEPING R - RESTLESS Q - QUIET W - WITHDRAWN UN - UNCOOPERATIVE FA - FLAT AFFECT	AFFECT & BEHAVIOR	SELF CONCEPT MODE																									
		SELF CONCEPT MODE																									
E - EQUIPMENT T - TUBES M - MEDS D - DIET SK - SKIN CARE DX - DISEASE DC - DISCHARGE IV - O2 - TCDB IS - INCENTIVE SPIRO PM - PAIN MGMT. BM - BOWEL MGMT. A - ACTIVITY I - INFECTION P - PROCEDURE POT - PRE-OP TEACHING O - ORIENTED TO UNIT	PATIENT EDUCATION	ROLE FUNCTION MODE																									
	FAMILY EDUCATION	ROLE FUNCTION MODE																									
		ROLE FUNCTION MODE																									
V/U - VERBALIZES UNDERSTANDS R/D - RETURN DEMONSTRATION NFT - NEEDS FURTHER TEACHING TR - TEACHING REINFORCEMENT	PATIENT TEACHING RESPONSE	ROLE FUNCTION MODE																									
	FAMILY TEACHING RESPONSE	ROLE FUNCTION MODE																									
+ ASSISTS - DOES NOT + PARTICIPATES - DOES NOT	ASSISTS IN SELF CARE / PARTICIPATES IN DECISIONS RE: CARE	ROLE FUNCTION MODE																									
+ EFFECTIVE INTERACTION - INEFFECTIVE INTERACTION A - NO FAMILY MEMBER PRESENT	FAMILY PRESENT	IDM																									
+ EFFECTIVE INTERACTION - INEFFECTIVE INTERACTION	CHAPLAIN PRESENT	IDM																									
			07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07

NARRATIVE NOTES

PLAN OF CARE REVIEWED WITH PATIENT / FAMILY
(Circle One or Both)

Yes ◯
☐ No Change Requested
☐ Requested Change, see:
____ Care Plan
____ Nurses Notes
____ Other

No ◯
Unable, R/T patient status and no family present

TIME	NARRATIVE

PROBLEM EVALUATION: DATA / ACTION / RESPONSE

LEGEND: I - INITIATED P - PROGRESSING N - NONPROGRESSING M - MET

#	EVAL	EXPLANATION / DAY SHIFT SUMMARY	INITIALS

#	EVAL	EXPLANATION / DAY SHIFT SUMMARY	INITIALS

County Hospital

24 Hr. Daily Nursing Flow Sheet
(Covers the period of time from 7a - 7a)

Beginning Date_____

Addressograph

Intake							Output				
Time	P.O.	I.V.	NG Flush	Blood	Tube Fdg.	TPN	Void / Cath	Stool	Emesis	NG	Other
Shift Total 7a - 7p											
Shift Total 7p - 7a											
24 Hr. Total											
24 Hr. Intake Total:							24 Hr. Output Total:				

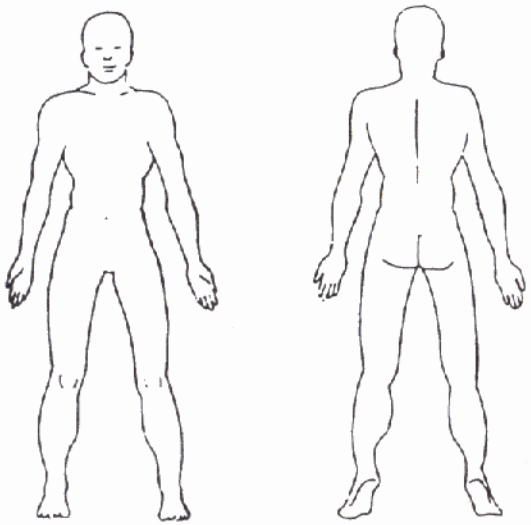
FALL RISK ASSESSMENT

	SCORE	7A - 7P	7P - 7A		
Confused, disoriented, hallucinating, combative	20				
Unstable gait, weakness	20				
Hx of syncope, seizures, postural hypotension	20				
Recent hx of falls	20				
Use of restraints	20				
Paralysis, hemiplegia, stroke, TIA	15				
Post-op condition, sedated	10				
Impaired vision	10				
Drug or alcohol withdrawal	10				
Use of walker, cane (other assistive aids)	10				
Narcotics, diuretics, antihypertensives, hypnotics, tranquils, poly-pharmacy (more than 5 scheduled meds)	10				
Bowel, bladder urgency, incontinent	10				
Equipment with risk for entanglement (IV's O2, feeding tubes, etc.)	10				
Age 70 or above	10				
Age 12 or below	5				
Language barrier	5				
Poor hearing	5				
SCORE					
High Risk Interventions Implemented OR In Place (Initial)					

A score of **35** or above may indicate the patient is at high risk for falling. These patients at high risk for fall shall have the following interventions implemented. Nursing shall monitor these at least every 2 hours.

- Visually observe patient every 2 hours. If awake, offer comfort measures and toileting.
- Instruct patient and/or family to ask for assistance for any patient activities.
- All items for patient's use will be within easy reach.
- Reassess for safe footwear.
- Reinforce use of assistive devices, if used.
- Reassess for a clutter free, well-lit environment.
- Re-orient and repetitively reinforce use of call bell. Ensure it is within reach.
- Consider a room closer to the nursing station.
- Utilize the Bed Check Alarm System / chair alarms.
- Utilize high-risk identification including green dots on wristband, door chart, and near room number on the nurse call system.

SKIN ASSESSMENT
(Please mark appropriate area on figure)



0700-1900	DESCRIBE SKIN ALTERATION	1900-0700
	Type	
cm	**Width**	cm
cm	**Length**	cm
	Drainage -	
	AMOUNT	
	COLOR	
	ODOR	
Y N	**Tissue Necrosis**	Y N
Y N	**Tissue Granulation**	Y N
	Color of Surrounding Tissue	
	Decub Care / Time	

High risk for fall documentation. Initial below only when high risk interventions in place / implemented.

0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700

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