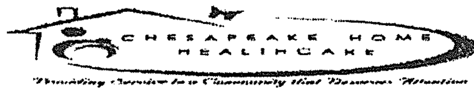

NURSING FLOW SHEET

Patient Name: Doe, John | **Today's Day & Date** 3/31/09 Tuesday

Patient's DOB: 10/24/95 | **Time In:** 7:03pm **Time Out:** 7:00 AM

☑ Care Plan / MD Orders Checked ☑ Travel Bag Packed | ☑ AmbuBag / Extra Trach on site ☑ Equipment Checked

NEUROLOGICAL ☐ Assessment WNL

☐ Verbal ☑ Non Verbal ☐ Disoriented ☐ Oriented ________

☑ Alert ☐ Lethargic ☐ Sedated ☐ Comatose ☐ Semi-Comatose

Tone: ☑ Active ☐ Flaccid ☐ Jittery ☐ Rigid

Fontanel: ☐ Flat ☐ Soft ☐ Sunken ☐ Tense ☐ Bulging ☑ N/A

Seizure Activity: ☑ Yes ☐ No ☑ See Seizure Record

Face: ☑ Symmetrical ☐ Asymmetrical

Ears: ☑ Unremarkable ☐ Low R L ☐ Other: ________

Eyes: Cornea: ☑ Clear R L ☐ Opaque R L

Sclera: ☑ White R L ☐ Jaundiced R L ☐ Hemorrhage R L

Nose: ☑ Patent ☐ Other: ________

Mouth: ☑ Unremarkable ☐ Other: ________

CARDIOVASCULAR ☐ Assessment WNL

Heart Tones: ☐ Strong ☑ Regular ☐ Irregular ☐ Murmur

☐ Other: ________

Color: ☐ Pink ☑ Flushed ☐ Pale ☐ Dusky ☐ Cyanotic ☐ Jaundiced 101.3

Skin Temp: ☐ Warm ☐ Cool ☑ Diaphoretic ☐ Clammy ☑ Hot ↑Temp

Edema: ☑ No ☐ Yes ☐ LUE ☐ LLE ☐ RUE ☐ RLE

Describe: ________

Capillary Refill: ☑ Less than 3 seconds ☐ Greater than 3 seconds

☑ LUE ☑ LLE ☑ RUE ☑ RLE

Peripheral Pulses: ☑ Strong ☐ Bounding ☐ Weak ☐ Thready

☐ Doppler ☐ Absent ☐ Other: ________

☑ LUE ☑ LLE ☑ RUE ☑ RLE

RESPIRATORY ☐ Assessment WNL

☑ Regular ☐ Labored ☐ Shallow ☐ Grunting ☐ Panting

☐ Wheezing ☐ Clear ☑ Rhonchi ☐ Rales

Secretions: ☐ Thin ☑ Thick Color: White

☐ Apnea Monitor: Alarm Set: High Lo Delay

☑ O2 2 L/min via: ☐ NC ☐ Mask ☑ Trach ☐ Cont

☑ Trach Appliance/Size: #8Fr Site Condition: good

Date of Last Trach Changed: 3/30/09

Inner Cannula Changed: ☑ Y ☐ N Date: 3/31/09

Ventilator ☐ Y ☑ N/A ☐ Type: ________

Settings: ________

Alarm Checked-Audible / Set At: ________ High ________ Low

Hrs. / Day on Ventilator: ________ Comments: ________

GASTROINTESTINAL ☐ Assessment WNL

Diet: ☐ NPO ☐ Regular ☐ Restricted / Type: ________

Abdomen: ☐ Firm ☐ Rigid ☐ Tender ☐ Distended

Bowel Sounds: ☑ Normal ☐ Hyper ☐ Hypo ☐ Absent

Feeding Tube: ☐ N/A ☐ NG ☐ J Tube ☐ G Tube ☑ Mickey Button

Size of Appliance: #14 Fr Diet: Pediasure

Rate: 60cc/hr Flush Amount 50cc

Appliances: ☐ Ileostomy ☐ Colostomy ☐ Rectal Bag

MUSCULO-SKELETAL ☐ Assessment WNL

Gait: ☐ Unsteady ☐ Steady ☐ Not Observed ☐ Bedrest

☑ Non-Ambulatory ☑ Poor Head Control ☐ Contractures

☑ Range of Motion ☐ Paralysis ☑ AFO's ☑ Splints

Types: Bilat LE AFO's / Arm splints

Growth and Development Age Appropriate: Y (N)

Comments: ________

GENITO-URINARY ☐ Assessment WNL

Genitalia: ☐ Swollen ☐ Ecchymotic Odor: Y N

Drainage: ☐ Serous ☐ Purulent ☐ Menses ☐ Bloody

☐ Continent ☑ Incontinent Diapered: (Y) N

Catheter: ☐ External ☐ Suprapubic ☐ I/O ☐ Stents

☐ Other Describe: ________

Color: ☐ Amber ☐ Bloody ☐ Other

Character: ☐ Cloudy ☐ Clear ☐ Sediment ☐ Clots

Odor: ☐ Foul ☐ Fruity Voiding: ☐ Burning ☐ Frequency

INTEGUMENTARY ☑ Assessment WNL

☐ Pale ☐ Cyanotic ☐ Jaundiced ☐ Diaphoretic ☐ Clammy

Wound/Decubitus site: ________ Size: ________ Drainage: ________

Type of Dressing: ________ Wound Care: ________

Ecchymotic Location: ________ Rash/Uticaria Location: ________

Topical ointment/powder/lotion applied: ☐ Yes ☐ No

Comments: ________

INTRAVENOUS ☑ N/A

Access: ☐ N/A ☐ Peripheral ☐ CVL ☐ PICC ☐ Port

☐ Other: ________ Location: ________

Site Condition: ☐ Intact ☐ Without Redness or Swelling

Drainage described: ________

Dressing Changed using: ☐ Y ☐ N Date: ________

Labs: ☐ N/A Tests: ________

Nurse Name Print: Shannon Harley RN | Nurse Signature: [signature] RN

NURSING FLOW SHEET CONT

Patient Name: Doe, John

Today's Day & Date: Tuesday 3/31/09

☒ Teaching Done ☐ PCG not available

☐ Night Shift / teaching not appropriate 8:30pm

Describe: Taught PCG (mom) how to prevent infection around peg tube. Explained importance of washing site $\bar{c}$ soap & H_2O & ensure area is thoroughly dried so as to prevent infections. Mom verbalized understanding.

PAIN: ☒ Yes ☐ No

Duration: ☐ Continuous ☐ Intermittment ☒ With Movement

Intervention: ☒ Yes ☐ No

Pain level after intervention (describe): Turn & Reposition pain ↓ to level 0

Wong-Baker Faces Pain Rating Scale: Pain Level: 2

0	1	2	3	4	5
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST
0	2	4	6	8	10

	TIME	7p	8p	9p	10p	11p	12A	1A	2A	3A	4A	5A	6A	7A		
VITAL SIGNS	Temperature	101.3		99.8		98.4					98.6					
	Pulse	98		88												
	Respiratory Rate	16														
	Pulse Oximeter	98%	100	100	100	100	99	99	100	100	99	100	100	100		
	Apnea Monitor															
	BP															
HYGIENE	Bath T/A/S			Total							Partial					
	Oral Care			✓										✓		
	Foley/ Peri Care			✓		✓					✓			✓		
	Skin/GT Care			✓		✓					✓			✓		
RESPIRATORY	Oxygen		2L	2L	2L	1L	1L	1L	1L	0.5L	0.5L	0.5L				
	Humidity															
	Trach Care			✓								✓				
	CPT			✓									✓			
PROCEDURES	Suction			✓		✓	✓			✓		✓		✓		
	Turn + Rep			✓		✓		✓			✓			✓		
	Splints	ON	ON	OFF	—	—	—	—	—	—	—	—	—	ON		
INTAKE	PO /MEDS				50								50			
	TF/ FLUSHES		60	60	60	60	60	60	60	60	60	60	60	60		
OUTPUT	Urine			X1		X1					X1			X1		
	Emesis															
	Stool										X1					

TOTALS: INTAKE 820 OUTPUT X5

NURSE DOCUMENTATION / SHIFT SUMMARY: 7pm - Rec'd client from mom. Client pleasant @ present. ↑ Temp - admin prn Tylenol will continue to monitor ——— [signature]

9p - Temp ↓ 99.8, O_2 on 2L r/t ↓ 98% pulse Ox will continue to monitor ——— [signature]

11p - Turn & Reposition - noted reddened peri area applied baby powder to peri area $\bar{p}$ peri care will continue to monitor ——— [signature]

4A - pt large BM - peri care done noted reddened peri area - applied A+D ointment to area per MD order. TF infusing Ø incident. BS auscultated $\bar{p}$ 4:00AM Neb Tx BS ↓ bilat lower lobes $\bar{c}$ occassional coughing nonproductive. O_2 ↓ 0.5L sat @ 100% will continue to monitor ——— [signature]

6:50AM - pt left clean & dry for Day Nurse. ——— [signature]

☒ Reported off to: Day Nurse ☐ Pt. Left in care of:

Nurse Signature: [signature]