STANDARD PRECAUTIONS ARE PRACTICED ON ALL PATIENTS

	DATE:	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
SAFETY	Call light within reach																								
	Bed low position																								
	Wheels locked Side rails up x_____																								
	Special Precautions:																								
	Aspiration: H.O.B. _____																								
	Seizure																								
	Fall																								
	Other:																								
ACTIVITY	Dangle																								
	Up ad lib / Up with assistance																								
	Chair with assistance																								
	Bedrest (turn q 2 hours) R/L/B & Self																								
	Ambulate with assistance																								
	Tray set up / Feed / Assist **(T/F/A)**																								
HYGEINE	Mouth Care q shift + PRN (q 4 hrs on vent)																								
	Bath: Self / Assist / Complete **(S/A/C)**																								
	Pericare (q shift & PRN)																								
	Shampoo / Shaved																								
	Linen Changed																								
TREATMENTS	Anti-embolic hose off (Q 8 hrs X 20 minutes)																								
	ETT position chg / Trach care																								
	Suction (NT / Oral)																								
	Lavage, bag & suction																								
	Ambu bag BS																								
	Incentive spirometer																								
	Cough / Deep Breathe																								
	Ostomy care																								
	Foley care (Q shift)																								
	Other:																								
	IV Site Appearance (Q 2 hours) + PRN																								
	Specialty bed:																								
EQUIP IN USE	Heating / Cooling Device																								
	SCD / PP																								
	IV Pump																								
	Cervical Collar																								
	Wound vac																								
	Feeding pump																								
	Invasive Line Insertions Flush bag changed X																								

IV SITES:

LOCATION/TYPE	DATE INSERTED	APPEARANCE write applicable nos.	DRSG Δ /DI	INIT

IV SITE APPEARANCE

0 - No pain, no redness, no swelling, no drainage
1 = Pain
2 = Redness
3 = Swelling
4 = Drainage
5 = Pain, redness, swelling, drainage

DRESSING

DI - Dressing Intact
Δ - Changed

DR. VISITS – TIME & PHYSICIAN	

INIT.	SIGNATURE & TITLE / PRINT NAME

PATIENT LABEL

STANDARD PRECAUTIONS ARE PRACTICED ON ALL PATIENTS

DATE: _____

F = FLACC SCORING V - VERBAL PAIN SCALE W = WONG BAKER ☐ REFER TO PLAN OF CARE

F = FLACC SCORING

CATEGORIES	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

V = VERBAL PAIN SCALE

0 PAIN FREE | 1 2 3 MILD | 4 5 6 MODERATE | 7 8 9 SEVERE | 10 WORST

W = WONG BAKER PAIN SCALE

Pain free (A) | Mild pain (B) | Moderate (C) | Severe (D) | Worst (E)

PAIN ASSESSMENT Q 2 HRS & PRN (ICU)

PAIN DOCUMENTATION

COMFORT GOAL _____

DURATION: C - Continuous; I = Intermittent

CHARACTER/QUALITY DESCRIPTORS: A = Aching; B = Burning; C1 = Cramping; S1 - Stabbing; S2 = Spasmodic; T = Throbbing; S3 = Sharp; D = Dull; P = Pressure; S4 = Superficial; D2 = Deep; O = Other _____

AGGRAVATED BY DESCRIPTORS: M = Movement; C = Coughing; E - Environmental; CC = Cannot Communicate; DB - Deep Breathing; P = Palpation; O = Other _____; S = Swallowing; F = Fatigue; * = See Notes; N/A = Not Applicable

PAIN DOCUMENTATION	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
PAIN SCALE (V, W, F)																									
SITE #1																									
SITE #2																									
DURATION																									
QUALITY/CHARACTER																									
AGGRAVATED BY																									
RADIATES Y = YES N = NO																									

SAFETY/FALL PREVENTION FALL RISK ASSESSMENT

☐ FALL RISK BAND ☐ REFER TO PLAN OF CARE

PERIODIC REASSESSMENT	7A-7P	7P-7A	REASSESS POST FALL/ OR OTHER
If yes to any below, enter points			
Age 65 or older (3 pts)			
Confused/disoriented (5)			
History of falls (10)			
Frequenty/urgency/incontenent (5)			
Elimination with assistance (5)			
Visual impairment (4)			
Confined to chair or bed (3)			
Hearing impaired (2)			
Bowel prep (4)			
Mobility/gait/balance/decreased peripheral sensation/ neuropathy (5)			
Assistive device for amb/transfer attached to EKG leads, IV pole, oxygen, chest tube, SCD (3)			
Fall Risk Medications - List is below (2)			
Language/communication deficit (1)			
Syncope/dizzy/postural hypotension (4)			
Drug/alcohol problem/depression (2)			
Total points for each assessment			
Protocol initiated based on score			
Initials			

Protocol A Point Total 0 - 9 Low to moderate risk

- ☐ Consider therapy consult
- ☐ Educate pt/family regarding risk and prevention of falls
- ☐ Bed in low position, wheels locked, 2-3 siderails up
- ☐ Ensure adequate lighting and remove clutter
- ☐ Provide non slip footwear
- ☐ Observe sleep and elimination patterns, offer assistance every 2 hours PRN
- ☐ Place call light, phone, and personal items within reach
- ☐ Consider pharmacy consult
- ☐ Consider timing of diuretic, bowel prep, laxative administration

Protocol B Point Total ≥ 10 High risk

- ☐ Place "STAR" outside of door/place fall risk band
- ☐ Initiate all interventions for Protocol A
- ☐ Anticipate toileting needs, take to BR q2 or q4 at night
- ☐ Consider bed alarm or landing strip
- ☐ Move pt near nurse's station
- ☐ Involve the family for assistance during high risk times
- ☐ Consider sitter, low bed or enclosure bed (MD order needed)
- ☐ BR light on (evenings and nights)
- ☐ Place IV, foley, landing strip on side of bed that patient exits

Fall Risk Medications

Antihistamines
Cathartics Laxative
Diuretics
Narcotics
Psychotropic Drugs
Benzodiazepines
Hypnotics
Antidepressants
Hypotensives
Muscle Relaxant

RESTRAINT FLOW SHEET

☐ REFER TO PLAN OF CARE

Non-Behavioral

A. Alternatives attempted and deemed ineffective

- ☐ Reorientation
- ☐ Decreased environmental stimulus
- ☐ Family or S.O. involvement
- ☐ Bed alarm
- ☐ Repositioning
- ☐ Educate/explain Plan of Care, treatments and procedures
- ☐ Provide diversional activities
- ☐ Moved closer to the nursing station
- ☐ Increased observation
- ☐ Secure lines and tubes
- ☐ Other: _____

B. Reason for restraint use

- ☐ Poor judgment
- ☐ Unable to understand the need for treatment
- ☐ Inability to follow directions
- ☐ Poor safety awareness
- ☐ Prevent removal of lines/tubes

C. Types of restraint

- ☐ Soft limb restraint ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- ☐ Mitten (Tied/Untied) ☐ Right ☐ Left ☐ Both
- ☐ Enclosure Bed
- ☐ Side Rails ☐ X4 ☐ 2 full rails up
- ☐ Lap Belt
- ☐ Chemical/Medication

Observed Behavior Key:

CA = Calm CP = Cooperative NC = No Change AG = Agitated
S = Sleeping DI = Disoriented OR = Oriented AV = Aggressive
UC = Unable to cooperate with instruction

TODAY'S DATE	0800	1000	1200	1400	1600	1800	2000	2200	2400	0200	0400	0600
OBSERVED BEHAVIOR (See above key list)												
RESTRAINT RELEASED AT LEAST EVERY 2 HOURS FOR 10 MINUTES/ PROPERLY APPLIED												
SKIN/CIRCULATION CHECKED AT LEAST EVERY 2 HOURS												
ROM/REPOSITIONED AT LEAST EVERY 2 HOURS												
HYDRATION/NOURISHMENT NEEDS MAINTAINED AT LEAST EVERY 2 HOURS												
ELIMINATION NEEDS ADDRESSED AT LEAST EVERY 2 HOURS IF NEEDED												
SAFETY/PRIVACY/MODESTY MAINTAINED												
CONTINUED NEED FOR RESTRAINT ASSESSED AT LEAST EVERY 2 HOURS												
INITIALS												

PATIENT LABEL

☐ REPORT RECEIVED FROM PREVIOUS SHIFT

ISOLATION (TYPE) SOURCE/LOCATION

☐ Contact
☐ Droplet
☐ Airborne
☐ Other:

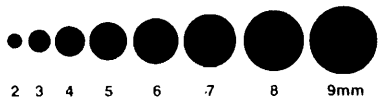
DATE: _____ TIME: (7P-7A) _____

NURSE: _____

NEUROLOGICAL

PUPILS: mm BRISK SLUG. FIXED

R	☐	☐	☐
L	☐	☐	☐



LOC: ALERT ☐ LETHARGIC ☐ OBTUNDED ☐ STUPOROUS ☐ COMATOSE ☐

BEHAVIOR: APPROP. ☐ INAPPROP. ☐ CONFUSED ☐ AGITATED ☐ COMBATIVE ☐

ORIENTATION: PERSON ☐ PLACE ☐ TIME ☐

SPEECH: CLEAR ☐ SLURRED ☐ INCOMPRE. ☐ ETT/TRACH ☐
APHASIC ☐ IF APHASIC: EXPRESSIVE ☐ RECEPTIVE ☐

MOVEMENT:	RA	LA	RL	LL
VOLUNTARY	☐	☐	☐	☐
COMMAND	☐	☐	☐	☐
STRENGTH (0-4)				

MOVEMENT CODES:
4+ = NORMAL
3+ = OVERCOME RESISTANCE
2+ = CAN'T OVERCOME RESISTANCE
1+ = OVERCOME GRAVITY
Ø = NONE

OTHER: _____

CARDIOVASCULAR: ECG ALARMS LOW _____ HI _____ ON ☐ MAX ☐

RHYTHM: _____ ECTOPY _____ LEAD _____

PM: N/A ☐ INT ☐ EXT ☐ SETTINGS _____

BOX # _____ TELEMETRY BOX # _____

HEART SOUNDS: ☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ OTHER _____

NAILBEDS: PINK ☐ PALE ☐ DUSKY ☐ CYANOTIC ☐

CAP REFILL: BRISK ☐ SLUGGISH ☐

PULSES:	BRAC	RAD	FEM	POP	DP	PT
GRADE R						
(Ø,D,P) L						

Ø = ABSENT
D = DOPPLER
P = PALPABLE

CHEST TUBES: N/A ☐ PLEURAL: R ☐ L ☐ MEDIASTINAL X _____

SXN ____ cm DRAINAGE: SANG ☐ SEROSANG ☐ SEROUS ☐

OTHER: _____

PULMONARY: ROOM AIR ☐ ASSISTED ☐ DOI - DATE OF INSERTION

RATE: EVEN ☐ UNEVEN ☐ SLOW ☐ RAPID ☐ UNLABORED ☐ LABORED ☐

DEPTH: SHALLOW ☐ MOD ☐ DEEP ☐

COUGH ☐ PRODUCTIVE ☐ NON PRODUCTIVE SECRETIONS: _____

B.S.:	CLEAR	DIMINISHED	RHONCHI	CRACKLES	WHEEZES
RUL	☐	☐	☐	☐	☐
RLL	☐	☐	☐	☐	☐
LUL	☐	☐	☐	☐	☐
LLL	☐	☐	☐	☐	☐

CHEST EXPANSION: EQUAL ☐ OTHER: _____

ASSISTED: N/C ☐ ____ VM ☐ ____% NRB ☐ ETT ☐ DOI: _____ SIZE: _____

TRACH ☐ DOI: SIZE/TYPE _____

BIPAP ☐ E_____ I_____ RATE _____ FiO_2 _____

VENT SETTINGS: V_T RATE _____ FiO_2 _____ PS _____ PEEP _____

AC ☐ SIMV ☐ T-TUBE ☐ CPAP ☐ OTHER _____ ALARMS ON ☐

POSITION: ETT/OTHER: _____ PULSE OX ON ☐ ALARMS ON ☐

GASTROINTESTINAL

ABD: SOFT ☐ FIRM ☐ DISTD. ☐ NON-TEND ☐ TEND. ☐ _____ QUADS

BOWEL SOUNDS: ABSENT ☐ PRESENT ☐ X _____ _____ QUADS

HYPOACTIVE ☐ NORMOACTIVE ☐ HYPERACTIVE ☐

NG TUBE: N/A ☐ NARE R ☐ L ☐ SXN _____ cm PLACEMENT ☐

COLOR: _____

FEEDING TUBE: N/A ☐ NARE R ☐ L ☐ PLACEMENT ☐ TYPE: _____

DIET: NPO ☐ PO ☐ _____ DIET ENTERAL FEEDING ☐ TPN ☐

FORMULA: _____ OTHER: _____

RECTAL TUBE ☐ RECTAL BAG ☐ COLOSTOMY ☐

RENAL: CONTINENT ☐ INCONTINENT ☐ VOID ☐ FOLEY ☐ ANURIC ☐ DUE TO VOID ☐ TIME _____

COLOR: COLORLESS ☐ YELLOW ☐ STRAW ☐ AMBER ☐ PINK ☐ BLOODY ☐

CLARITY: CLEAR ☐ CLOUDY ☐ SEDIMENTS ☐ CLOTS ☐

DIALYSIS: N/A ☐ HEMO ☐ PERIT. ☐

HD CATH ☐ TYPE/LOCATION _____

AV GRAFT ☐ RA ☐ LA ☐ THRILL ☐ BRUIT ☐

FOLEY DOI: _____

OTHER: _____

SKIN TEMP: WARM ☐ DRY ☐ COOL ☐ DIAPHORETIC ☐

COLOR: MEMBRANES PINK ☐ PALE ☐ DUSKY ☐ CYANOTIC ☐ JAUNDICED ☐

EDEMA: N/A ☐ TYPE _____ AMT. _____ LOCATION _____

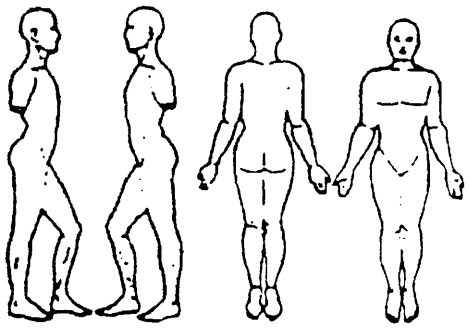
TYPE: P = PITTING D = DEPENDENT

AMOUNT: 1+ = SLIGHT 2+ = MINIMAL 3+ = MODERATE 4+ = SEVERE

HEMATOMAS: N/A ☐ LOCATION _____ ECCHYMOSIS ☐ LOCATION _____

MOTTLING ☐

NUMBER LACERATIONS/BRUISES/PRESSURE ULCERS/SKIN TEARS/EXCORIATIONS



☐ NO SKIN BREAKDOWN NOTED

NUMBER	PRESSURE WOUNDS/OTHER	STAGE	DRAINAGE AMT/TYPE	ODOR
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	

WOUND LEGEND:

STAGE: (APPLIES ONLY TO PRESSURE WOUNDS)
I = REDNESS, SKIN INTACT
II = SHALLOW, OPEN ULCER
III = TISSUE LOSS DOWN TO SUBCUTANEOUS LEVEL
IV = TISSUE LOSS DOWN TO BONE/MUSCLE/TENDON
US = UNSTAGEABLE, COVERED WITH SLOUGH/ESCAR
DTI = DEEP TISSUE INJURY, PURPLE/MAROON AREA/SKIN INTACT

ODOR
Y = YES
N = NO

DRAINAGE AMOUNT:
Ø = NONE
S = SCANT
M = MODERATE
H = HEAVY
TYPE:
S = SEROUS
SS - SEROSSANGUINEOUS
P = PURULENT

DRESSINGS/INCISIONS/DRAINS: N/A ☐ JP X _____ HEMOVAC X _____

LOCATION OF TUBES: _____

DRESSINGS/LOCATION: _____

IV MONITORING / ASSIST DEVICES N/A ☐

ALINE: N/A ☐ SITE _____ WAVE: GOOD ☐ DAMP ☐ Ø CAL'D ☐ DRSG D/I ☐

AL/NIBP: SBP LO ___ / HI ___ DBP LO ___ / HI ___ MAP LO ___ / HI ___ ON ☐

CVP: N/A ☐ SITE _____ WAVE: GOOD ☐ DAMP ☐ Ø CAL'D ☐ DRSG D/I ☐

SAFETY DEVICES/RESTRAINTS YES ☐ NO ☐ WRITTEN ORDER (NO PHONE/VERBAL) ☐

REFER TO PLAN OF CARE ☐

PLAN OF CARE: REVIEWED ☐ UPDATED ☐

EDUCATION: ☐ PATIENT/FAMILY EDUCATED ABOUT PLAN OF CARE, MEDICATION, TREATMENTS AND PROCEDURES

PATIENT LABEL

☐ REPORT RECEIVED FROM PREVIOUS SHIFT

ISOLATION (TYPE) SOURCE/LOCATION

☐ Contact
☐ Droplet
☐ Airborne
☐ Other:

DATE: _____ TIME: (7P-7A) _____

NURSE: _____

NEUROLOGICAL

PUPILS: mm BRISK SLUG. FIXED

R ☐ ☐ ☐

L ☐ ☐ ☐

2 3 4 5 6 7 8 9mm

LOC: ALERT ☐ LETHARGIC ☐ OBTUNDED ☐ STUPOROUS ☐ COMATOSE ☐

BEHAVIOR: APPROP. ☐ INAPPROP. ☐ CONFUSED ☐ AGITATED ☐ COMBATIVE ☐

ORIENTATION: PERSON ☐ PLACE ☐ TIME ☐

SPEECH: CLEAR ☐ SLURRED ☐ INCOMPRE. ☐ ETT/TRACH ☐

APHASIC ☐ IF APHASIC: EXPRESSIVE ☐ RECEPTIVE ☐

MOVEMENT:	RA	LA	RL	LL
VOLUNTARY	☐	☐	☐	☐
COMMAND	☐	☐	☐	☐
STRENGTH (0-4)				

MOVEMENT CODES:
4+ = NORMAL
3+ = OVERCOME RESISTANCE
2+ = CAN'T OVERCOME RESISTANCE
1+ = OVERCOME GRAVITY
Ø = NONE

OTHER: _____

CARDIOVASCULAR: ECG ALARMS LOW _____ HI _____ ON ☐ MAX ☐

RHYTHM: _____ ECTOPY _____ LEAD _____

PM: N/A ☐ INT ☐ EXT ☐ SETTINGS _____

BOX # _____ TELEMETRY BOX # _____

HEART SOUNDS: ☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ OTHER _____

NAILBEDS: PINK ☐ PALE ☐ DUSKY ☐ CYANOTIC ☐

CAP REFILL: BRISK ☐ SLUGGISH ☐

PULSES:	BRAC	RAD	FEM	POP	DP	PT
GRADE R						
(Ø,D,P) L						

Ø = ABSENT
D = DOPPLER
P = PALPABLE

CHEST TUBES: N/A ☐ PLEURAL: R ☐ L ☐ MEDIASTINAL X _____

SXN ____cm DRAINAGE: SANG ☐ SEROSANG ☐ SEROUS ☐

OTHER: _____

PULMONARY: ROOM AIR ☐ ASSISTED ☐ DOI - DATE OF INSERTION

RATE: EVEN ☐ UNEVEN ☐ SLOW ☐ RAPID ☐ UNLABORED ☐ LABORED ☐

DEPTH: SHALLOW ☐ MOD ☐ DEEP ☐

COUGH ☐ PRODUCTIVE ☐ NON PRODUCTIVE SECRETIONS: _____

B.S.:	CLEAR	DIMINISHED	RHONCHI	CRACKLES	WHEEZES
RUL	☐	☐	☐	☐	☐
RLL	☐	☐	☐	☐	☐
LUL	☐	☐	☐	☐	☐
LLL	☐	☐	☐	☐	☐

CHEST EXPANSION: EQUAL ☐ OTHER: _____

ASSISTED: N/C ☐ ____ VM ☐ ____% NRB ☐ ETT ☐ DOI: _____ SIZE: _____

TRACH ☐ DOI: SIZE/TYPE _____

BIPAP ☐ E_____ I _____ RATE _____ FiO_2 _____

VENT SETTINGS: V_T RATE _____ FiO_2 _____ PS _____ PEEP _____

AC ☐ SIMV ☐ T-TUBE ☐ CPAP ☐ OTHER _____ ALARMS ON ☐

POSITION: ETT/OTHER: _____ PULSE OX ON ☐ ALARMS ON ☐

GASTROINTESTINAL

ABD: SOFT ☐ FIRM ☐ DISTD. ☐ NON-TEND ☐ TEND. ☐ _____ QUADS

BOWEL SOUNDS: ABSENT ☐ PRESENT ☐ X _____ QUADS

HYPOACTIVE ☐ NORMOACTIVE ☐ HYPERACTIVE ☐

NG TUBE: N/A ☐ NARE R ☐ L ☐ SXN _____ cm PLACEMENT ☐

COLOR: _____

FEEDING TUBE: N/A ☐ NARE R ☐ L ☐ PLACEMENT ☐ TYPE: _____

DIET: NPO ☐ PO ☐ _____ DIET ENTERAL FEEDING ☐ TPN ☐

FORMULA: _____ OTHER: _____

RECTAL TUBE ☐ RECTAL BAG ☐ COLOSTOMY ☐

RENAL: CONTINENT ☐ INCONTINENT ☐ VOID ☐ FOLEY ☐ ANURIC ☐ DUE TO VOID ☐ TIME _____

COLOR: COLORLESS ☐ YELLOW ☐ STRAW ☐ AMBER ☐ PINK ☐ BLOODY ☐

CLARITY: CLEAR ☐ CLOUDY ☐ SEDIMENTS ☐ CLOTS ☐

DIALYSIS: N/A ☐ HEMO ☐ PERIT. ☐

HD CATH ☐ TYPE/LOCATION _____

AV GRAFT ☐ RA ☐ LA ☐ THRILL ☐ BRUIT ☐

FOLEY DOI: _____

OTHER: _____

SKIN TEMP: WARM ☐ DRY ☐ COOL ☐ DIAPHORETIC ☐

COLOR: MEMBRANES PINK ☐ PALE ☐ DUSKY ☐ CYANOTIC ☐ JAUNDICED ☐

EDEMA: N/A ☐ TYPE _____ AMT. _____ LOCATION _____

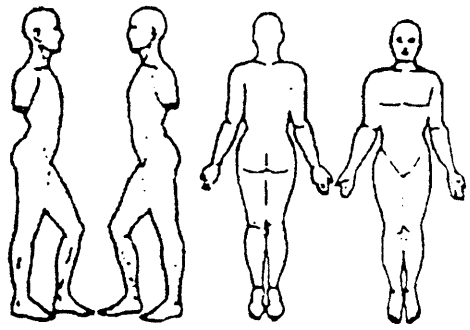
TYPE: P = PITTING D = DEPENDENT

AMOUNT: 1+ = SLIGHT 2+ = MINIMAL 3+ = MODERATE 4+ = SEVERE

HEMATOMAS: N/A ☐ LOCATION _____ ECCHYMOSIS ☐ LOCATION _____

MOTTLING ☐

NUMBER LACERATIONS/BRUISES/PRESSURE ULCERS/SKIN TEARS/EXCORIATIONS



☐ NO SKIN BREAKDOWN NOTED

NUMBER	PRESSURE WOUNDS/OTHER	STAGE	DRAINAGE AMT/TYPE	ODOR
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	

WOUND LEGEND:

STAGE: (APPLIES ONLY TO PRESSURE WOUNDS)
I = REDNESS, SKIN INTACT
II = SHALLOW, OPEN ULCER
III = TISSUE LOSS DOWN TO SUBCUTANEOUS LEVEL
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US = UNSTAGEABLE, COVERED WITH SLOUGH/ESCAR
DTI = DEEP TISSUE INJURY, PURPLE/MAROON AREA/SKIN INTACT

ODOR
Y = YES
N = NO

DRAINAGE
AMOUNT:
Ø = NONE
S = SCANT
M = MODERATE
H = HEAVY
TYPE:
S = SEROUS
SS - SEROSSANGUINEOUS
P = PURULENT

DRESSINGS/INCISIONS/DRAINS: N/A ☐ JP X _____ HEMOVAC X _____

LOCATION OF TUBES: _____

DRESSINGS/LOCATION: _____

IV MONITORING / ASSIST DEVICES N/A ☐

ALINE: N/A ☐ SITE _____ WAVE: GOOD ☐ DAMP ☐ Ø CAL'D ☐ DRSG D/I ☐

AL/NIBP: SBP LO ____ / HI ____ DBP LO ____ / HI ____ MAP LO____ / HI ____ ON ☐

CVP: N/A ☐ SITE _____ WAVE: GOOD ☐ DAMP ☐ Ø CAL'D ☐ DRSG D/I ☐

SAFETY DEVICES/RESTRAINTS YES ☐ NO ☐ WRITTEN ORDER (NO PHONE/VERBAL) ☐

REFER TO PLAN OF CARE ☐

PLAN OF CARE: REVIEWED ☐ UPDATED ☐

EDUCATION: ☐ PATIENT/FAMILY EDUCATED ABOUT PLAN OF CARE, MEDICATION, TREATMENTS AND PROCEDURES

PATIENT LABEL

STANDARD PRECAUTIONS ARE PRACTICED ON ALL PATIENTS DATE:_____

BRADEN SCALE

		Score
Sensory Perception	1: Completely limited, unresponsive 2: Very limited, responds to pain only 3: Slightly limited, responds to voice 4: No impairment, no sensory deficit	
Moisture	1: Constantly moist, frequent linen changes 2: Usually moist, +2 linen changes/shift 3: Occasionally moist, +2 linen changes/day 4: Rarely moist, daily linen changes	
Activity	1: Bedrest or confined to bed 2: Chair only, and need assist to/from chair 3: Walks occasionally, in bed/chair mostly 4: Walks frequently, at least 2X per shift	
Mobility	1: Completely immobile, totally dependent 2: Very limited, mostly dependent 3: Slightly limited, minimally dependent 4: No limitations, completely independent	
Nutrition	1: Very poor intake/NPO +5 days 2: Probably inadequate, eats < 50% meals 3: Adequate, eats > 50%, TPN, tube feeding 4: Excellent, eats > 75% all meals, snacks	
Friction & Shear	1: Problem, mod/max assist in moving 2: Potential problem, min. assist in moving 3: No apparent problem, moves w/o assist	

Completed by_____ Total Score_____
Licensed Nurse

Braden Score: 17 – 23 CONSERVATIVE PRESSURE ULCER PREVENTION PROTOCOL

INTERVENTION

- ☐ Keep skin clean and dry.
- ☐ Use moisturizing lotion for dry skin.
- ☐ DO NOT MASSAGE bony prominences
- ☐ Protect skin from moisture.
- ☐ Use skin barrier cream to protect skin exposed to urine/stool. Institute measures to contain feces and/or urine if incontinent (i.e.; fecal bag, indwelling or external catheter.).
- ☐ Decrease friction and shear by
  - Keep head of bed elevated at or lower than 30 degree angle. Elevate HOB only as needed for meals, treatments and if medically necessary
  - LIFT the patient. Do not slide the patient when moving up in bed.
  - Use assistive devices to reduce friction and facilitate patient movement (i.e., truning sheets, overbed trapeze).
- ☐ Position patient with pillows and other suypport devices. DO NOT USE DONUTS.
- ☐ Provide padding for casts, braces and splints, elbows and heels, (i.e.: heel protectors, pillows, wedges).
- ☐ Apply padding around the ears to protect against irritation from oxygen cannula use (i.e.; O_2 tubing foam wraps).
- ☐ Increase activity and mobility in patients that are bed bound or chair bound (i.e.; ROM, LIFE program).
- ☐ Monitor nutrition and hydration status. Notify dietitian for any changes – inadequate hydration/nutrition (i.e.; tube feeding not tolerated, eats <50% of diet, poor appetite).
- ☐ Monitor weight weekly, intake and output measurement every shift. Refer to appropriate authorities significant findings.
- ☐ Monitor laboratory data (i.e.; serum albumin, total protein, prealbumin) as ordered.
- ☐ Assess skin every shift for signs and symptoms of skin breakdown and document changes. Consult wound care nurse for any changes in skin integrity (i.e.; redness, non-blanchable skin).
- ☐ Turn/reposition every 2 hours while in bed and while sitting in chair.

Braden Score: 12 – 16 MODERATE PRESSURE ULCER PREVENTION PROTOCOL

- ☐ Follow the conservative prevention protocol.
- ☐ Pressure reduction device (i.e.; heel protectors, pillows, multiboots). Consult wound care nurse for pressure reduction surface/specialty mattress.

Braden Score: 0 – 11 STRICT PRESSURE ULCER PREVENTION PROTOCOL

- ☐ Follow moderate pressure ulcer protocol
- ☐ Notify dietitian/wound care nurse for NEW BRADEN SCORE of 11 and below.
- ☐ Increase turning frequency as needed for any new skin breakdown noted (i.e.; non-blanchable area of redness).

TIME	NURSING NOTES (Initial at end of each entry)

PATIENT LABEL

STANDARD PRECAUTIONS ARE PRACTICED ON ALL PATIENTS

DATE _____

PATIENT LABEL

ALLERGIES: NKA ☐ ALLERGY BAND ☐

CODE STATUS _____ AS OF _____

CODE BAND ☐

MEDICATION TITRATION

07 08 09 10 11 12 13 14

DOSE X =

DOSE X =

DOSE X =

DOSE X =

RAMSEY SCORE

BLOOD SUGAR

ADMISSION VITAL SIGNS: TEMP: _____ HR: _____ RESP: _____ BP: _____

MODIFIED RAMSEY SEDATION SCALE

1. Anxious, Agitated, Restless
2. Awake, Cooperative, Oriented, Tranquil
3. Semi-Asleep, but responds to commands
4. Asleep, but responds briskly to glabellar tap or loud auditory stimulus
5. Asleep with sluggish or decreased response to glabellar tap or loud auditory stimulus
6. No response can be elicited

PRN MEDICATIONS

REASSESSMENT

TIME	REASON	MEDICATION	DOSE	ROUTE SITE	INIT	TIME	RESULT	INIT

TEMP:
po = ORAL
R = RECTAL
Ax - AXILLARY
T = TYMPANIC

BP:
V = SYSTOLIC
Λ = DIAMOSTOLIC
— = MAP
• = HEART RATE

240 220 200 180 160 140 120 100 80 60 40 30

RHYTHM
RESP.
TEMP
SpO_2
O2
VENT MODE
V_T/RATE
PEEP/PS
BIPAP I/E

IM/SQ SITE CODES
1. L ARM
2. R ARM
3. L ABD
4. R ABD
5. L HIP
6. R HIP
7. L THIGH
8. R THIGH

MEDICATION RESULTS
S = SUCCESSFUL
U = UNSUCCESSFUL
* = SEE NURSING PROGRESS SECTION

REASSESSMENT
IV: WITHIN 15 MINUTES
IM/SC: WITHIN 30 MINUTES
PO/RECTAL: WITHIN 60-90 MINUTES

CODES FOR EXTREMITIES:
4+ = NORMAL
3+ = OVERCOME RESISTANCE
2+ = CAN'T OVERCOME RESISTANCE
1+ = OVERCOME GRAVITY
Ø = NONE

GCS - Score:_____ Time: 7A				GCS - Score:_____ Time: 7P	
Eye Opening		Best Verbal Response		Best Motor Response	
Spontaneous	4	Oriented	5	Obeys Commands	6
To Voice	3	Confused	4	Localize Pain	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible		Abnormal Flexion	3
		Sounds	2	Extensor Response	2
		None	1	None	1

N V S	GLASCOW COMA SCALE	E V M	4 5 6
	PUPILS		R.L. SIZE
	EXTREMITIES		R.A. L.A.
			R.L. L.L.

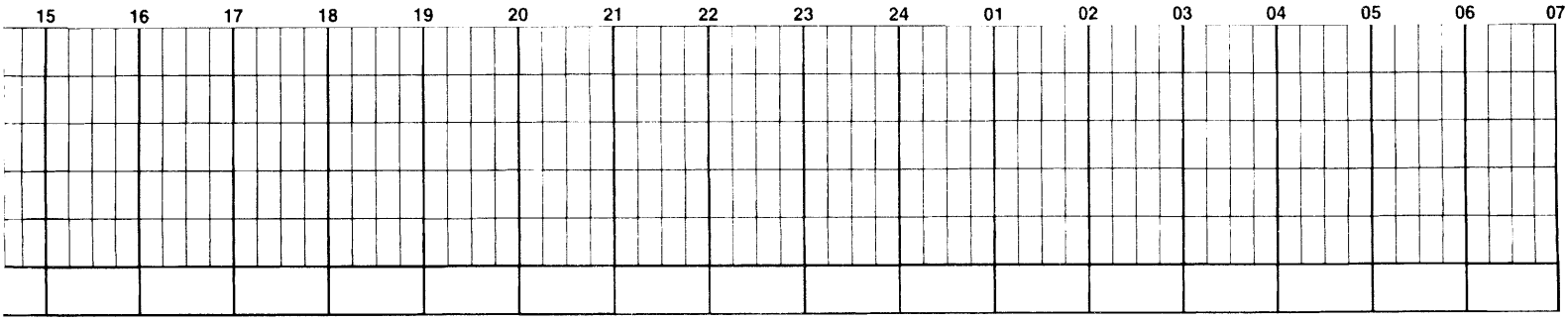
RESPIRATORY VALUES TIME_____ NIF _____ VC_____ VT _____

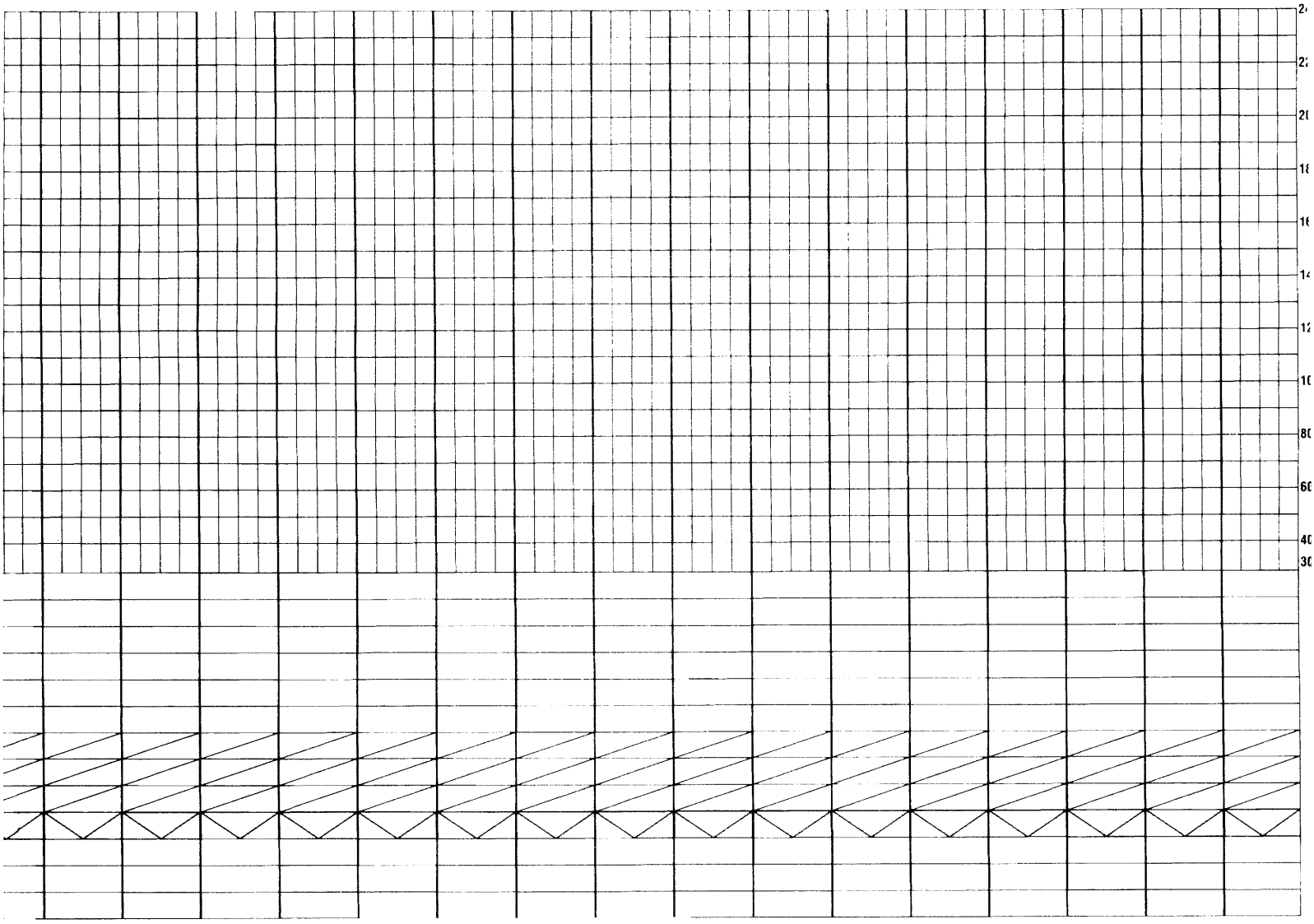
TIME	V_T	MODE / RATE	PS / PEEP	FiO_2	pH	$PaCO_2$	PaO_2	O_2Sat	HCO_3 / BE

LABORATORY VALUES

TIME	WBC	HGB	HCT	PLT	PT / INR	ACT / PTT	CPK / MB BANDS	TROP 1	NA+	K+	CL

DATE _____





BUN	Cr	GLU	MG++	CO_2	PRE-ALBUMIN	CHEMISTRY				MISC. LAB		MISC. TEST
						TIME		BILI (TOT)		BNP		CHEST X-RAY ☐
						CA++		BILI (DIRECT)		LACTIC ACID		CT ☐
						PHOS		ALK PO4		BLD CULTURE ☐		EKG ☐
						URIC ACID		LDH		U/A ☐		EEG ☐
						CHOL		SGOT		SPUTUM CULTURE ☐		
						PRO (TOT)		SGPT		WOUND CULTURE ☐		
						ALB						

TIME	CRITICAL RESULTS:

PATIENT LABEL

STANDARD PRECAUTIONS ARE PRACTICED ON ALL PATIENTS

PATIENT ID BAND: R L

7 A Initials _____

7 P Initials _____

DATE: _____

IV SOLUTIONS

IV #	IV SOLUTION/ADDITIVES	VOI	I P	SITE	BAG Δ RN INITIALS						TUBING & RN INITIAL

TUBE / DRAIN CODES

JP = JACKSON PRATT P = PLEURAL
HV = HEMOVAC M = MEDIASTINAL
SX = SUCTIONED
*IP = INFUSION PUMP

IV SITE CODES

R = RIGHT J = JUGULAR F = FEMORAL
L = LEFT S - SUBCLAVIAN B = BRACHIAL
W = WRIST FA = FOREARM H = HAND

Diet: Supplemental:

Breakfast % Lunch % Dinner % Snack %

Fluid Restriction: / day

Yesterday's I_____ O _____

Yesterday's Balance +

Cumulative Balance +

ADMISSION WEIGHT	lb/kg
PREVIOUS WEIGHT	lb/kg
TODAY'S WEIGHT	lb/kg

	INTAKE												OUTPUT											
TIME	IV FLUIDS						IV TOTAL	PO	TUBE FEEDING		BLOOD	TOTAL INTAKE	URINE	DIAL-YSIS	NG SUC-TION	EME-SIS	TUBES/DRAINS			REC-TAL TUBE	STOOL	OTHER	TOTAL OUT-PUT	I/O BAL-ANCE
	#1	#2	#3	#4	#5	#6			RATE / RESIDUE	FLUSH							#1	#2	#3					
0700																								
0800																								
0900																								
1000																								
1100																								
1200																								
1300																								
1400																								
1500																								
1600																								
1700																								
1800																								
12 HR. TOTAL																								
1900																								
2000																								
2100																								
2200																								
2300																								
2400																								
0100																								
0200																								
0300																								
0400																								
0500																								
0600																								
12 HR. TOTAL																								
24 HR. TOTAL																								

IN / OUT	7A – 7P	7P – 7A	24 HR. TOTAL	24 HR. BALANCE

PATIENT LABEL