HEALTHCARE SERVICES

2610486

ADULT EXTENDED HOUR NURSING FLOW SHEET

Name: _____ Client No.: _____

Time In: _____ Time Out: _____ Total Hours: _____ Date: _____

☐ Emergency Equipment Check
☐ Care Plan / MD Orders Checked
☐ AmbuBag / Extra Trach on site
☐ Infection Control Kit / Micro Shield
☐ Last Date DME Equipment Check _____

PHYSICAL ASSESSMENT Wt. _____ Ht. _____

Temp: _____ ☐ Oral ☐ Axillary ☐ Rectal

Pulse: Apical _____ Radial _____ ☐ Regular ☐ Irregular

Respiration: _____ ☐ Regular ☐ Irregular

BP _____ / _____

NUTRITIONAL ASSESSMENT

Diet: ☐ NPO Nutritional Screening Risk: ☐ Low ☐ Med ☐ High

☐ Regular ☐ Restricted / Type: _____ Amt: _____ Frequency: _____

Fluids: ☐ No Restriction ☐ Restriction _____ 24/hr.

Appetite: ☐ Good ☐ Fair ☐ Poor ☐ N/A ☐ Other: _____

Blood Sugar _____ ☐ N/A

NEUROLOGICAL ☐ Verbal ☐ Non Verbal

☐ Seizures ☐ Yes ☐ No ☐ **See Seizure Record**

☐ Alert ☐ Lethargic ☐ Sedated ☐ Comatose ☐ Semi-comatose

Oriented: ☐ Time ☐ Place ☐ Person

Tone: ☐ Active ☐ Flaccid ☐ Jittery ☐ Rigid ☐ Tremors

CARDIOVASCULAR

Heart Tones: ☐ Strong ☐ Regular ☐ Irregular ☐ Murmur

Other: _____

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

Skin Temp: ☐ Warm ☐ Dry ☐ Cool ☐ Cold ☐ Diaphoretic ☐ Clammy ☐ Hot

Edema: ☐ None ☐ Non-pitting ☐ Pitting ____+ ☐ Dependent ☐ LUE ☐ LLE ☐ RUE ☐ RLE

Capillary Refill: ☐ Less than 3 seconds ☐ Greater than 3 seconds ☐ LUE ☐ LLE ☐ RUE ☐ RLE

Peripheral Pulses: ☐ Strong ☐ Bounding ☐ Weak ☐ Thready ☐ Absent ☐ LUE ☐ LLE ☐ RUE ☐ RLE

RESPIRATORY

☐ Regular ☐ Labored ☐ Shallow ☐ Grunting ☐ Panting

☐ Nasal Flaring ☐ Retractions ☐ Mild ☐ Deep ☐ Abdominal

Breath Sounds: ☐ Clear ☐ Rales ☐ Rhonchi ☐ Diminished ☐ Wheeze ☐ Inspiratory ☐ Expiratory

If other than clear indicate lobe or lobes adventitious Breath sounds auscultated: _____

Cough: ☐ None ☐ Productive ☐ Non-Productive

Secretions: ☐ N/A

Amount: ☐ Small ☐ Moderate ☐ Large

Consistency: ☐ Thin ☐ Thick ☐ Tenacious ☐ Frothy

Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Blood tinged ☐ Frank Bleeding ☐ Tan

☐ Apnea Monitor Alarm Setting: High _____ Low _____ Delay _____

Pulse Oximetry: ☐ Continual ☐ Intermittent

Oxygen: ____ L/min via: ☐ NC ☐ Trach ☐ Mask ☐ Continual ☐ Intermitt.

O_2 Sat: _____ Other: _____

Respiratory Care

☐ Trach Type _____ Size _____ ☐ Cuffed ☐ Uncuffed

Date last changed: _____

Changed by: ☐ RN ☐ MD ☐ Other _____

Trach. Care: ☐ 1/2 strength H_2O_2 + H_2O ☐ NS ☐ Warm soapy H_2O

☐ Other: _____ Technique: ☐ Clean/Aseptic ☐ Sterile

☐ Trach. Ties Changed

Inner Cannula Changed: _____ (Date): using ☐ clean ☐ sterile technique

Trach Site: ☐ Dry ☐ Intact ☐ Redness ☐ Excoriation ☐ Drainage

Intervention: ☐ MD notified ☐ RN ☐ Supervisor ☐ Other: _____

VENTILATOR Type: _____ Rate: _____ ☐ CPAP: rate _____

TV: _____ PEEP: _____ PIP: _____

Hours / Day on Ventilator: _____

☐ Alarm Checked-Audible Set At: _____ High _____ Low

GASTROINTESTINAL

Abdomen: ☐ Soft ☐ Tense ☐ Flat ☐ Distended ☐ Obese

Bowel Sounds: ☐ Present ☐ Hyper ☐ Hypo ☐ Absent

Feeding Tube: ☐ N/A ☐ NG ☐ J Tube ☐ G Tube

Feeding Tube Size: _____ ☐ Residual Check

Feeding Tube Care: ☐ 1/2 strength H_2O_2 + H_2O ☐ NS ☐ Warm soapy H_2O ☐ Other: _____

Flushes: Solution _____ Amount _____ Frequency _____

Last BM _____ Stool: Color & Consistency _____

Ostomy Care: ☐ N/A Type: _____ Condition: _____ Irrig. X: _____

Solution: _____ Amount: _____ Results: _____

Enema Type: _____ Results: _____ ☐ Appliance chg. ☐ Dilatation: ☐ Yes ☐ No

Stoma Site: ☐ Red ☐ Drainage ☐ Edema

GENITO-URINARY

☐ Unremarkable ☐ Continent ☐ Incontinent ☐ Frequency ☐ Discharge

Urine: Color _____ Odor: _____ Appearance: _____

Foley: ☐ Indwelling ☐ Suprapubic ☐ External ☐ Intermittent

Catheter Care: ☐ Warm soapy H_2O ☐ Other: _____

Foley Cath or Suprapubic Type / Size: _____

Last Catheter Change / Date: _____

Technique: ☐ Sterile ☐ Aseptic

Irrigation: Solution: _____ Amount: _____ Freq.: _____

MOBILITY

Muscle Strength: ☐ Unimpaired ☐ Weak ☐ Hypertonic ☐ Flaccid ☐ Rigid

Gait: ☐ WNL ☐ Limited ☐ Unsteady ☐ N/A ☐ Ambulatory ☐ Wheelchair ☐ Bedrest ☐ To Bathroom ☐ With Assist

☐ Hoyer Lift ☐ Standing Frame

ADL: ☐ Self ☐ With Assistance ☐ Total Assistance

Range of Motion: ☐ Passive ☐ Active ☐ CVA ☐ Right ☐ Left

☐ Reposition q2hrs.

PAIN

☐ Yes ☐ No Regime Adequate: ☐ Yes ☐ No

Location: _____

Pain Quality: ☐ Aching ☐ Pressure ☐ Cramping ☐ Burning ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp

Pain at Rest: _____ 0-5+ With Activity: _____ 0-5+

Pain Interventions: ☐ Medication ☐ Repositioned ☐ Distraction ☐ MD Notified ☐ RN Supervisor ☐ Other: _____

Pain to be reassessed and documented in narrative portion of note with response to intervention.

SKIN CONDITION / WOUND CARE ☐ **See Wound Care Flow Sheet**

Skin: ☐ Intact ☐ No S/S Infection ☐ Other: _____

Wound/Decubitus Site: _____

Size: _____

Stage: ☐ N/A ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4

Observation / Drainage

Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Blood tinged ☐ Frank Blood ☐ Tan

Granulation: ☐ N/A ☐ Yes ☐ No

Tunneling: ☐ N/A ☐ Yes ☐ No

Dressing: ☐ Dry & Intact ☐ Damp ☐ Saturated ☐ Reinforced

Amount: ☐ Absent ☐ Small ☐ Moderate ☐ Large

Old Dressing Removed: ☐ Yes ☐ No Using: ☐ Sterile ☐ Clean Tech.

Type of Dressing: ☐ Transparent ☐ Gauze ☐ Other: _____

Wound Care: _____