AU MEDICAL CENTER
ADULT CRITICAL CARE FLOW SHEET

FLWSHEET

PATIENT LABEL

____/____/____ _____
MM DD YY Military Time

Service _____

Allergies _____

TIME		00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
• Temp °C (Blk) 40.0	230																								
39.0	220																								
38.0	210																								
37.0	200																								
36.0	190																								
35.0	180																								
34.0	170																								
	160																								
	150																								
	140																								
	130																								
∨ SBP (Cuff) - Blk	120																								
∧ DBP (Cuff) - Blk	110																								
∗ MAP (Cuff) - Blk																									
∨ SBP (Art) - Red	100																								
∧ DBP (Art) - Red	90																								
∗ MAP (Art) - Red	80																								
• Pulse - Red	70																								
• ICP - Blk	60																								
	50																								
	40																								
	30																								
	20																								
	10																								
Total Resp Rate																									
Vent Rate																									
Pulse Ox																									
Sv02																									
RA/CVP																									
PAS																									
PAD																									
PAOP																									
CO																									
CI																									
SVR																									
CPP																									
Blood Glucose																									
Initials																									

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____/____/____ _____
MM DD YY Military Time

	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
ACTIVITY/TURN																								
PERSONAL CARE																								
TEDs/SCDs																								
Fall Risk																								
PUP Protocol ☐ yes ☐ no																								
TRACHEAL SECRETIONS																								
Amount Consistency																								
Color																								
DRESSINGS																								
MONITOR ALARMS ON																								
LINES ZEROED																								
TESTS/PROCEDURES																								
PAIN SCALE																								
RASS score_____																								
MISC.																								
Physician Rounds																								
Signature/Initials:	_____ Date/Time: _____/_____								_____ Date/Time: _____/_____								_____ Date/Time: _____/_____							

ACTIVITY/TURN:
C=Chair
A=Ambulate
R=Right
L=Left
S=Supine
P=Prone

PERSONAL CARE:
BB=Bed Bath
PB=Partial Bath
PC=Peri Care
BC=Back Care
OC=Oral Care
TC=Trach Care
FC=Foley Care
SH=Shave

TRACHEAL SECRETIONS:

AMOUNT	Color
S=Small	C=Clear
M=Moderate	W=White
L=Large	B=Brown
	T=Tan
CONSISTENCY	Y=Yellow
Th=Thick	G=Green
T=Thin	Bl=Bloody
F=Frothy	P=Pink

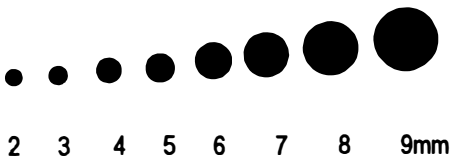
DRESSINGS:
D&I=Dry and Intact
Δ=Changed
R=Reinforced
D=Drainage

PAIN SCALEIN USE:
☐ NRS
☐ FACES
☐ OPS

FALL RISK:
H=High
M=Moderate
L=Low

TESTS/PROCEDURES:
CXR ECG
KUB CT
TCD MRI
ECHO

PUPIL SIZE:



MISC:
ROM=Range of Motion
CDB=Cough/Deep Breathe
IS=Incentive Spirometer

Comments: _____

See Addendum _____

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____/____/____ _____
MM DD YY Military Time

PATIENT LABEL

Height _____ kg
Dosing Weight _____ kg
Admission Weight _____ kg
Previous Day's Weight _____ kg
Today's Weight _____ kg Diet _____

TIME	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
PRN/STAT MEDS																								
FLUIDS IN																								
Oral or Tube mL																								
TOTAL/HR																								
SHIFT TOTAL IN																								
24 HOUR TOTAL IN																								
FLUIDS OUT																								
Urine mL																								
NG mL																								
Stool																								
TOTAL/HR																								
SHIFT TOTAL OUT																								
24 HOUR TOTAL OUT																								

AU MEDICAL CENTER
ADULT CRITICAL CARE FLOW SHEET

FLWSHEET

PATIENT LABEL

___/___/___ _____
MM DD YY Military Time

AM SHIFT

NEURO **Stimulus Response/Mood:** ☐ NMBA ☐ Spontaneous ☐ Alert ☐ Appropriate ☐ Combative ☐ Sedated ☐ Lethargic ☐ Stuporous ☐ Unresponsive ☐ Disoriented ☐ Calm ☐ Pleasant ☐ Anxious ☐ Withdrawn ☐ Flat affect
Oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation **CAM ICU:** ☐ Positive ☐ Negative
Speech: ☐ Clear ☐ Appropriate ☐ lnappropriate ☐ Slurred ☐ Aphasic ☐ Incomprehensible ☐ None
Patient & Diagnosis of Stroke: ☐ Yes ☐ No
Best Motor Response: ☐ Obeys commands ☐ Localizes to pain ☐ Flex to pain ☐ Extends to pain ☐ Random ☐ None GCS_____
Pupils: Right ___mm Reaction: ☐ Brisk ☐ Sluggish ☐ Fixed **Left** ___mm Reaction: ☐ Brisk ☐ Sluggish ☐ Fixed
Ventriculostomy: ☐ Patent ☐ Not Draining ☐ Clear ☐ Straw Color ☐ Bloody ☐ Set to Drain at_____
ICP: ☐ Reference #_____ ☐ Parenchymal **Comments:**_____

CARDIOVASCULAR & SKIN **Heart Sounds:** ☐ S1/S2 ☐ Other:_____
Rhythm: ☐ Regular ☐ Irregular **Edema:** ☐ None ☐ +1 ☐ +2 ☐ +3 ☐ +4 ☐ Location _____
Peripheral Pulses: ☐ RUE____ ☐ LUE____ ☐ RLE____ ☐ LLE____
Comments:_____ **Skin:** ☐ warm ☐ Cool ☐ Dry ☐ Shiny ☐ Moist
Color: ☐ Normal ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundiced **Turgor:** ☐ Good ☐ Fair ☐ Poor
Capillary Refill: ☐ Brisk (<2 sec) ☐ Prolonged (>2 sec)
Skin Integrity: ☐ Intact ☐ Rash ☐ Bruises ☐ Pressure Sore ☐ Laceration ☐ Avulsion ☐ Abrasion
☐ Other:_____
☐ Location/description:_____
☐ Wounds/incisions/location:_____
☐Drain/drainage:_____
Comments: _____

RESPIRATORY **Respirations:** ☐ Normal ☐ Labored ☐ Shallow ☐ Irregular ☐ Asymmetrical
Breath Sounds: ☐ Clear ☐ Equal ☐ Decreased ☐ Crackles ☐ Rhonchi ☐ Inspiratory Wheezes ☐ Expiratory Wheezes
Location:_____ **Airway:** ☐ Oral ☐ Nasal ☐ Trach ☐ OET Tube
☐ NET Tube Tube Size: ____ Cm Mark:____ O_2 Admin:_____
Cough Effort: ☐ None ☐ Productive ☐ Non-productive ☐ Spontaneous ☐ Stimulated
Chest Tube: Location:_____ ☐ Suction____ ☐ Waterseal ☐ Tidaling Air Leak: ☐ Yes ☐ No
Drainage: ☐ Serosanguinous ☐ Sanguinous ☐ Serous Comments:_____

GASTROINTESTINAL/GENITOURINARY **Abdomen:** ☐ Soft ☐ Firm ☐ Rigid ☐ Tender ☐ Flat ☐ Distended
☐ Girth:_____ **Bowel Sounds:** ☐ Active ☐ Not audible ☐ Hypoactive ☐ Hyperactive
GI Tube: ☐ NG ☐ Gastric ☐ PEG ☐ PEJ ☐ Enteral Tube ☐ Clamped ☐ Gravity ☐ Constant Suction
☐ Intermittent Suction ☐ Placement Checked **Drainage:** ☐ None ☐ Brown ☐ Black ☐ Green ☐ Yellow
☐ Coffee Ground ☐ Blood ☐ Other_____
Stools: ☐ Continent ☐ Incontinent ☐ Rectal Bag ☐ Colostomy ☐ Ileostomy ☐ No Stool ☐ Formed ☐ Loose
☐ Hard ☐ Tarry ☐ Brown ☐ Yellow/green ☐ Bloody ☐ Other:_____
Voiding: ☐ Continent ☐ Incontinent **Drainage Devices:** ☐ Foley ☐ Condom Cath ☐ S.P. Cath ☐ 3-way
Urine: ☐ Clear ☐ Cloudy ☐ Sediment ☐ Colorless ☐ Light Yellow ☐ Yellow ☐ Amber ☐ Red ☐ Dark Amber
☐ Clots ☐ Green ☐ Foul odor **Comments:** _____

SAFETY ☐ Siderails up x _____ ☐ Bed in lowest position ☐ Wheels Locked ☐ Call light within reach
☐ Ambu bag with flow meter ☐ Restraints ☐ 24 hour Supervision

DATE:_____ TIME: _____ NURSE SIGNATURE_____

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PATIENT LABEL

PM SHIFT

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Color: ☐ Normal ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundiced **Turgor:** ☐ Good ☐ Fair ☐ Poor
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☐ Other:_____
☐ Location/description:_____
☐ Wounds/incisions/location:_____
☐Drain/drainage:_____
Comments: _____

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Cough Effort: ☐ None ☐ Productive ☐ Non-productive ☐ Spontaneous ☐ Stimulated
Chest Tube: Location:_____ ☐ Suction____ ☐ Waterseal ☐ Tidaling Air Leak: ☐ Yes ☐ No
Drainage: ☐ Serosanguinous ☐ Sanguinous ☐ Serous Comments:_____

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☐ Intermittent Suction ☐ Placement Checked **Drainage:** ☐ None ☐ Brown ☐ Black ☐ Green ☐ Yellow
☐ Coffee Ground ☐ Blood ☐ Other_____
Stools: ☐ Continent ☐ Incontinent ☐ Rectal Bag ☐ Colostomy ☐ Ileostomy ☐ No Stool ☐ Formed ☐ Loose
☐ Hard ☐ Tarry ☐ Brown ☐ Yellow/green ☐ Bloody ☐ Other:_____
Voiding: ☐ Continent ☐ Incontinent **Drainage Devices:** ☐ Foley ☐ Condom Cath ☐ S.P. Cath ☐ 3-way
Urine: ☐ Clear ☐ Cloudy ☐ Sediment ☐ Colorless ☐ Light Yellow ☐ Yellow ☐ Amber ☐ Red ☐ Dark Amber
☐ Clots ☐ Green ☐ Foul odor **Comments:** _____

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DATE:_____ TIME: _____ NURSE SIGNATURE_____

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____/____/____ _____
MM DD YY Military Time

PATIENT LABEL

ICU Day_____ Post-Op Day_____

TIME										
pH										
pC02										
p02										
HC03										
BE										
02 Sat										
Fi02										
Vt										
Mode										
Vent Rate										
PEEP/CPAP										
PS/PC										
Pulse Ox										
Na										
K										
Cl										
CO2										
Glucose										
BUN										
Cr										
Ca										
Mg										
Phos										
WBC										
Hgb										
Hct										
Platelets										
PT										
INR										
PTT										
ACT										

EQUIPMENT:

- ○ Specialty Bed/Mattress
  Type:
- ○ Cooling /Warming Blanket
- ○ Heating Lamps
- ○ Feeding Pump
- ○ IV Pump x _____ Channels
- ○ PCA Pump
- ○ Epidural Pump
- ○ Suction Canister Set(s) # ___ used
- ○ Sequential Compression Device
- ○ Balloon Pump
- ○ Traction/Type:
- ○ Transmission Based Precautions:
  _____
- ○ Vent:_____
- ○ Other:_____
- ○ Other:_____
- ○ Signature:_____
  Date/Time:_____

BRADEN RISK ASSESSMENT:

Category	Score
Sensory Perception (1-4)	_____
Moisture (1-4)	_____
Activity (1-4)	_____
Mobility (1-4)	_____
Nutrition (1-4)	_____
Friction & Shear (1-3)	_____
TOTAL SCORE	_____

*Score below 18 requires nursing intervention.

Signature:_____

Date/Time: _____

Whole Blood Glucose (Expected Fasting Range) Adult: 70-110 mg/dl

INVASIVE LINES/DEVICES

Type & Site	Gauge/Size	Insert Date	D/C Date	Dressing Δ	Tubing Δ	Site Condition	Signature/Date/Time

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Skin Integrity Assessment

Complete on admission and daily for all patients 9 years or greater.

*Sensory Perception
- ☐ (1) Completely limited
- ☐ (2) Very limited
- ☐ (3) Slightly limited
- ☐ (4) No Impairment

*Moisture
- ☐ (1) Completely moist
- ☐ (2) Very moist
- ☐ (3) Occasionally moist
- ☐ (4) Rarely moist

*Activity
- ☐ (1) Bedfast
- ☐ (2) Chairfast
- ☐ (3) Walks occasionally
- ☐ (4) Walks frequently

*Mobility
- ☐ (1) Completely limited
- ☐ (2) Very limited
- ☐ (3) Slightly limited
- ☐ (4) No limitations

*Nutrition
- ☐ (1) Very poor
- ☐ (2) Probably inadequate
- ☐ (3) Adequate
- ☐ (4) Excellent

*Friction and Shear
- ☐ (1) Problem
- ☐ (2) Potential problem
- ☐ (3) No apparent problem

*Skin Integrity Risk Score _____
Add all checked items to obtain score

The patient is at risk for skin breakdown when the Skin Integrity Risk Score is ≤ 18.

For patients 18 or greater, initiate plan of care utilizing the Pressure Ulcer Prevention and Treatment Protocol.

For patients 9 years to 18 years, initiate plan of care utilizing the Skin Assessment for Neonates and Children policy.

*Denotes Required Field

Medications

Current medications improving your condition/symptoms
- ☐ Yes
- ☐ No
- ☐ Poor/No historian
- ☐ Sedated (ICU only)

Current medications causing any side effects
- ☐ Yes
- ☐ No
- ☐ Other

What side effects are you having? _____

_____

Review side effects of currect medications given during hospitalization to assist patients in answering questions.

_____ _____ _____
Signature/Title Date Military Time