INTENSIVE CARE FLOWSHEET

Form# 1-1105

MONITOR PARAMETERS

HR H/L ____/____ SBP H/L ____/____

MAP H/L ____/____ DBP H/L ____/____

PATIENT PLATE

Date _____ Admit Weight _____ (kg) Today's Weight _____ (kg) Prior 24° Intake _____ Output _____

TIME																		
Temp.																		
HR																		
Rhythm																		
Resp/O_2 SAT																		
BP S/D																		
MAP																		
Pain level (0-10)																		
Sedation/agitation level																		
DRIPS / DOSAGE																		

	TIME	0700	0800	0900	1000	1100	1200	1300	1400	8° TOTAL
INTAKE										
TOTAL INTAKE										
OUTPUT	URINE									
TOTAL OUTPUT										

HOSPITAL

Healthcare System

INTENSIVE CARE FLOWSHEET

Form# 1-1105

MONITOR PARAMETERS

HR H/L ____ / ____ SBP H/L ____ / ____

MAP H/L ____ / ____ DBP H/L ____ / ____

PATIENT PLATE

Date _____

TIME																		
Temp.																		
HR																		
Rhythm																		
Resp/O_2 SAT																		
BP S/D																		
MAP																		
Pain level (0-10)																		
Sedation/agitation level																		
DRIPS / DOSAGE																		

	TIME	1500	1600	1700	1800	1900	2000	2100	2200	8° TOTAL
INTAKE										
	TOTAL INTAKE									
OUTPUT	URINE									
	TOTAL OUTPUT									

Obtain serum and urine osmo if urine output is > 250 ccs/hr x 3 hrs. Check specific gravity when urine output is > 250 ccs/hr x 3 hrs, or whenever serum osmo > 300, or patient is receiving mannitol. Write in value.

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HR H/L ____/____ SBP H/L ____/____

MAP H/L ____/____ DBP H/L ____/____

PATIENT PLATE

Date _____

TIME																	
Temp.																	
HR																	
Rhythm																	
Resp/O_2 SAT																	
BP S/D																	
MAP																	
Pain level (0-10)																	
Sedation/agitation level																	
DRIPS / DOSAGE																	

	TIME	2300	2400	0100	0200	0300	0400	0500	0600	8° TOTAL
INTAKE										
TOTAL INTAKE										
OUTPUT	URINE									
TOTAL OUTPUT										

Date of Last Bowel Movement: ____/____/____

24° Total I _____ O _____

INTENSIVE CARE FLOWSHEET

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MONITOR PARAMETERS

HR H/L ____/____ SBP H/L ____/____

MAP H/ ____ DBP H/L ____/____

PATIENT PLATE

Date ____

	OXYGEN THERAPY									RESPIRATORY/WEANING COMMENTS
TIME										
Appliance Type										
Mode										
Rate										
FI02										
VT										
PEEP/PS										
PIP										
Suctioned										
IS										
ABGs/Time										
pH										
PaCO2										
PaO2										
HCO3										
O2 Sat.										

ET/TRACH	Insertion Date ____	Time						
	Size ____	Trach Care						
	Taped @ lip ____	Tape Δ						
		Position Δ						

LABORATORY FLOW SHEET

TIME	YESTERDAY						TIME	YESTERDAY					
WBC							Na++						
RBC							K+						
Hgb							Cl.						
Hct							CO2						
Platelets							Glu/Accu						
PT							Creat						
PTT							BUN						
INR							Ca++						
Prealbumin							Phos						
							Mg++						
							Troponin						

Initials	Signature	Hours	Initials	Signature	Hours

INTENSIVE CARE FLOWSHEET

Form# 1-1105

MONITOR PARAMETERS

Date

HB H/L _____ SBP H/L ____/____

MAP H/L _____ DBP H/L ____/____

PATIENT PLATE

NEUROLOGICAL

TIME	Eye Open	Best Verbal	Best Motor	TOTAL	Pupil Size & Reaction		Best Motor/Strength				Reflexes				Eye Movement	Speech	Comments
					L	R	LUE	LLE	RUE	RLE	Cough	Gag	Corneals	Babinski			

Sedation/Agitation Scale Key

- +4 Combative Violent, immediate danger to staff. Consistently high airway pressures
- +3 Very agitated Pulls or removes tube(s) or catheter(s) Aggressive. High airway pressures
- +2 Agitated Frequent nonpurposeful movement, fights ventilator; bites tubes. Restraints required.
- +1 Restless Anxious, apprehensive. Not Aggressive or vigorous. Calms with verbal instruction.
- 0 Alert and calm Awakens easily. Follows commands.
- -1 Drowsy Not fully alert, but has sustained awakening to voice (eye opening and contact < 10 sec).
- -2 Light sedation Briefly awakens to voice (eye opening & contact < 10 sec.).
- -3 Moderate sedation Movement or eye opening to voice (but no eye contact).
- -4 Deep sedation No response to voice. Movement or eye opening to physical stimulation only.
- -5 Unarousable No response to voice or physical stimulation.

Neuro Key

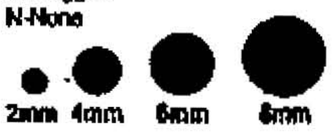
Eye Open
4-Spontaneous
3-To Sound
2-To Pain
1-No Response

Best Verbal
5-Oriented
4-Confused
3-Inappropriate Words
2-Incomprehensible
1-No Response
T-Tubed

Best Motor
6-Follows Commands
5-Localizes Pain
4-Withdraws
3-Decorticate
2-Decerebrate
1-No response

Reflexes
P-Present
0-Absent
NT-Not Tested
U-Unable to assess

Pupil Reaction
B-Brisk
S-Sluggish
N-None



Extremity Strength
5-Normal
4-Weak Lift Against Resistance
3-Lift Only
2-Withdew along plane of bed
1-Minimal Movement or Flicker
0-No Movement

Speech
C-Clear
G-Garbled
S-Slurred
E-Effective
R-Receptive Aphasia
EA-Expressive Aphasia
M-Mixed Aphasia

Eye Movement
T-Track
R-Roving
C-Conjugate
D-Disconjugate
N-Nystagmus

INTENSIVE CARE FLOWSHEET

Format 1-1181

MONITOR PARAMETERS

HR H/L ____/____ SBP H/L ____/____

MAP H/L ____/____ DBP H/L ____/____

Date _____ PATIENT PLATE

Cardiovascular Key

Heart Sounds-S1, S2, S3, S4, m, R-Rub
JVD-P-Present, Ø-Absent
Pacemaker Type-E-External, TI-Temporary Internal, P-Permanent
Pulses-Ø, 1+,2+,3+, D-Doppler
Edema-Ø,1+,2+,3+
Location-UE-Upper Extrem,LE-Lower Extrem,G-General,D-Dependent

Capillary Refill-N-Normal, D-Delayed, Ø-None
Sensation-P-Present,D-Diminished,Ø-Absent
Color-WNL-Normal, P-Pale, J-Jaundiced, C-Cyanotic, R-Ruddy,
M-Mottled, B-Blanched
Temp-C-Cool, W-Warm, H-Hot

Dryness-D-Dry, M-Moist
Turgor-N-Normal, L-Loose, T-Tight
Mucosal Color-P-Pink, PA-Pale, C-Cyanotic
No Change
* See Progress Notes

Document Q4° and with change

CARDIOVASCULAR

TIME/Initials												
Rhythm/Ectopy												
Heart Sounds												
JVD												
Pacemaker - Type												
Mode/MA/Rate												
Pulses -Radial	R	L	R	L	R	L	R	L	R	L	R	L
-DP	R	L	R	L	R	L	R	L	R	L	R	L
Other												
Edema/Location												
Capillary Refill												
Sensation												
Motion												
Skin Color / Temp												
Dryness / Turgor												
Mucosal												

RESPIRATORY

Respiratory Key

Pattern & Effort-R-Regular, I-Irregular, L-Labored, U-Unlabored,
D-Dyspneic,DOE, A-Apneic,T-Tachypneic,V-Vent
Chest Excursions-S-Symmetrical,A-Asymmetrical,F-Flail,P-Paradoxical
Cough-Ø-None,P-Productive,NP-Nonproductive
Sputum Amount-SC-Scant,SM-Small,M-Moderate,L-Large
Color-C-Clear,W-White,Y-Yellow,T-Tan,G-Green,B-Bloody
Consistency-TN-Thin,TK-Thick,F-Frothy
Odor-P-Present,Ø-Absent

Lung Sounds-CL-Clear,R-Rhonchi,CR-Crackles,W-Wheezes,
D-Diminished,Crepitus-P-Present,Ø-Absent,
Chest Tube Location-Describe
Suction Type-G-Gravity,H20-20cm Water
Drainage-B-Bloody,SS-Serosanguinous,S-Serous,P-Purulent
Airleak-P-Present,Ø-Absent
No Change
* See Progress Notes

TIME/Initials												
Pattern and Effort												
Chest Excursions												
Cough												
Sputum - Amount												
- Color												
- Consistency												
- Odor												
Sounds Right Upper	A	P	A	P	A	P	A	P	A	P	A	P
- Right Lower	A	P	A	P	A	P	A	P	A	P	A	P
- Left Upper	A	P	A	P	A	P	A	P	A	P	A	P
- Left Lower	A	P	A	P	A	P	A	P	A	P	A	P
Crepitus/Location												
Chest Tube-Location												
- Suction/Type												
- Drainage												
- Air Leak												

INTENSIVE CARE FLOWSHEET

MONITOR PARAMETERS

IR H/L ____/____ SBP H/L ____/____

MAP H/L ____/____ DBP H/L ____/____

Date _____ PATIENT PLATE

GI Key
Abdomen-S-Soft,F-Firm,H-Hard,T-Tender,D-Distended,FL-Flat,P-Protuberant,O-Obese Bowel Sounds-P-Present,Ø-Absent,<Hypo,>Hyper
Tube&Location-NG/Nare, OG, PEG, PEJ Tube Suction-Ø-None, LCS-Lo Continuous, LIS-Lo Intermit.
Drng. Color-CL-Clear,G-Green,B-Brown,T-Tan, CG-Coffee Ground,BU-Burgundy,BL-Bloody

Stool Color-T-Tan,BR-Brown,BU-Burgundy, BLO-Bloody,BLA-Black
Stool Consist-L-Liquid,S-Soft,F-Formed,H-Hard RB-Rectal Bag,RT-Rectal Tube
↑ No Change
* See Progress Notes

Document Q4* and with change

GASTROINTESTINAL

TIME/Initials						
Abdomen						
Bowel Sounds-RUQ,RLQ,LUQ,LLQ						
Tube & Location -Suction						
Check Placement/Residual						
Drainage-Color						
Stool						
Hemoccult/QC Check						
Other						

GENITOURINARY

GU Key
Urine-V-Void, F-Foley, S -Suprapublic, U -Urostomy
I-Incontinent, C-Continent
Color-Y-Yellow, A-Amber, P-Pink, B-Bloody
Character-CLE-Clear, CLO-Cloudy, S-Sediment
Odor-Ø-None, F-Foul, S-Strong
Genitalia-WNL-Normal, ED-Edematous, ER-Erythematous, D-Deferred

↑ No Change
* See Progress Notes

TIME/Initials						
Urine Collection Method						
-color, character, odor						
Genitalia-Appearance						
-Drainage						
Other						

INTEGUMENTARY

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK: (If total score ≤ 16 initiate Pressure Ulcer Prevention Protocol.

Sensory / Perceptions	1 Completely Limited	2 Very limited	3 Slightly Limited	4 No Impairment	
Moisture	1 Constantly Moist	2 Very Moist	3 Occasionally Moist	4 Rarely Moist	
Activity	1 Bedfast	2 Chairfast	3 Walks Occasionally	4 Walks Frequently	
Mobility	1 Completely Immobile	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		Total Score

Support Surface: ☐ Total Care Bed ☐ Zone Air Bed ☐ Obesity Bed ☐ Other_____

Pressure Ulcer Key
Color: R(red), Y(yellow), BL (black), BR (brown), C (cream)
Drainage: S (serous), SS (serous sanguineous), P (purulent)
Surrounding Skin: WNL, R (reddened), D (darkened)

Pressure Ulcer Staging
Stage I Skin intact but reddened or darkened
Stage II Skin broken, Superficial; an abrasion, blister.
Stage III Full thickness skin loss involving subcutaneous tissue.
Stage IV Full thickness wound extending to muscle and or bone.

Pressure Ulcer Assessment

Time / Initials			
Skin Breakdown (Y or N)			
Location			
Size (LxWxD)			
Base Color			
Surrounding Skin			
Odor (Y or N)			
Drainage Type			
Drainage Amount			
Treatment			

Pressure ulcers are measured weekly (Tuesday) For additional wounds, use "Pressure Ulcer Progress Sheet"

INTENSIVE CARE FLOWSHEET

Form# 141005

MONITOR PARAMETERS

HR H/L ____/____ SBP H/L ____/____

MAP H/L ____/____ DBP H/L ____/____

Date _____

PATIENT PLATE

Document Q2° as appropriate **ADLs**

TIME												
Bath												
Mouth Care												
Foley Care												
TEDs/SCDs												
ROM												
OOB												
Turned Q 2°(R, L, S, P)												
Back Care												

Assess Q2°, Document Q8° **IV's**

TIME			Days				Evenings				Nights			
Insert Date	Type/ Location or (mark)	Size	Condition	Dsg Type / Δ	Tubing Δ	Catheter Flush	Condition	Dsg Type / Δ	Tubing Δ	Catheter Flush	Condition	Dsg Type / Δ	Tubing Δ	Catheter Flush
	PA/___ CM													

Key: **Type** - PVA, CVA, PA, A line, TLL **Dsg. Type** - **T**-Transparent, **G**-Gauze Dsg Δ - Y Tubing Δ - Y-yes, N-no
Condition - **NR**-Non-reddened, **L**-Leaking, **P**-Phlebitic, **R**-Reddened, **D**-Discomfort, **ND**-No discomfort, **U** -Unable to assess
Catheter flush - Y-yes, N -no

SAFETY/FALLS/ISOLATION

SAFETY/FALLS/ISOLATION Key I-Initiated, M-Maintained, N/A-Not Applicable, Y = Yes N = No	Isolation - organism (MRSA, VRE, C.Dif. TB) Days	Evenings	Nights
Monitor Alarm Check			
Reassess for falls			
Falls Precautions			
Call light in reach			
Bed Low and Locked			
Side Rails up (x2 or x3)			
Family Spokesperson Updated			
Isolation/location			

RESTRAINT: OBSERVATION FLOWSHEET ***Directions:*** **Document every 2 hours** (Y=Yes: N=No)

TIME												
Safety Risk (Y/N)												
Restraints in use (Y/N)												
Restraint type - soft wrist (sw) vest (v)												
Restraints ON/OFF												
Hydration/Nutrition (Y/N)												
Toilet/Comfort (Y/N)												
Skin Integrity (Y/N)												
ROM (Y/N)												
Circulation Checked (Y/N)												
Calm=C Agitated=A												
Initials												