

CRITICAL CARE FLOW SHEET

PAGE 1

HOSPITAL _____

ADMISSION WEIGHT/HT: _____

DAILY WEIGHT: _____

ISOLATION/TYPE: _____

Date: _____

TIME	T	P	R	Cuff BP	Arterial Dwp BP	MAP			PULSE OX	Pain Score Ranney	Cardiac Rhythm		REMARKS
							/	/					
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Date: _____

*ml abs = ml absorbed
**dosage administration units

INTRAVENOUS

ENTERAL

IV INTAKE
ORAL
TUBE FEEDINGS

	INTRAVENOUS														ENTERAL			
	TIME	ml abs*	DOSE	ml abs*	DOSE	ml abs*	DOSE	ml abs*	DOSE	ml abs*	DOSE	ml abs*	DOSE	ml abs*	DOSE	IV INTAKE	ORAL	TUBE FEEDINGS
DAY	** UNITS																	
	TOTALS																	
EVE. & NIGHT																		
	TOTALS																	

PREVIOUS 5 DAYS INTAKE & OUTPUT

TOTAL

1	0	1	0	1	0	1	0	1	0
---	---	---	---	---	---	---	---	---	---

Total 24 hr. Intake

CODES

CRITICAL CARE FLOWS

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THERAPY MODE	VENT MODE
NC = Nasal Cannula	AC = Assist Control
A/V = Aerosol Face Mask	IMV = Intermittent Mech. Ventilation
NIMV = Non-Invasive Mech. Vent.	PSV = Pressure Support Ventilation
VM = Vent-Mask	PCV = Pressure Control Ventilation
V = Ventilator	BL = Bilevel Ventilation
RA = Room Air	
TP = T-Piece	
TC = Trach Collar	

TUBE POSITION

- R = Right
- M = Middle
- L = Left

Date: _____

DRUG CALCULATION

$$\text{Amt/ml/hr} = \frac{\text{Mg/Kg/Min wanted} \times \text{Weight (KG)} \times 60 \text{ Min}}{\text{Concentration in Mg}}$$

$$\text{Mg/Kg/Min} = \frac{\text{Amt ml} \times \text{Concentration in Mg}}{\text{Pt Weight (KG)} \times \text{Minutes}}$$

OUTPUT

TIME	Urine	Stool	
			DAY
TOTALS			8 hr.
			EVENING
TOTALS			8 hr.
			NIGHT
TOTALS			8 hr.

Total 24 hr. Output

TIME:					
BUN					
Na+					
K+					
CL-					
CO ₂					
Blood Glucose					
Creat					
Ca					
Mg					
Phos					
CK					
CK - MB					
Myoglobin					
Trop					
WBC					
Hgb					
Hct					
Platelets					
PT/INR					
PIT					
TIME:					
BCBGM					
Insulin Coverage (Units)					
TIME:					
Therapy Mode					
FiO ₂					
Tidal Volume					
Vent Mode					
Rate/PSV Level					
PEEP/CPAP					
PIP/Plateau Press					
Spontaneous TV					
Minute Volumes					
ET# / cm					
Tube Position					
TIME:					
PH					
PCO ₂					
PO ₂					
HCO ₃					
B.E.					
SAT %					

LAB DATA

OXYGEN THERAPY

BLOOD GASES

CRIT FLC

DEPARTMENT OF NURSING
AICU/CCU BRADEN SKIN RISK ASSESSMENT
Measure on admission and daily. Circle value for each item. If score ≤ 18 Initiate Risk Plan of Care

Date: _____

DAY
EVE. N
NIGHT

Completely Immobile: Does not make even slight change in body or extremity position w/o assistance	1	MOBILITY	
Very Limited: Makes occasional slight change in body or extremity position/unable to make frequent or significant changes independently	2		
Slightly Limited: Makes frequent though slight changes in body or extremity position independently	3		
No Limitations: Makes major and frequent changes in position without assistance	4		
Bedfast: Confined to bed	1	ACTIVITY	
Chairfast: Ability to walk severely limited, cannot bear weight, and/or must be assisted to chair	2		
Walks Occasionally: Walks very short distances with or without help, spends majority of each shift in bed/chair	3		
Walks Frequently: Walks outside of room at least twice a day and inside of room at least every 2 hrs during waking hrs	4		
Completely Limited: Unresponsive to painful stimuli OR limited ability to feel pain over most of body	1	SENSORY PERCEPTION	
Very Limited: Responds only to painful stimuli, OR limited ability to feel pain over 1/2 of body	2		
Slightly Limited: Responds to verbal commands, cannot always communicate need to be turned OR limited ability to feel pain in 1 or 2 extremities	3		
No Impairment: Responds to verbal commands, no limitation on ability to feel or voice pain/discomfort	4		
Constantly Moist: Skin always moist, dampness is detected every time patient is moved or turned	1	MOISTURE	
Very Moist: Skin often but not always moist, linen must be changed at least once a shift	2		
Occasionally Moist: Skin occasionally moist, requiring linen change approximately once a day	3		
Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals	4		
Problems: Requires moderate to maximum assistance in moving. Complete fitting without sliding against sheets is impossible. Frequently slides down in bed or chair. Spasticity, contractures, or agitation lead to almost constant friction	1	FRICTION/SHEER	
Potential Problem: Moves feebly or requires minimum assistance. Skin probably slides to some extent against sheets, chair, restraints or other device. Maintains relatively good position in chair/bed, occasionally slides down	2		
No Apparent Problems: Moves in bed or chair independently. Has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	3		
Very Poor: Never eats a complete meal, rarely eats more than 1/3 of any food offered, takes fluids poorly. Does not take a dietary supplement OR is in NPO and/or maintained on clear liquids or IV's for more than 5 days	1	NUTRITION	
Probably Inadequate: Rarely eats a complete meal, generally eats only 1/2 of food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding	2		
Adequate: Eats over half of most meals, occasionally will refuse a meal but will take a dietary supplement if offered OR is on tube feeding or TPN which probably meets nutritional needs	3		
Excellent: Eats most of every meal, does not require supplementation	4		
IF SCORE ≤ 18 INITIATE PLAN OF CARE FOR PATIENTS AT RISK		TOTAL SCORE	4

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Date: _____

PLAN OF CARE FOR PATIENTS AT RISK FOR IMPAIRED SKIN INTEGRITY RELATED TO: EXPECTED OUTCOME: Skin integrity maintained	0700 1500	1500 1900	1900 2300	2300 0700
Changed position q2h. Kept patient off high risk area; but not directly on trochanter. If sacral area affected, kept patient off back except for meals. Educated patient and family about importance of turning, if appropriate. Maintained HOB at 30 or less, unless contraindicated. Used pillows/padding to keep bony prominences apart. Pressure reducing mattress on bed. Bed pad used for lifting/moving.				
Kept heels and ankles off bed surface with: <input type="checkbox"/> PILLOWS <input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SPLINTS <input type="checkbox"/> FOOT PILLOWS <input type="checkbox"/> AIRBOOT <input type="checkbox"/> OTHER:				
Patient has: <input type="checkbox"/> Accuair <input type="checkbox"/> Flexicare <input type="checkbox"/> Clintron <input type="checkbox"/> Other:				
Padded/protected the following area (eg. anatomic bony deformities, ears from nasal cannula, areas in contact with firm surface) Location: _____ Device/dressing: _____				
Pressure reducing device for chair/wheelchair. DO NOT USE DONUT TYPE DEVICE. Patient instructed to reposition/shift frequently.				
Splint schedule maintained/skin assessed. SPLINT TYPE 1: _____ Schedule: <input type="checkbox"/> 2hrs on/2hrs off <input type="checkbox"/> while awake <input type="checkbox"/> at night <input type="checkbox"/> as tolerated <input type="checkbox"/> while ambulating/standing SPLINT TYPE 2: _____ Schedule: <input type="checkbox"/> 2hrs on/2hrs off <input type="checkbox"/> while awake <input type="checkbox"/> at night <input type="checkbox"/> as tolerated <input type="checkbox"/> while ambulating/standing				
Educated family re: prevention of pressure ulcers				
OTHER PLAN:				
Used incontinence cleanser and protective barrier ointment after each incontinent episode, using minimal friction when washing. No diapers; underpads only.				
Applied <input type="checkbox"/> skin sealants <input type="checkbox"/> protective creams <input type="checkbox"/> other				
TOILETING SCHEDULE: <input type="checkbox"/> q2h <input type="checkbox"/> q3h <input type="checkbox"/> q4h <input type="checkbox"/> other				
EXTERNAL COLLECTION DEVICE:				
TYPE 1: _____ TYPE 2: _____				
INTACT _____ INTACT _____				
APPLIED _____ APPLIED _____				
REMOVED/REAPPLIED _____ REMOVED/REAPPLIED _____				
OTHER PLANS:				
Alpha kerl added to bath water. Moisturized all bony prominence and extremities after bath and pm				
Encouraged patient to use trapeze to assist with movement				
<input type="checkbox"/> Skin sealant <input type="checkbox"/> Transparent dressing <input type="checkbox"/> Thin hydro colloid lo;				
Nutritional Interventions: <input type="checkbox"/> Supplement offered <input type="checkbox"/> Other				
REQUESTED CONSULTS: <input type="checkbox"/> Dietitian consult				
<input type="checkbox"/> OT consult for positioning <input type="checkbox"/> PT consult for impaired mobility				
<input type="checkbox"/> Wound/Skin/Ostomy Nurse for special mattress when patient cannot be kept off pressure ulcer/high risk area				
<input type="checkbox"/> Wound/Skin/Ostomy Nurse for ischial ulcer				
<input type="checkbox"/> Wound/Skin/Ostomy Nurse for Stage III and IV and non-resolving Stage II				

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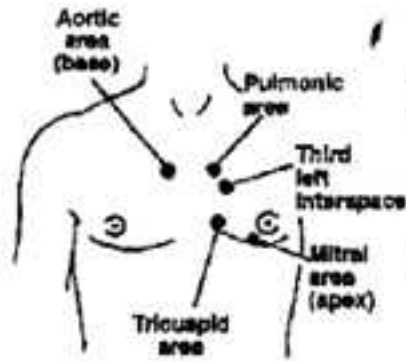


Date: _____

C O D E S	Eye Opening	Pupil Reaction	Orientation	Best Verbal Response	Best Motor Response	Motor Strength	PUPIL SIZE		
	4 = Spontaneously 3 = To Command 2 = To pain 1 = No response 0 = Unstable	B = Brisk S = Sluggish U = Unstable N = None	3 = Person, place, time 2 = 2 out of 3 1 = 1 out of 3 U = Unstable 0 = None	5 = Oriented & converses 4 = Confused & converses 3 = Disoriented words/phrases 2 = Moans/groans 1 = None T = ET/Trach Tube A = Aphasia/Dysphasia	6 = Follows commands 5 = Attempts to remove painful stimulus 4 = Random withdrawal 3 = Rigid/abnormal flexion 2 = Rigid extension 1 = No response	3 = Lts & holds against resistance 2 = Lifts off bed 1 = Moves on bed 0 = None			
N E U R O L O G I C A L	TIME:								
	Eye Opening R/L								
	Pupil Size R/L								
	Pupil Reaction R/L								
	Orientation								
	Verbal Response								
	Motor Response								
	Motor Strength Arms R/L								
Motor Strength Legs R/L									
C O D E S	*Respirations L = Labored S = Shallow R = Regular A = Apnea I = Irregular CS = Cheyne Strokes		Chest Assessment CI = Clear E = Expiratory RA = Rales/Cracks I = Inspiratory WZ = Wheeze ↓ = Decreased R = Rhonchus D = Absent T = Tubular C = Coarse		Chest Tubes Drainage Color Bubbling S = Serous C = Continuous Sr = Sero-sang I = Intermittent B = Bloody N = None P = Purulent		Fluctuation A = Absent P = Present	Sub Q A = Absent P = Present	
	R E S P I R A T O R Y	TIME:							
		Respirations*							
		VENTILATOR ASSISTING YES/NO							
Breath Sounds		LLL							
		LUL							
		RLL							
		Anterior/Posterior	RUL						
			RML LATERAL						
Lung Secretions		TIME:							
		AMOUNT							
	MODERATE								
	THIN								
	THICK								
Chest Tubes	COLOR								
	TIME								
	LOCATION		R	L	R	L	R	L	
	DRAINAGE								
	On H ₂ O Section								
FLUCTUATION*									
BUBBLING									
SUB Q									

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Date: _____

CARDIOVASCULAR	TIME:					HEART SOUNDS	TIME:				
	Central / Periph. Color						S/S:				
JVD @ 45°					S/S:						
Capillary Refill					RUB/MURMUR						
Periph. Pulse Quality											
PULSE	Right	Radial				Time:		Time:			
	Left	Femoral				EDEMA LOCATION	Time:	Time:			
		Popliteal									
		Dorsalis Pedis									
		Post Tibial									
OPERATIVE	TIME:										
	Location:										
	Incision Appearance:										
	Drainage/Color, Amt. Drains: Type/Drainage Color										
Dressing Change:											
TIME:											
Location:											
Incision Appearance:											
Drainage/Color, Amt. Drains: Type/Drainage Color											
Dressing Change:											
TIME:											
Location:											
Incision Appearance:											
Drainage/Color, Amt. Drains: Type/Drainage Color											
Dressing Change:											
GI	TIME:										
	Abdomen										
	Bowel Sounds										
	Abdominal Girth										
	GI Drainage										
	Stool (Color Consistency)										
	Stoma Description										
Appliance Changed:											
GU URINE	TIME:										
	Color										
	Odor										
	Sediment										
	Elimination Mode										

CODE:
 1. Normal Skin Tone
 2. Cyanotic/Dusky
 3. Pale
 4. Mottled
 5. Jaundiced

TEMPERATURE:
 W = Warm D = Diaphoretic
 C = Cool H = Hot

JVD:
 P = Present NP = Not Present

CAPILLARY REFILL:
 N = Normal < 3 Sec.
 S = Sluggish > 3 Sec.

PULSE QUALITY:
 A = Absent
 B = Bounding
 S = Strong (Normal)
 W = Weak, Thready

PULSES:
 A = Absent P = Present
 I = Intermittent L = Arterial Line
 D = Doppler

EDEMA:
 None Dependent
 Pitting Generalized

DRAINAGE AMOUNT:
 1 = Scant
 2 = Moderate
 3 = Large
 4 = None

DRAINAGE COLOR:
 S = Serous
 Gr = Serous-Gang.
 B = Bloody
 P = Pusulent
 O = Other

ABDOMEN:
 R = Flat B = Bony
 D = Distended BK = Black
 L = Large YG = Bile
 T = Tender G = Green
 S = Soft R = Red
 F = Firm T = Taut
 R = Rigid CG = Coffee Ground

GI DRAINAGE:
 S = Suction TF = Tube Feeding

STOMA:
 P = Present T = Tended
 H = Hypoactive R = Reversed
 D = Absent F = Flush

COLORE:
 Y = Yellow R = Rust
 A = Amber B = Blood-tinged

ODOR:
 N = Normal
 F = Foul Smelling

SEDIMENT:
 A = Absent
 P = Present

SIGNATURE	DAY SHIFT (0700-1530)	DAY SHIFT (1500-1930)	EVENING SHIFT (1915-2330)	NIGHT SHIFT (2300-0700)
	R.N.	R.N.	R.N.	R.N.
	R.N.	R.N.	R.N.	R.N.
	R.N.	R.N.	R.N.	R.N.