24 HOUR NURSING FLOW SHEET

0700 – 1500 (7 AM – 3 PM) 0700 – 1900 (7 AM – 7 PM)	1500 – 2300 (3 PM – 11 PM)	2300 – 0700 (11 PM – 7 AM) 1900 – 0700 (7 PM – 7 AM)
PATIENT ASSESSMENT	PATIENT ASSESSMENT	PATIENT ASSESSMENT
SKIN ○ NORMAL COLOR	**SKIN** ○ NORMAL COLOR	**SKIN** ○ NORMAL COLOR
○ PALE ○ FLUSHED ○ JAUNDICED	○ PALE ○ FLUSHED ○ JAUNDICED	○ PALE ○ FLUSHED ○ JAUNDICED
○ CYANOTIC ○ OTHER _____	○ CYANOTIC ○ OTHER _____	○ CYANOTIC ○ OTHER _____
CIRCLE: WARM/HOT/COOL DRY/MOIST/DIAPHORETIC	CIRCLE: WARM/HOT/COOL DRY/MOIST/DIAPHORETIC	CIRCLE: WARM/HOT/COOL DRY/MOIST/DIAPHORETIC
TURGOR ○ GOOD ○ FAIR ○ POOR	TURGOR ○ GOOD ○ FAIR ○ POOR	TURGOR ○ GOOD ○ FAIR ○ POOR
WOUND _____	WOUND _____	WOUND _____
OTHER _____	OTHER _____	OTHER _____
NEUROLOGICAL/PSYCHOSOCIAL ○ ALERT	**NEUROLOGICAL/PSYCHOSOCIAL** ○ ALERT	**NEUROLOGICAL/PSYCHOSOCIAL** ○ ALERT
Oriented ○ Person ○ Place ○ Time	Oriented ○ Person ○ Place ○ Time	Oriented ○ Person ○ Place ○ Time
Mental ○ Cheerful ○ Agitated* ○ Anxious*	Mental ○ Cheerful ○ Agitated* ○ Anxious*	Mental ○ Cheerful ○ Agitated* ○ Anxious*
○ Disoriented* ○ Confused* ○ Combative* ○ Depressed* ○ Lethargic* ○ Impaired Memory*	○ Disoriented* ○ Confused* ○ Combative* ○ Depressed* ○ Lethargic* ○ Impaired Memory*	○ Disoriented* ○ Confused* ○ Combative* ○ Depressed* ○ Lethargic* ○ Impaired Memory*
Responds to ○ Commands ○ Pain ○ Nothing	Responds to ○ Commands ○ Pain ○ Nothing	Responds to ○ Commands ○ Pain ○ Nothing
Maintains Eye Contact ○ No ○ Yes	Maintains Eye Contact ○ No ○ Yes	Maintains Eye Contact ○ No ○ Yes
Speech ○ Clear ○ Garbled ○ Slurred ○ Inappropriate* ○ Aphasic	Speech ○ Clear ○ Garbled ○ Slurred ○ Inappropriate* ○ Aphasic	Speech ○ Clear ○ Garbled ○ Slurred ○ Inappropriate* ○ Aphasic
Sight/Hearing Impaired ○ Yes* ○ No	Sight/Hearing Impaired ○ Yes* ○ No	Sight/Hearing Impaired ○ Yes* ○ No
Seizure Disorder ○ Yes* ○ No	Seizure Disorder ○ Yes* ○ No	Seizure Disorder ○ Yes* ○ No
Sedatives, Psychotropics, Hypnotics, Tranquilizers, Antidepressives ○ Yes* ○ No	Sedatives, Psychotropics, Hypnotics, Tranquilizers, Antidepressives ○ Yes* ○ No	Sedatives, Psychotropics, Hypnotics, Tranquilizers, Antidepressives ○ Yes* ○ No
RESPIRATORY ○ No Problem	**RESPIRATORY** ○ No Problem	**RESPIRATORY** ○ No Problem
○ Reg. ○ Irreg. ○ Easy ○ SOB/Labored	○ Reg. ○ Irreg. ○ Easy ○ SOB/Labored	○ Reg. ○ Irreg. ○ Easy ○ SOB/Labored
Breath Sounds **Right/Left** 0_2 _____ **Right/Left**	Breath Sounds **Right/Left** 0_2 _____ **Right/Left**	Breath Sounds **Right/Left** 0_2 _____ **Right/Left**
○ Clear ○ ○ ○ Absent ○ ○	○ Clear ○ ○ ○ Absent ○ ○	○ Clear ○ ○ ○ Absent ○ ○
○ Crackles ○ ○ ○ Rhonchi ○ ○	○ Crackles ○ ○ ○ Rhonchi ○ ○	○ Crackles ○ ○ ○ Rhonchi ○ ○
○ Wheezes ○ ○ Chest Tube ○ ○	○ Wheezes ○ ○ Chest Tube ○ ○	○ Wheezes ○ ○ Chest Tube ○ ○
IV FLUIDS	**IV FLUIDS**	**IV FLUIDS**
#1 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed	#1 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed	#1 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed
#2 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed	#2 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed	#2 SITE _____ ○ No Redness/Swelling ○ Tube Changed ○ Dressing Changed
CARDIOVASCULAR ○ Pacemaker ○ Telemetry	**CARDIOVASCULAR** ○ Pacemaker ○ Telemetry	**CARDIOVASCULAR** ○ Pacemaker ○ Telemetry
Pulse Apical ○ Reg. ○ Irreg. ○ Strong ○ Faint	Pulse Apical ○ Reg. ○ Irreg. ○ Strong ○ Faint	Pulse Apical ○ Reg. ○ Irreg. ○ Strong ○ Faint
or Radial ○ Reg. ○ Irreg. ○ Strong ○ Faint	or Radial ○ Reg. ○ Irreg. ○ Strong ○ Faint	or Radial ○ Reg. ○ Irreg. ○ Strong ○ Faint
Extremity pulse ○ NA **Right Left**	Extremity pulse ○ NA **Right Left**	Extremity pulse ○ NA **Right Left**
Clear ○ ○	Clear ○ ○	Clear ○ ○
Faint ○ ○	Faint ○ ○	Faint ○ ○
Absent ○ ○	Absent ○ ○	Absent ○ ○
Extremity feels cold ○ ○	Extremity feels cold ○ ○	Extremity feels cold ○ ○
Extremity is discolored _____ ○ ○	Extremity is discolored _____ ○ ○	Extremity is discolored _____ ○ ○
Edema present ○ No ○ Yes ○ ○	Edema present ○ No ○ Yes ○ ○	Edema present ○ No ○ Yes ○ ○
○ Anithypertensive Medications ○ Yes* ○ No	○ Anithypertensive Medications ○ Yes* ○ No	○ Anithypertensive Medications ○ Yes* ○ No
○ Non-pitting ○ Pitting _____	○ Non-pitting ○ Pitting _____	○ Non-pitting ○ Pitting _____
GASTROINTESTINAL ○ No Problem	**GASTROINTESTINAL** ○ No Problem	**GASTROINTESTINAL** ○ No Problem
Abdomen ○ Soft ○ Firm ○ Distended ○ Tender	Abdomen ○ Soft ○ Firm ○ Distended ○ Tender	Abdomen ○ Soft ○ Firm ○ Distended ○ Tender
NG Tube (type) _____ ○ Placement verified	NG Tube (type) _____ ○ Placement verified	NG Tube (type) _____ ○ Placement verified
○ Suction ○ Hi ○ Low ○ Cont. ○ Intermitt.	○ Suction ○ Hi ○ Low ○ Cont. ○ Intermitt.	○ Suction ○ Hi ○ Low ○ Cont. ○ Intermitt.
Drainage _____	Drainage _____	Drainage _____
Enteral feeding ○ Cont. @_____ ○ Intermitt.	Enteral feeding ○ Cont. @_____ ○ Intermitt.	Enteral feeding ○ Cont. @_____ ○ Intermitt.
Bowel Sounds ○ Present ○ Absent	Bowel Sounds ○ Present ○ Absent	Bowel Sounds ○ Present ○ Absent
Ostomy _____	Ostomy _____	Ostomy _____
GENITOURINARY ○ No Problem	**GENITOURINARY** ○ No Problem	**GENITOURINARY** ○ No Problem
Catheter ○ No ○ Yes Taped ○ No ○ Yes	Catheter ○ No ○ Yes Taped ○ No ○ Yes	Catheter ○ No ○ Yes Taped ○ No ○ Yes
Patent ○ No ○ Yes _____	Patent ○ No ○ Yes _____	Patent ○ No ○ Yes _____
Other _____	Other _____	Other _____
SIGNATURE	**SIGNATURE**	**SIGNATURE**
TIME _____ **DATE** _____	**TIME** _____ **DATE** _____	**TIME** _____ **DATE** _____

*Implement Fall Precautions

PATIENT ID

ONGOING NURSING CARE

0700 - 1500 / 0700 - 1900	DAY	(7AM - 3PM) / (7AM - 7PM)	1500 - 2300	EVENING	(3PM - 11PM)	2300 - 0700 / 1900 - 0700	NIGHT	(11PM - 7AM) / (7PM - 7AM)

HEALTH PERCEPTION / HEALTH MANAGEMENT PATTERN

SAFETY

DAY		EVENING		NIGHT	
○ SIDE RAILS UP	○ CHART FLAGGED	○ SIDE RAILS UP	○ CHART FLAGGED	○ SIDE RAILS UP	○ CHART FLAGGED
○ CALL LIGHT IN REACH	○ FALL PREVENTION ON KARDEX	○ CALL LIGHT IN REACH	○ FALL PREVENTION ON KARDEX	○ CALL LIGHT IN REACH	○ FALL PREVENTION ON KARDEX
○ BED IN LOW POSITION	○ BATHROOM SCHEDULE EVERY 2 HRS	○ BED IN LOW POSITION	○ BATHROOM SCHEDULE EVERY 2 HRS	○ BED IN LOW POSITION	○ BATHROOM SCHEDULE EVERY 2 HRS
○ SECURITY	○ ITEMS WITHIN REACH	○ SECURITY	○ ITEMS WITHIN REACH	○ SECURITY	○ ITEMS WITHIN REACH
○ BED CHECK	○ ROOM CHECK EVERY 1 HR (MIN)	○ BED CHECK	○ ROOM CHECK EVERY 1 HR (MIN)	○ BED CHECK	○ ROOM CHECK EVERY 1 HR (MIN)
○ ORANGE BRACELET	○ DOOR OPEN (UNLESS CONTRAINDICATED)	○ ORANGE BRACELET	○ DOOR OPEN (UNLESS CONTRAINDICATED)	○ ORANGE BRACELET	○ DOOR OPEN (UNLESS CONTRAINDICATED)
○ FAMILY NOTIFIED	○ ATTENDED AT ALL TIMES (UNLESS RESTRAINED)	○ FAMILY NOTIFIED	○ ATTENDED AT ALL TIMES (UNLESS RESTRAINED)	○ FAMILY NOTIFIED	○ ATTENDED AT ALL TIMES (UNLESS RESTRAINED)

NUTRITION / METABOLIC PATTERN

DAY	EVENING	NIGHT
DIET _____	DIET _____	DIET _____
FOOD (TIME)	FOOD (TIME)	FOOD (TIME)
TAKEN PER ○ SELF ○ ASSIST ○ FED_____	TAKEN PER ○ SELF ○ ASSIST ○ FED_____	TAKEN PER ○ SELF ○ ASSIST ○ FED_____
BREAKFAST ○ ¼ ○ ¾ ○ ½ ○ ¼ ○ REFUSED ○ NPO	DINNER ○ ¼ ○ ¾ ○ ½ ○ ¼ ○ REFUSED ○ NPO	INTERVAL FEEDING ○ ¼ ○ ¾ ○ ½ ○ ¼ ○ REFUSED ○ NPO
LUNCH ○ ¼ ○ ¾ ○ ½ ○ ¼ _____ ○ REFUSED ○ NPO	INTERVAL FEEDING ○ ¼ ○ ¾ ○ ½ ○ ¼ ○ REFUSED ○ NPO	CALORIE COUNT ○ YES ○ NO
INTERVAL FEEDING ○ ¼ ○ ¾ ○ ½ ○ ¼ ○ REFUSED ○ NPO	CALORIE COUNT ○ YES ○ NO	
CALORIE COUNT ○ YES ○ NO		

ELIMINATION PATTERN

DAY	EVENING	NIGHT
VOID ○ YES ○ NO ○ CATH TYPE _____	VOID ○ YES ○ NO ○ CATH TYPE _____	VOID ○ YES ○ NO ○ CATH TYPE _____
APPEARANCE ○ CLEAR ○ CLOUDY ○ AMBER ○ STRAW ○ BLOODY	APPEARANCE ○ CLEAR ○ CLOUDY ○ AMBER ○ STRAW ○ BLOODY	APPEARANCE ○ CLEAR ○ CLOUDY ○ AMBER ○ STRAW ○ BLOODY
INCONTINENT* ○ YES X _____ ○ NO ○ FOLEY CARE	INCONTINENT* ○ YES X _____ ○ NO ○ FOLEY CARE	INCONTINENT* ○ YES X _____ ○ NO ○ FOLEY CARE
○ STOOL ○ OSTOMY _____	○ STOOL ○ OSTOMY _____	○ STOOL ○ OSTOMY _____
DESCRIBE _____	DESCRIBE _____	DESCRIBE _____
INCONTINENT* ○ YES X _____ ○ NO (TIME, TYPE)	INCONTINENT* ○ YES X _____ ○ NO (TIME, TYPE)	INCONTINENT* ○ YES X _____ ○ NO (TIME, TYPE)
○ ENEMA* (RESULTS) _____ ○ LAXATIVE*	○ ENEMA* (RESULTS) _____ ○ LAXATIVE*	○ ENEMA* (RESULTS) _____ ○ LAXATIVE*
○ DEVICES _____ ○ DIURETICS*	○ DEVICES _____ ○ DIURETICS*	○ DEVICES _____ ○ DIURETICS*

ACTIVITY / EXERCISE PATTERN

DAY	EVENING	NIGHT
BATHING ○ COMPLETE ○ PARTIAL ○ SELF ○ N / A ○ LOTION ○ POWDER	BATHING ○ COMPLETE ○ PARTIAL ○ SELF ○ N / A ○ LOTION ○ POWDER	BATHING ○ COMPLETE ○ PARTIAL ○ SELF ○ N / A ○ LOTION ○ POWDER
ROM (TIME AND EXTREMITIES) _____ _____ ○ N / A (TIME)	ROM (TIME AND EXTREMITIES) _____ _____ ○ N / A (TIME)	ROM (TIME AND EXTREMITIES) _____ _____ ○ N / A (TIME)
TEDS ○ YES ○ NO ○ REMOVED AND REAPPLIED _____	TEDS ○ YES ○ NO ○ REMOVED AND REAPPLIED _____	TEDS ○ YES ○ NO ○ REMOVED AND REAPPLIED _____
SKIN STATUS _____	SKIN STATUS _____	SKIN STATUS _____
ACTIVITY _____ ASSISTIVE DEVICE ○ YES* ○ NO	ACTIVITY _____ ASSISTIVE DEVICE ○ YES* ○ NO	ACTIVITY _____ ASSISTIVE DEVICE ○ YES* ○ NO
AMBULATED x_____ ○ LOWER EXTREMITY PROSTHESIS*	AMBULATED x_____ ○ LOWER EXTREMITY PROSTHESIS*	AMBULATED x_____ ○ LOWER EXTREMITY PROSTHESIS*
UP IN CHAIR x_____ c_____ ASSISTING*	UP IN CHAIR x_____ c_____ ASSISTING*	UP IN CHAIR x_____ c_____ ASSISTING*
POSITIONED ○ NO ○ YES ○ HISTORY OF FALLS*	POSITIONED ○ NO ○ YES ○ HISTORY OF FALLS*	POSITIONED ○ NO ○ YES ○ HISTORY OF FALLS*
NASAL/ORAL CARE (TIME) _____	NASAL/ORAL CARE (TIME) _____	NASAL/ORAL CARE (TIME) _____
PERINEAL CARE (TIME) _____	PERINEAL CARE (TIME) _____	PERINEAL CARE (TIME) _____

SLEEP / REST PATTERN

DAY	EVENING	NIGHT
SLEEPING x_____ HOURS _____	SLEEPING x_____ HOURS _____	SLEEPING x_____ HOURS _____
RESTLESS _____ QUIET _____	RESTLESS _____ QUIET _____	RESTLESS _____ QUIET _____

ROLE / RELATIONSHIP PATTERN

DAY	EVENING	NIGHT
VISITORS ○ YES ○ NO	VISITORS ○ YES ○ NO	VISITORS ○ YES ○ NO
COMMUNICATION PATTERN ○ QUIET ○ TALKATIVE	COMMUNICATION PATTERN ○ QUIET ○ TALKATIVE	COMMUNICATION PATTERN ○ QUIET ○ TALKATIVE

NURSING PROCEDURES/TREATMENTS

	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500
PATIENT ROUNDS																							
REPOSITIONING (R. SIDE, L. SIDE, B = BACK, P = PRONE, C = CHAIR)																							
COUGH & DEEP BREATHE																							
PHYSICIAN VISIT																							
AMBULATION (A = ASSISTED, H = HALL, R = ROOM)																							

* IMPLEMENT FALL PROTOCOL

E I = REDDENED
E II = BLISTER/SKIN BREAK
E III = SKIN BREAK EXPOSING SQ TISSUE
E IV = SKIN BREAK EXPOSING MUSC/BONE

ARANCE
INK
EE PIE NOTES

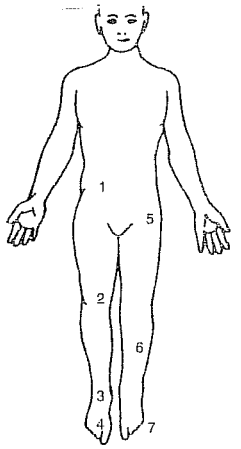
E
REGULAR
OUND

NAGE
URULENT
EROSANGUINEOUS

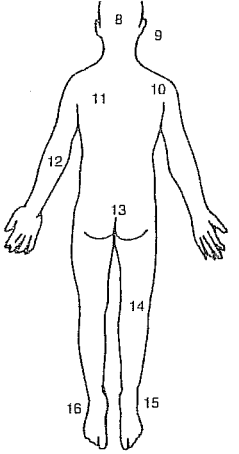
R
ONE
OUL

OUNDING SKIN
EALTHY/PINK
EE PIE NOTES/NURSING NOTES

TIONAL SITE > 3 USE SKIN TREATMENT FLOWSHEET



1 ILIAC CREST
2 KNEE
3 MEDIAL ANKLE
4 MEDIAL FOOT
5 TROCHANTER
6 SHIN
7 TOES
8 HEAD
9 EAR
10 SHOULDER
11 SCAPULA
12 ELBOW
13 COCCYX
14 POSTERIOR KNEE
15 LATERAL ANKLE
16 HEEL



P = PRESENT
A = ABSENT

OUTCOME
R = RELIEVED
* = SEE PIE NOTES/NURSING NOTES

	DAYS 0700-1500					EVES 1500-2300				NIGHTS 2300-0700		
TIME:												
SKIN ASSESSMENT	SITE 1	SITE 2	SITE 3			SITE 1	SITE 2	SITE 3		SITE 1	SITE 2	SITE 3
LOCATION												
STAGE												
APPEARANCE												
SIZE (cm)												
SHAPE												
DRAINAGE												
ODOR												
SURROUNDING SKIN												
TREATMENT *												
PAIN ASSESSMENT												
SCALE (0-10)												
CONSTANT												
INTERMITTANT												
RADIATION												
TREATMENT *												
OUTCOME*												

UIPMENT

/ PUMP ○ FEEDING PUMP UCTION ○ TRACTION/OVERBED GG CRATE ○ K PADS IR MATTRESS ○ OTHER _____	○ IV PUMP ○ FEEDING PUMP ○ SUCTION ○ TRACTION/OVERBED ○ EGG CRATE ○ K PADS ○ AIR MATTRESS ○ OTHER _____	○ IV PUMP ○ FEEDING PUMP ○ SUCTION ○ TRACTION/OVERBED ○ EGG CRATE ○ K PADS ○ AIR MATTRESS ○ OTHER _____

V. STICKS	URINE	STOOL	OTHER	I.V. STICKS	URINE	STOOL	OTHER	I.V. STICKS	URINE	STOOL	OTHER
_____	___ UA	___ Cult	___ ABG	Time _____	___ UA	___ Cult	___ ABG	Time _____	___ UA	___ Cult	___ ABG
_____	___ 24 hr. Coll.	___ Sen.	___ Throat Cult.	Site/ _____	___ 24 hr. Coll.	___ Sen.	___ Throat Cult.	Site/ _____	___ 24 hr. Coll.	___ Sen.	___ Throat Cult.
auge _____	___ Culture	___ Hemo	___ Sputum	Gauge _____	___ Culture	___ Hemo	___ Sputum	Gauge _____	___ Culture	___ Hemo	___ Sputum
ccessful	___ Sensitivity	___ O&P	___ Wound	Unsuccessful	___ Sensitivity	___ O&P	___ Wound	Unsuccessful	___ Sensitivity	___ O&P	___ Wound
pts _____	___ Other	___ Oth.	___ Site	Attempts _____	___ Other	___ Oth.	___ Site	Attempts _____	___ Other	___ Oth.	___ Site
_____			___ Sen	Nurse _____			___ Sen	Nurse _____			___ Sen
			___ Other				___ Other				___ Other

#		INITIAL

NURSES NOTES

	NURSE'S NOTES	
DATE AND HOUR	ND / AC	NURSES SIGNATURE