PATIENT ASSESSMENT FLOWSHEET

Directions for Use:

DATE:		NIGHT:	DAYS:	EVENING:
CNS	LOC/Orientation			
	Pain Scale (0 – 10)			
RESPIRATORY	Chest sounds (A/E, Adventitia)			
	Sputum (describe)			
	DB & C			
	Spirometry			
	Suction			
CARDIOVASCULAR	CWCM			
	Edema: Location/Amount			
	Peripheral Pulses			
	Mech. VTE Prophylaxis			
	Telemetry			
INTRAVENOUS	Site #1			
	Patency			
	Site Status			
	Site #2			
	Patency			
	Site Status			
	See *CVAD Flow Sheet*			
GASTROINTESTINAL	Diet (indicate if NPO)			
	Method: PO/NG /J-Peg; Self; Assist; Feed			
	Amount Eaten: 25%, 50%, 75%, All, None			
	Abdomen: Soft/Firm/Distended			
	Bowel Sounds			
	Nausea/Vomiting			
	Bowel Movements			
G-U	Voiding/Catheter/ Other			
	Urine: Color; Odor; Continence			
Staff Initials				

Directions for Use:

- *Documentation* must reflect assessment, diagnosis, plan, implementation, and evaluation.
- Using this flow sheet can place the provider, patient, and patient outcomes at risk if not used correctly. If the documentation does not give a clear picture of care provided and what happened to the patient, write it out in *Integrated Progress Notes (IPN)* (CLI.4510.PR.002.FORM.01) or other appropriate form.
- Establish a baseline of what is normal for the individual patient and plan of care; document in *IPN.*
- **Base patient assessment frequency on the patient's individual health care needs and status.** (e.g. a patient who is acute or one who is medically stable and awaiting placement for PCH).
- Document all that is applicable on this form minimally twice in 24 hours (a minimum of once per shift)

		NIGHT:	DAYS:	EVENING:
PSYCH-SOC	Mood/Motivation Cooperation			
	Family/Friends/Visitors Participation in care			
SKIN	Pressure Relieving Devices			
	Turning/Positioning			
	Skin Integrity			
WOUNDS	Site #1			
	Appearance/ Dressing			
	Site #2			
	Appearance/ Dressing			
	See *Wound Assessment and Treatment Flow sheet*			
DRAINAGE TUBES	Site #1			
	Drainage/ Appearance			
	Site #2			
	Drainage/ Appearance			
HYGIENE	Self/Assist/Complete			
	Basin/Tub/Shower			
	Oral Care			
	Peri/foley care			
SAFETY	Monitoring			
	Call bell/Side Rails			
	Alerts (e.g. wander guards/tab alarms)			
	Restraints			
MOBILITY & ADLs	Transfer/Mobility:			
	Mobility Aids			
	Exercise / Distance Walked			
	Rest/Sleep			
	Dressing: Self/Assist/Complete			
Staff Initials				

Directions for Use (cont):

- For each system, complete all fields (see examples provided on reverse side).
- Indicate not-applicable fields with N/A.
- If amount of space available is not sufficient, document on *IPN.*
- Complete documentation of **all** changes in patient health status in the *IPN.* This includes any deterioration or improvement.
- Use only approved abbreviations noted in the legend.
- **The form is 2-sided,** one calendar day per side.
- When night shift begins before 0000 hr, enter the date range (see example).
- Next to N, D, and E, based on shift pattern, enter time span covered by the charting entry (see example).

Legend: IPN=Integrated Progress Notes; CNS=Central nervous System; LOC=Level of consciousness; A&Ox3 = Alert & oriented to person, place & time; A/E=air entry; DB&C=Deep breathing & coughing; CWCM=Colour, Warmth, Capillary refill, Movement; VTE=Venous thromboembolism; CVAD=Central Venous Access Device; NPO=Nothing by mouth; PO=By mouth; NG=nasogastric; J-PEG=jejunal-percutaneous endoscopic gastrostomy; Bkft=Breakfast; LUQ=Left upper quadrant; LLQ=Left lower quadrant; RUQ=Right upper quadrant; RLQ=Right lower quadrant; Bil.=Bilaterally; Lt=left; Rt=right; ACF=antecubital fossa; Amt=amount; N/A=not applicable; G-U=Genito-Urinary; qs=quantity sufficient; WC = Wheel chair; PSYCH-SOC = Psychological-social; Abd=abdomen

PATIENT ASSESSMENT FLOWSHEET

Directions for Use:

DATE:		NIGHT:		DAYS:		EVENING:	
CNS	LOC/Orientation	A & O x 3		Alert/confused to time;see IPN		A & O x 3	
	Pain Scale (0 – 10)	0200	0600	1000	1400	1800	2200
		N/A	N/A	2/10	0/10	0/10	0/10
RESPIRATORY	Chest sounds (A/E, Adventitia)	N/A - slept		Decreased bil. Moist crackles See IPN		Clear with good A/E bilat See IPN	
	Sputum (describe)	NIL		Clear; tenacious		NIL	
	DB & C	N/A - slept		x 3		x 1	
	Spirometry	N/A		N/A		N/A	
	Suction	N/A		x 1		N/A	
CARDIOVASCULAR	CWCM	Intact		See IPN		Intact	
	Edema: Location/Amount	N/A - slept		1+ Lt ankle to mid-calf		Resolved See IPN	
	Peripheral Pulses	N/A - slept		See IPN		Present bil.	
	Mech. VTE Prophylaxis	Compression stocking		N/A		Pneumatic compression	
	Telemetry	On – see IPN		N/A – see IPN		N/A	
INTRAVENOUS	Site #1	Lt hand		Lt hand		Lt hand	
	Patency	Not accessed		Infusing well		Not infusing – see IPN	
	Site Status	N/A - slept		Dry & intact		Leaking	
	Site #2	N/A		N/A		N/A	
	Patency	N/A		N/A		N/A	
	Site Status	N/A		N/A		N/A	
	See *CVAD Flow Sheet*	N/A		N/A		N/A	
GASTROINTESTINAL	Diet (indicate if NPO)	N/A - slept		NPO		Clear fluids	
	Method: PO/NG /J-Peg; Self; Assist; Feed	N/A - slept		J-PEG		see IPN	
	Amount Eaten: 25%, 50%, 75%, All, None	None		Bkft	None	Supper	25%
				Lunch	None	Snack	ALL
	Abdomen: Soft/Firm/Distended	N/A - slept		Soft		Distended	
	Bowel Sounds	N/A - slept		Present x 4		Diminished LUQ	
	Nausea/Vomiting	N/A - slept		None		Emesis x 1 See IPN	
	Bowel Movements	N/A - slept		Soft x1		none	
G-U	Voiding/Catheter/ Other	N/A - slept		X 1 small		none	
	Urine: Color; Odor; Continence	N/A - slept		Reports qs		Reports qs	
Staff Initials		2345 AB		1000 DE		2005 FG	

		NIGHT:	DAYS:	EVENING:
PSYCH-SOC	Mood/Motivation Cooperation	N/A - slept	Pleasant; engaged	Yelling; refusing care
	Family/Friends/Visitors Participation in care	None	Husband in; assisted with mobility	Husband in; assisted with feeding
SKIN	Pressure Relieving Devices	Air mattress	ROHO cushion	Heal protector
	Turning/Positioning	N/A - slept	x 3	self
	Skin Integrity	N/A - slept	Intact	1 cm. skin tear Rt elbow
WOUNDS	Site #1	Lt arm	Lt arm	Lt arm
	Appearance/ Dressing	Dressing dry & intact	Wound clean; healing	Wound weeping
	Site #2	N/A	N/A	N/A
	Appearance/ Dressing	N/A	N/A	N/A
	See *Wound Assessment and Treatment Flow sheet*	N/A	N/A	Yes
DRAINAGE TUBES	Site #1	Abd	Abd	Abd
	Drainage/ Appearance	N/A	Skin clean & dry; patent	Protruding 2 inches
	Site #2	Lt Chest	Lt Chest	Lt Chest
	Drainage/Appearance	N/A	Dressing dry & intact; patent	Site leaking; clogged See IPN
HYGIENE	Self/Assist/Complete	N/A	Assist	self
	Basin/Tub/Shower	N/A	Basin	Basin
	Oral Care	N/A	x 1	x 2
	Peri/foley care	N/A	x 1	x 1
SAFETY	Monitoring	Rounded q1h x 7	q15-60 min x 15	Q15-60 min x 4
	Call bell/Side Rails	On pillow; x 1 rail	Within reach x 1 rail	On pillow; x 1 rail
	Alerts (e.g. wander guards/tab alarms)	Bed alarm	Bed Alarm & tab	Bed alarm
	Restraints	N/A	Broda chair with table	N/A
MOBILITY & ADLs	Transfer/Mobility:	N/A	1-assist	N/A
	Mobility Aids	N/A	Walker	N/A
	Exercise / Distance Walked	N/A	Up in room to chair x 2	N/A
	Rest/Sleep	Slept well x 6 hrs.	Nap x 2	Nap x 1
	Dressing: Self/Assist/Complete	N/A	Assist	Assist
Staff Initials		2345 AB	1000 DE	2005 FG

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