QUALITY CARE NURSING SERVICES, INC.

PEDIATRIC EXTENDED HOUR NURSING FLOW SHEET

Name: ____ M.R. #: ____

Time In: ____ Time Out: ____ Total Hours: ____ Date: ____

☐ Emergency Equipment Check
☐ Care Plan / MD Orders Checked
☐ AmbuBag / Extra Trach on site
☐ Infection Control Kit / Micro Shield
☐ Last Date DME Equipment Check ____
☐ Pt. ID Verified
☐ Consent Received

Weight ____ lbs. ____ oz. ____ kg.

VITAL SIGNS

Time	Temp	Pulse	Resp. Rate	BP

NUTRITIONAL ASSESSMENT

Diet: ☐ NPO ☐ Regular ☐ Restricted / Type: ____
☐ Breast ☐ Formula -Type: ____ Other: ____
Amount: ____ Frequency: ____
Fluids: ☐ Restriction ☐ No Restriction
Nutritional Screening Risk: ☐ LOW ☐ MED ☐ HIGH
Appetite: ☐ Good ☐ Fair ☐ Poor

NEUROLOGICAL ☐ Verbal ☐ Non Verbal
☐ Alert ☐ Lethargic ☐ Sedated ☐ Comatose ☐ Semi-Comatose
Appropriate for Age: ☐ Yes ☐ No
Tone: ☐ Active ☐ Flaccid ☐ Jittery ☐ Rigid
Fontanel: ☐ Flat ☐ Soft ☐ Sunken ☐ Tense ☐ Bulging ☐ N/A
Reflexes Present: ☐ Suck ☐ Gag ☐ Grasp ☐ Startle ☐ Blink ☐ N/A ☐ Other: ____
Seizure Activity: ☐ Yes ☐ No ☐ See Seizure Record

RESPIRATORY
☐ Regular ☐ Labored ☐ Shallow ☐ Grunting ☐ Panting
☐ Nasal Flaring ☐ Retractions ☐ Mild ☐ Deep ☐ Abdominal
Breath Sounds: ☐ Clear ☐ Rales ☐ Rhonchi ☐ Diminished ☐ Wheeze ☐ Inspiratory ☐ Expiratory
If other than clear indicate lobe or lobes adventitious Breath sounds auscultated: ____
Cough: ☐ None ☐ Productive ☐ Non-Productive
Secretions: ☐ N/A
Amount: ☐ Small ☐ Moderate ☐ Large
Consistency: ☐ Thin ☐ Thick ☐ Tenacious ☐ Frothy
Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Blood tinged ☐ Frank Bleeding ☐ Tan
☐ Apnea Monitor Alarm Setting: High ____ Low ____ Delay ____
Pulse Oximetry: ☐ Continual ☐ Intermittent
Oxygen: ____ L/min via: ☐ NC ☐ Mask ☐ Trach ☐ Intermittent ☐ Continual
02 Saturation: ____ Other: ____

RESPIRATORY CARE
Tracheostomy Type: ____ Size: ____ ☐ Cuffed ☐ Uncuffed
Date last changed: ____
Changed by: ☐ RN ☐ MD ☐ Other ____
Trach. Care: ☐ 1/2 strength $H_2O_2 + H_2O$ ☐ NS ☐ Warm soapy H_2O
Technique: ☐ Clean ☐ Sterile
☐ Trach. Ties Changed
Inner Cannula Changed: ____ (Date) using ☐ clean ☐ sterile technique
Trach. Site: ☐ Dry ☐ Intact ☐ Redness ☐ Excoriation ☐ Drainage
Intervention: ☐ MD notified ☐ RN notified ☐ Supervisor
Other: ____

VENTILATOR Type: ____ Rate: ____ ☐ CPAP: rate ____
TV. ____ PEEP: ____ PIP: ____
Alarm Checked / Set At: ____ High ____ Low
☐ Equipment Cleaned Solution Used: ____
Hrs. / Day on Ventilator: ____

CARDIOVASCULAR
Heart Tones: ☐ Strong ☐ Regular ☐ Irregular ☐ Murmur ☐ Other: ____
Color: ☐ Pink ☐ Flushed ☐ Pale ☐ Dusky ☐ Cyanotic ☐ Jaundiced
Skin Temp: ☐ Warm ☐ Cool ☐ Cold ☐ Diaphoretic ☐ Clammy ☐ Hot
Edema: ☐ No ☐ Yes Site: ____ ☐ LUE ☐ LLE ☐ RUE ☐ RLE
Capillary Refill: ☐ Less than 3 seconds ☐ Greater than 3 seconds ☐ LUE ☐ LLE ☐ RUE ☐ FILE
Peripheral Pulses: ☐ Strong ☐ Bounding ☐ Weak ☐ Thready ☐ Doppler ☐ Absent ☐ Other: ____ ☐ LUE ☐ LLE ☐ RUE ☐ RLE

HEAD
(Circle R for Right or L for Left)
Face: ☐ Symmetrical ☐ Asymmetrical
Ears: ☐ Unremarkable ☐ Low R L ☐ Other: ____
Eyes: Cornea: ☐ Clear R L ☐ Opaque R L
Sclera: ☐ White R L ☐ Jaundiced R L ☐ Hemorrhage R L
Nose: ☐ Patent ☐ Other: ____
Mouth: ☐ Unremarkable ☐ Other: ____

MUSCULO-SKELETAL
☐ Full ROM ☐ Limited ROM
Comments: ____
☐ Contractures ☐ Reposition q 2hrs.

SKIN CONDITION
☐ Intact ☐ Clear ☐ Peeling ☐ Rash ☐ No S/S infection
Wound/Decubitus site: ____ Size: ____ Drainage: ____
Type of Dressing: ____ Wound Care: ____

GASTROINTESTINAL
Abdomen: ☐ soft ☐ Tense ☐ Flat ☐ Distended
Bowel Sounds: ☐ Present ☐ Hyper ☐ Hypo ☐ Absent
Feeding Tube: ☐ N/A ☐ NG ☐ J Tube ☐ G Tube ☐ Mickey Button
Feeding Tube Care: ☐ 1/2 strength $H_2O_2 + H_2O$ ☐ NS ☐ Warm Soapy H_2O ☐ Other: ____
Flushes: Solution ____, Amount ____, Frequency ____
GT Site: ☐ Dry ☐ Intact ☐ Redness ☐ Excoriation ☐ Drainage ☐ No S/S of Infection ☐ Other ____

GENITO-URINARY
☐ Unremarkable ☐ Discharge ☐ Circumcised
Bladder Frequency: ____
Urine: Color ____ Odor: ☐ Yes ☐ No Appearance: ____
☐ Foley Cath ☐ Suprapubic ☐ Intermittent

INTRAVENOUS
Access: ☐ N/A ☐ Peripheral ☐ CVL ☐ PICC ☐ Port ☐ Other:
Location: ____
Site Condition: ☐ Intact ☐ Without Redness or Swelling
☐ Dressing Changed using: ☐ Sterile ☐ Aseptic technique ☐ Transparent ☐ Other: ____
☐ Bag Changed ☐ Tubing Changed ☐ Cap Change
Irrigated / Flushed with: ____
Labs: ☐ N/A Tests: ____
Site used: ____
Labs Taken to: ____ or Picked up by: ____

BN System 305.818.5940
SAMPLE

QUALITY CARE
NURSING SERVICES, INC.

PEDIATRIC EXTENDED HOUR NURSING FLOW SHEET

Name:	**M.R. #:**	**Date:**

PHYSICIAN NOTIFICATION

☐ MD Called Time:______________

Spoke with:______________

To report:______________

☐ No new orders ☐ Orders received ☐ MD to call back

PAIN ☐ Yes ☐ No

Pain Behaviors: ☐ Moaning ☐ Crying ☐ Grinding Teeth ☐ Restless ☐ Irritable

Intervention: ☐ Yes ☐ No
If yes, describe in narrative section

PATIENT EDUCATION

☐ Night Shift / /teaching not appropriate ☐ PCG not available

Topic:______________

Taught to: ☐ Patient ☐ Family ☐ Pcg. ☐ Other______

Method: ☐ Discussion ☐ Demo ☐ Handout ☐ Video

Pt./Pcg. Response:______________

Level of Understanding: ☐ Good ☐ Fair ☐ Poor ☐ Needs Reinforcement

Eval. Method: ☐ Verbal ☐ Return Demo

Need for further teaching: ☐ Yes ☐ No

Caregiver Lacks knowledge of: ☐ Equip. ☐ Therapies ☐ Disease process ☐ Medications ☐ Diet

☐ Discharge Planning Reviewed ☐ N/A at this time

Consults Needed:______________

INTAKE RECORD						OUTPUT RECORD	Urine	Stool	Blood	Emesis	Other
Time:					Total Hr.	Time:					
Total:						Total:					

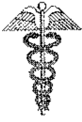
NURSING DOCUMENTATION / SHIFT SUMMARY:

Nurse Signature: ______________ RN / LPN-LVN (circle one)

Pt. / Pcg. Signature: ______________ Reviewed by:______________

White - Medical Record Yellow - Patient Record

PN System 305 818 5940 SAMPLE



QUALITY CARE
NURSING SERVICES, INC.

VENTILATOR MONITORING

Enter readings every 4 hrs (minimum) completing column heading requested information. For new orders, enter date, time and M.D.'s new order(s) on the next available line. On this monitoring record and the Nsg. Care Plan, yellow out the previous order and write the date changed. There must be a written M.D. order for all changes.
Enter changes on the NCP.

Ventilator Model

Ordered Settings

PN System 305 818.5940
SAMPLE

M/D YEAR	TIME A/PM	VENT PRESS LIMIT	TIDAL VOLUME	IMV	I-E RATIO	SYSTEM PRESS (PIP)	FLOW	FI 0_2	CASCADE TEMP	02 SAT	PULSE	RESPIRA				

Patient ____

Week Beginning ______________________________________

QUALITY CARE
NURSING SERVICES, INC.

Pediatric Weekly Medication Sheet

Medication (dose, route, freq.)		Mon. Date____ Time	Initials	Tues. Date____ Time	Initials	Wed. Date____ Time	Initials	Thurs. Date____ Time	Initials	Fri. Date____ Time	Initials	Sat Date____ Time	Initials	Sun Date____ Time	Initials
Order Date ____ Recent Date ____															
Order Date ____ Recent Date ____															
Order Date Recent Date ____															
Order Date ____ Recent Date ____															
Order Date ____ Recent Date ____															
Order Date ____ Recent Date ____															

Allergies____

Print and Sign Name

PN System 305.818.5940
SAMPLE

QUALITY CARE
NURSING SERVICES, INC.

PEDIATRIC NURSING PROGRESS NOTES CONTINUATION

Client's Name: ______________________ SHIFT: ______________________

TIME	

Name:

Signature/ Title: ______________________ Report Given to: ______________________ Date: ______________

PN System 305.818.5940
SAMPLE