QUALITY CARE
NURSING SERVICES, INC.

EXTENDED HOUR NURSING FLOW SHEET NOTE

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.

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

VITAL SIGNS

Time	Temp	Pulse	Resp. Rate	BP

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:_____

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EXTENDED HOUR NURSING FLOW SHEET NOTE 2 of 2

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

QUALITY CARE
NURSING SERVICES, INC.

NURSING PROGRESS NOTES CONTINUATION

Client's Name:_____ SHIFT: _____

TIME	

Name:

Nurse Name / Title: _____ Signature:_____ Date:_____

Florida Home Health Care Providers

Date of Service ___/___/___ M T W Th F Sa Su | **Time in:** AM PM | **Time out:** AM PM

Patient Name | **Patient Number**

Employee Name (print) | **Employee Signature/Title** x

I was seen by the nurse today. I am satisfied with the services I received. I confirm that the time in/time out are correct — **Patient Signature** x

Visit Type (mark all that apply)
- ☐ RN ☐ LPN
- ☐ Aide Supervisory Visit
- ☐ LPN Supervisory Visit
  Following plan of care Y / N

Vital Signs (circle)
Temp:_____ Po/Ax/ Pr
Pulse:_____ Ap / Rd
Resp:_____

	Left	Right	
B/P:	_____/_____	/_____	Lying
	_____/_____	/_____	Sitting
	_____/_____	/_____	Standing

Homebound Status (check all that apply)
- ☐ Bedbound
- ☐ Chairbound
- ☐ SOB/DOE ___ feet
- ☐ Pain limits mobility
- ☐ Unsteady gait
- ☐ Other: _____
- ☐ Uses assistive device:_____
- ☐ Taxing effort to leave home
- ☐ Unsafe to leave home unsupervised
- ☐ Medically contraindicated
- ☐ Needs assist ____ people to ambulate/transfer

Pain Pain intensity scale: 0 --1--2--3--4--5--6--7--8--9--10 (circle)
Location: _____ Meds: _____
Type: _____ Relief: _____

Mental Status ☐ WNL
- ☐ Confused ☐ Combative
- ☐ Comatose ☐ Depressed
- ☐ Disoriented ☐ Agitated
- ☐ Forgetful ☐ Lethargic
- ☐ Stuperous

Nervous System ☐ WNL
- ☐ Headaches ☐ Diplopia
- ☐ Numbness ☐ Vertigo
- ☐ Seizures ☐ Unsteady Gait
- ☐ Tremors ☐ Tinnitus
- ☐ Hyperreflexia

Paralysis: Location _____

Sensory System ☐ WNL
- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Dysphasia
- ☐ Aphasia, expressive/receptive

Respiratory System ☐ WNL

Lung sounds:	Left	Right
Rhonchi	☐	☐
Decreased BS	☐	☐
Inspiratory wheeze	☐	☐
Expiratory wheeze	☐	☐

- ☐ SOB ☐ Orthopnea
- ☐ DOE ___ Ft ☐ Hemoptysis
- ☐ Cough
  - ☐ Dry ☐ Productive
  - Sputum color_____
  - Sputum amount_____
- ☐ Oxygen_____L/min via _____
- ☐ SOB relieve by rest

Musculoskeletal ☐ WNL
- ☐ Contractures ☐ Cramping
- ☐ Pain ☐ Stiffness
- ☐ Trauma/Fracture ☐ Tremor
- ☐ Unsteady gait ☐ Swelling
- ☐ Amputation ☐ Weakness
- ☐ Decreased ROM

Activity:
- ☐ Walker/Cane
- ☐ Wheelchair
- ☐ Prosthesis
- ☐ Walls / Furniture

Skin System ☐ WNL
- ☐ Petechiae ☐ Surgical incisions
- ☐ Jaundice ☐ Pruritis
- ☐ Dry/cracked ☐ Poor turgor
- ☐ Rash ☐ Pallor
- ☐ Clammy ☐ Bruises
- ☐ Flushed ☐ Sutures
- ☐ Skin tears
- ☐ Hyperpigmented
- ☐ Pressure areas:_____
- ☐ Open wound: _____
- ☐ Other: _____

Cardiovascular System ☐ WNL
- ☐ Arrhythmia ☐ Tachycardia
- ☐ Bradycardia ☐ Chest pain
- ☐ Cyanosis ☐ BB Change
- ☐ Distended neck veins
- ☐ Edema-RUE +1 +2 +3 +4
- ☐ Edema-LUE +1 +2 +3 +4
- ☐ Edema-RLE +1 +2 +3 +4
- ☐ Edema-LLE +1 +2 +3 +4
- ☐ Pitting
- ☐ Pacemaker
- ☐ Other implanted cardiac devices
- ☐ Capillary Refill >3 sec
- ☐ Weight:_____

Peripheral Pulses
☐ WNL ☐ Absent ☐ Diminished

Gastrointestinal System ☐ WNL
- ☐ Oral
- ☐ Stomatitis ☐ Ulcers
- ☐ Lesions ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Coated tongue
- ☐ Abnormal Mouth Odor

Digestive System ☐ WNL
- ☐ Abdominal pain
- ☐ Abdominal distention
- ☐ Absent/Decreased bowel sounds
- ☐ Epigasric distress
- ☐ Dysphagia
- ☐ Nausea
- ☐ Vomiting
- ☐ Anorexia
- ☐ Feeding tube (type):_____Site:_____
- ☐ Ascites (abd.girth.)_____cm

Elimination ☐ WNL
- ☐ Colostomy ☐ Ileostomy
- ☐ Constipation ☐ Diarrhea
- ☐ Impaction ☐ Blood stool
- ☐ Incontinent
- ☐ Rectal bleeding
- ☐ Last BM ___/___/___

Nutritional Status ☐ WNL
- ☐ Inadequate fluid/food intake
- ☐ Diet changed to _____

Genitourinary System ☐ WNL
- ☐ Frequency ☐ Polyuria
- ☐ Oliguiria ☐ Nocturia
- ☐ Retention ☐ Hernaturia
- ☐ Burning/Pain ☐ Urgency
- ☐ Incontinence ☐ Diaper
- ☐ Catheter Type ___ Size ____
- ☐ Urine Color:_____
- Odor:_____ Appearance:_____
- ☐ Urostomy _____ ☐ Stents

Genitalia ☐ WNL
- ☐ Lesions ☐ Discharge
- ☐ Pain ☐ Bleeding
- ☐ Pelvic Pressure ☐ Itching
- ☐ Cyanosis

Endocrine System ☐ WNL
- ☐ Polyuria ☐ Polydypsia
- ☐ Heat/cold tolerance
- ☐ Sweating
- ☐ Capillary BS _____ am/pm F/NF
- ☐ Glucometer Calib ___ / ___ / ___

IV Dressing Assessment ☐ WNL
- ☐ Odor ☐ wet ☐ Missing ☐ Soiled

Dressing Change Maintenance:
- ☐ Not done this visit
- ☐ Hibiclense
- ☐ PVP / Oint / Swabs
- ☐ Alcohol Swabs
- ☐ Gauze ☐ Steristrips
- ☐ Transparent Dressing
- ☐ Skin Prep
- ☐ Tubing Change
- ☐ Extension ☐ IV ☐ N/A

IV Site Assessment ☐ WNL
- ☐ Erythema ☐ Drainage
- ☐ Induration ☐ Suture Out
- ☐ Rash ☐ Edema
- ☐ Phelebitis ☐ Pain

Location _____
Gauge _____
Insertion Date _____ ☐ N/A

Skill Instruction
☐ Patient ☐ Caregiver

Instructed on: _____

Outcome:
Patient caregiver verbalized / demonstrated:
- ☐ Competent knowledge
- ☐ Minimal knowledge
- ☐ No knowledge
- ☐ Pt./Cg unable to retain knowledge due to:

Florida Home Health Care Providers

Nursing Progress Note (Cont.)

Supplies Used: ☐ N/A

- ☐ Wound care supplies
- ☐ Glucose monitoring supplies
- ☐ Insulin administration supplies
- ☐ Other:
- ☐ Gloves
- ☐ Foley catheter
- ☐ Irrigation kit
- ☐ Needles / syringes

Notes on Abnormalities, Skilled Interventions and Patient Response to Treatment:

- ☐ All systems assessed
- ☐ Blood sugar checked
- ☐ Insulin administered per doctors orders
- ☐ Vital signs WNL
- ☐ Patient tolerated procedure well

Wound #1	Wound #2	Wound #3
Location: ☐ N/A	Location:	Location:
Cleansed with:	Cleansed with:	Cleansed with:
Rinsed with:	Rinsed with:	Rinsed with:
Applied:	Applied:	Applied:
Packed with:	Packed with:	Packed with:
Covered with:	Covered with:	Covered with:
Secured with:	Secured with:	Secured with:

Injection Management ☐ N/A ☐ Patient unable to self-inject ☐ No C/G available who is willing/able to provide/learn to provide injection

☐ Physical/mental limitations preventing patient from being able to self-administer _____ due to: _____

☐ Patient resides in ALF; Florida state regulations prohibit ALF employees/caregivers from administering injections to residents

☐ Patient able to self-inject insulin ☐ C/G willing to learn injection administration ☐ SN search for alternate C/G to administer injection ongoing

Wound #1 Location: _____ ___ L ___ W ___ D
Surrounding skin: Color _____
Induration _____ Edges _____
Exudate: Color _____ Odor _____
☐ N/A

Wound #2 Location: _____ ___ L ___ W ___ D
Surrounding skin: Color _____
Induration _____ Edges _____
Exudate: Color _____ Odor _____

Wound #3 Location: _____ ___ L ___ W ___ D
Surrounding skin: Color _____
Induration _____ Edges _____
Exudate: Color _____ Odor _____

- ☐ Observed standard / contact precautions
- ☐ Glucometer calibrated
- ☐ Aseptic technique
- ☐ Clean technique
- ☐ Biomedical waste disposed of per agency protocol
- ☐ Needles / syringes disposed of in sharps container

Medication Administration by Skilled Nurse ☐ N/A ☐ Labs checked ☐ Pump program verified

Drug/Solution	Dose/Volume	Site / IM / SQ / IV	Route/Pump Rate/Time		Start/Complete
☐ Novolin 70/30					
☐ Forteo					
☐ Regular					
Heparin Flush	uts/ml				
Saline Flush	ml				