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24 HOUR COMPLEX CARE RECORD
Surgical Services

NUNN106253C Rev: Mar 3/16

Date: _____ ☐ Hospital Day _____ ☐ Post Op _____

FLUID BALANCE RECORD ☐ N/A Initial _____ ☐ CVC Maintenance Worksheet

DAYS	INTAKE							OUTPUT				
Time	IV Solution, Meds, Flushes	Rate	Stop Time	Amt inf	Oral	Tube	Initial	Time	Urine			Initial
	12 HR Total: _____								12 HR Total: _____			

NIGHTS	INTAKE							OUTPUT				
Time	IV Solution, Meds, Flushes	Rate	Stop Time	Amt inf	Oral	Tube	Initial	Time	Urine			Initial
	12 HR Total: _____								12 HR Total: _____			
	24 HR Total: _____								24 HR Total: _____			

Previous 24 HR Balance: + / - Cumulative: + / -

Asymptomatic for fluid overload (edema, coarse breath sounds, cough)	**Time/initial**	
Asymptomatic for dehydration (dry mouth, oliguria, headache)	**Time/initial**	

☐ N/A Peripheral IV(s) ☐ CVC Maintenance Record

Time	PIV #	Site	# Tries if new	Gauge	Tubing/Cap Change Due	Tubing/Cap Change Done	Initial	Reason if IV D/C Note if saline lock applied	Time/init

Review need for PIV each shift CP difficult IV start & FC Time/Initial					
PIV # Site assessment Q1 to 4 hr. Document Q shift & prn					
Infiltration/Phlebitis Scale 0 - free of edema, blanching, redness, cord If score greater than 0, FC & CP with actions per PIV Therapy Clinical Record					
Patent and correct placement confirmed. Flush Q12h with NS per CPG					
Dressing dry & intact (change prn)					

Legend: ✓ = Yes **X** = No **FC**: Focus Chart **CP**: Care Plan **N/A**: Not Applicable **D/C**: Discontinued
Check ☐ If applicable to patient **TBA**: Amount to be infused **N/E**: Not evaluated

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SAFETY ☐ **Aggressive/Violent Behavior Risk Alert**

	Time			
Safety equipment. O_2 mask, nasal prongs, suction, airway.	Safety equipment checked Other equipment:				
Universal Falls Precautions: • Hearing aids, glasses functional & in use • Call bell/personal items, mobility aids within reach • Bottom bed rails down (unless otherwise assessed) • Lower bed to patient knee height/brakes on • Non-skid footwear or non-skid socks • Clutter free pathways & proper lighting • Safe and regular toileting • Mobilize at least twice daily, if appropriate • Engage patient and family in care	Added precautions:				
	Universal Falls Precautions in place				
	Focused hourly rounds: Pain, Peri needs,Position, Possessions				
	Free from falls this shift				
	ADDED FALLS RISK INTERVENTIONS ☐ N/A				
	Bed/chair alarm on				
	Patient room close to nursing station for observation				
Added Precautions: Isolation, Cytotoxic, Seizure **Added Falls Risk Factors:** cognitive, perceptual or communication changes or impairment - FC further interventions in place Hip Protectors - FC reason if criteria met & not applied Least restraint only as last resort - FC	Hip protectors on for 2 or more criteria and no hip staples: ☐ Osteoporosis/Bone Mets ☐ Unsteady ☐ Frail/Underweight/Weak ☐ Age over 75 ☐ Previous falls/injuries ☐ Poor safety awareness ☐ Dizzy/Syncope/Hypertension				
	Family encouraged to stay				

NEUROLOGICAL ☐ **CIWA Assessment Tool** ☐ **Neurovitals Flowsheet** ☐ **Delirium Monitoring Tool** ☐ **Behavior Pattern Summary**

Delirium screening CAM tool per shift and PRN **If CAM score positive, notify MRP & FC** 1-Acute/fluctuating 2-Inattention 3-Disorganized thinking 4-Altered LOC **If CAM score positive, notify MRP & FC** Use **PRISM-E** to address underlying cause of Delirium Pain, Retention, Restraint, Infection, Impaction Immobility, Sensory, Metabolic, Meds, Hypoxia Nutrition, Labs, Environment **(PRISM-E)**	Alert & orientated x 3 (person, place time)				
	Confusion Assessment Method (CAM) negative				
	Night sleep: ☐ Sound ☐ Intermittent ☐ Restless ☐ Patient report ☐ Observed Time/initial:_____				

MOOD/PSYCHOSOCIAL

Inform MRP if concerns re mood anxiety depression - FC Assess need for interpreter and arrange	Observed emotional status: Calm/comfortable				
	Denies concerns				
	Patient participates in care				
	Initial				

PAIN/SEDATION ☐ **Acute Pain Service Flowsheet**

Pasero Opioid Induced Sedation Scale*

Use pre & post opioid admin:

1. Awake and alert
2. Slightly drowsy, easily roused
3. Frequently drowsy, rousable, drifts off to sleep during conversation
4. Somnolent, minimal or no response to verbal or physical stimulation

*Permission, granted C Pasero 2014

Pain Scale: ☐ 0-10 ☐ Faces pain scale ☐ PAINAD ☐ Behaviour _____

Pain Goal: _____ /10 or _____

Pain location: #1 _____ #2 _____ #3 _____

Time												
Location #												
Pain at rest												
Movement												
30 min post analgesic												
Sedation score												
Tolerates activity no distress												
Initial												

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CARDIOVASCULAR ☐ Peripheral Vascular Flowsheet	**Time**						
If cardiac symptoms: Address underlying cause, compare apical pulse to radial pulse, and notify MRP, including potential need for ECG, cardiac blood work & FC. Venous Thromboembolism = VTE Use Peripheral Neurovascular Flowsheet for ortho/vascular patients	Heart rate regular or within normal limits						
	Venous Thromboembolism (VTE) prophylaxis in place Specify: _____ Reassess need if not ordered						
	CWMS to extremities within patient normal limits If abnormal, initiate Peripheral Vascular Flowsheet						
	No generalized edema						
RESPIRATORY							
If O_2 therapy needs increase or if unable to wean as expected: address underlying cause, notify MRP & consult RT if needed	Respirations regular, easy and symmetrical						
	Bilateral breath sounds clear throughout						
	Secretions / sputum within expected limits						
If symptomatic of respiratory infection obtain specimen, inform MRP & FC	Encouraged to Deep Breathe & Cough 10x/hr						
	☐ CPAP on while asleep if OSA						
TRACHEOSTOMY ☐ N/A							
	Emergency safety kit at the bedside						
Tracheostomy Assessment Q4H & PRN	☐ Uncuffed ☐ Cuffed ☐ Cuff inflated ☐ Cuff deflated **Size/Type:** _____						
	☐ Trach mask ☐ T-Piece ☐ Nasal prongs FiO_2						
Q4H temp & O_2 sat within normal limits	☐ Corked & tolerating **Date/Time corked:** _____						
	Stoma care & dressing change Q12H & PRN						
	Peristomal area free from redness swelling, exudate						
	Inner cannula changed Q12H and PRN						
	Minimal Suctioning required						
	Initial						

CHEST TUBE ☐ N/A	**Time**	1	2	3	1	2	3	1	2	3	1	2	3
Location/Type	Emergency chest tube kit at bedside												
	Drain patent												
	Dressing dry and intact												
1. _____ / _____	Dressing changed: site free of redness, minimal exudate												
2. _____ / _____	If Suction: Specify cm H_2O G = gravity C = clamped per MD												
	Absence of subcutaneous emphysema												
3. _____ / _____	Drainage: **S** =sang **Se** = Serous **SS** = Serosang **SP** = Seropurulent **P** = Purulent												
	Airleak meter reading												
	Initial												

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NUTRITION / HYDRATION ☐ Care Plan for Poor Intake

Provide fluids when not restricted

Swallowing screen if at risk for aspiration. Refer to SLP or OT if not already done

Taking average % of each meal per day

Dietary Referral for:
- Malnutrition screen tool score 2 or more
- Intake less than 75% of meal ongoing
- Ongoing food restriction (e.g. NPO)

If nausea and vomiting, assess and address underlying cause. Consider antiemetic (low dose if elderly) - FC

Estimated 24 hour ORAL fluid intake greater than 800 mL ☐ Yes ☐ No ☐ N/A

Diet: ☐ Regular ☐ Other _____ Texture: _____ **Time/initial:** _____

Diet updates: _____ **Time/initial:** _____

☐ Fluid restriction amount _____ mLs **Time/initial:** _____

Time						
No nausea or vomiting						
Eating: I = Independent **A**= Assist **T** = Total						

Circle amount taken below:

Breakfast	25%	50%	75%	100%	None taken
Lunch	25%	50%	75%	100%	None taken
Dinner	25%	50%	75%	100%	None taken

Snacks: _____ ☐ am ☐ pm ☐ hs

☐ NPO
Reason: _____
Day(s) NPO: _____
Time/inital: _____

Enteral Feeding Tube ☐ N/A ☐ TPN

Small Bore Feeding Tube:
☐ Nasogastric ☐ Nasoduodenal
☐ Nasojejunal
☐ X-ray confirmation of placement
Date: _____

Other:
☐ Gastrostomy
☐ Jejunostomy
☐ Gastro-jejunostomy
☐ Other

Tube Feed Formula: _____ ☐ See Continuous Enteral Nutrition Schedule

Initial external measurement (nares to external connection): _____ cm

Insertion site free from redness, swelling, exudate						
Head of bed 30° for nasogastric placement feeding tube						

GASTRO INTESTINAL

GOAL: BM type 4 per Bristol Stool Chart every 2-3 days OR per usual pattern

Use Bowel Movement Record

If 3 or more **unexplained** liquid stools within 24 hours, assess cause Notify MRP

Obtain specimen, begin contact plus precautions and FC

CP if Ostomy

If GI surgery consult MRP prior to initiating bowel protocol & FC. Reassess need for NG Tube

Last formed BM date: _____

Formed BM: **S** = Small **M** = Medium **L** = Large						
Fecal continent						
Abdomen soft, non-distended						
Bowel sounds present						
Flatus present						

Ostomy ☐ N/A
☐ Ostomy Assessment Flowsheet ☐ Other _____ Last appliance change _____

Ostomy type _____ stoma raised red & moist peristomal skin intact, not macerated						

N/G ☐ N/A

NG Suction: L= Low **H** = High **Co** = Continuous I = Intermittent **G** = Gravity **C** = Clamped						
NG Drainage: **Cl** = Clear **Bi** = Bilious **CG** =Coffee Grounds **Other**						
Initial						

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GENITOURINARY	Time						
Avoid incontinent briefs & bedpans.	Urine output adequate, urine clear amber						
Assess for urinary retention Q4H. Insert in and out as per order. If no MD orders, RN to initiate Urinary Retention CPG.	Continent						
	Asymptomatic for UTI						
If indwelling catheter remove ASAP in consult with MRP	**Urinary Catheter** ☐ N/A						
	Type:____ Size: ____ Insertion date: ____ Change: ____ Removal date: ____						
Monitor urinary output & bladder scan if void less than 300 mLs	Indicator for indwelling catheter						
Record Indicator # for indwelling catheter:	Catheter care: surrounding skin clean and intact						
1. Retention not relieved by in and out	Catheter patent						
2. Critically ill	☐ N/A **Ureteral stents (R) (L) in situ + patent**						
3. Urine Monitoring essential for this surgery	☐ N/A **Nephrostomy Tube (R) (L) in situ + patent**						
4. Advanced pressure ulcer & incontinent	☐ N/A **Continuous Bladder Irrigation** **R** = Dilute red **P** = Pink **Cl** = Clear /pale						
5. End of life comfort care	☐ N/A **Urinary Dialysis** H = Hemo C = CAPD ☐ See Flowsheet						
6. Specialized catheter	AV fistula thrill palpable/bruit audible						
_____	☐ N/A **Per Vaginal Flow**						
Instruct patient re: catheter care	**N** = Nil **S** = Scant **M** = Medium **L** = Large **MN** = Menstruating						
UTI S&S notify MRP, send culture & FC:	Vaginal pad changed						
☐ fever ☐ suprapubic tenderness ☐ flank pain ☐ urgency ☐ frequency ☐ dysuria							
	Initial						

INCISION / WOUND CARE ☐ N/A	Time							
☐ See Complex Wound Assessment/ Treatment Form	**Wound / Drain #**							
☐ See Negative Pressure Flowsheet	Dressing dry & intact							
Packing in situ, specify location:	Dressing changed & tolerated well							
_____	Site free of pain / tenderness							
Removed intact Date/Initial: ____	Site free of localized swelling							
	Site free of redness, heat							
Incision / Wound / Drain location /type	Site free of superficial blisters							
1. ____	Approximated							
2. ____	**S** = Sutures **RS** = Retention sutures **St** = Staples **SS** = Steristrips							
3. ____	**Drainage Amount:** **N** = Nil **S** = Scant **SM** = Small **M** = Medium **L** = Large							
4. ____	**Drainage Type:** **S** = Sang **Se** = Serous **SS** = Serosang **SP** = Seropurulent **P** = Purulent							
5. ____								
6. ____	Initial							
If any S&S of infection, notify MRP and send culture and FC								

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SKIN INTEGRITY: ☐ Initiate Braden Risk Assessment and Intervention Flowsheet

Therapeutic surface device:

	Braden Scale - Screening Score (see Braden tool)				Score
Sensory Perception	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	
Moisture	1. Constantly Moist	2. Often Moist	3. Occasionally Moist	4. Rarely Moist	
Activity	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	
Mobility	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitations	
Nutrition	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent	
Friction and Shear	1. Problem	2. Potential Problem	3. No Apparent Problem		

Braden Score on admission, even days & PRN Score: _____

Initiate Braden Risk Assessment and Intervention Flowsheet for score in any grey area or less than 18

Braces / Collars/ Splints / Cast location:

1. _____
2. _____
3. _____
4. _____

Time						
Repositioned Q2H to either side. Pressure alleviated on pressure points						
Perineum free of redness / breakdown						
Pressure points free of redness / breakdown						
Braces /casts area free of redness / breakdown						

MOBILITY ☐ See PT CP/ notes

If activity restrictions consult with MRP and CP.

If on bedrest, turn Q2H while in bed

Day 1 and on: Walk x 2 minimum

Mobility Assist:
I = Independent **S** = Supervision
1P = 1 person **2P** = 2 person

Equipment:
WR = Walker **Ca** = Cane
Cr = Crutches **FL** = Full Lift
SS = Sit to stand lift
WC = Wheelchair
N = None

Advance Mobility Daily:
e.g. walk to bathroom, hallway
Increase independence
Over age 70 or frail, avoid sitting longer than 1 hour at a time
Provide rest periods

Activity restrictions: ☐ Bedrest ordered ☐ Other						
Head of bed up 30 degrees (unless contraindicated)						
Walked x 3 (at least x 2 on days)						
Weight bear: F = Full P = Partial **Fe** = Feather **N** = None Affected limb _____						
On days: Up in chair for at least two meals Total **hours** out of bed: **None, less than 1, 1-2, 2-6, more than 6**						
Mobility assist required						
Mobility Equipment used						
Mobility advancing daily as per plan ☐**Post Op 0** ☐Dangle ☐Stand ☐Walked						

HYGIENE/ORAL CARE

Hand hygiene before each meal and after toileting

Base frequency of oral care on the condition of the patient's oral cavity and patient's level of comfort

Oral care for dependent patient:
Q4H & PRN assess & clean mouth

Moisturize lips/mouth with mouth moisturizer. Change Yankauer and suction tubing Q24

Hygiene: I = Independent A = Assist T = Total						
Pericare after toileting & PRN						
Independent patient: Teeth brushing facilitated BID & PRN						
Care dependent patient: Oral care Q4H & PRN						
Initial						