

GUIDELINES FOR: Medical-Surgical-Oncology, Medicine 4/Medical Stepdown, and GeroPsych Flowsheets

The minimum frequency of general assessment will be three times a day, done approximately every eight hours. The frequency of assessment for vital signs is every four hours (or by LIP order). Assessment of sedation score, sensory involvement, and/or vascular flow is dependent on physician orders, on the patient's overall condition, and policies/protocols applicable to the patient's care (i.e. Pain protocols, unit structure standards, etc.). If vital signs must be obtained more frequently than hourly, then the Frequent Vital Signs sheet should be used. Any staff member (RN, LPN, CNA, MA) documenting on the flowsheet must enter his/her initials and signature in the far-right margin of each page as well as at the bottom of page 7 as well as page 8 on Medicine/Medical Step Down 4.

Documentation on the Flowsheet should be recorded in the appropriate row specific to the time of day when the data was collected. All assessments should be entered in the row that corresponds with the time that they were done.

PAGE 1: VITALS/PAIN MANAGEMENT

Date	<ul style="list-style-type: none"> Enter dates for flow sheet
Pain	<ul style="list-style-type: none"> In the Pain box in the top left of the Flowsheet, check the pain scale being utilized for the patient for pain assessments: <ul style="list-style-type: none"> the 0-10 scale the Faces scale PAINAD scale (for dementia patients) FLACC (for non-verbal patients) Definitions and uses of the pain scales are defined in the policy : Pain: Care of the Adult Patient With (and Use of Pain Scales) located in the Nursing Practice Manual
PCA	<ul style="list-style-type: none"> √ applicable Morphine or Dilaudid infusion, if patient is receiving narcotics via PCA pump; otherwise enter specific infusion type. Enter dilution, delay and 1 hour limit. PCA's may ONLY have a basal rate for Sickle Cell patients located on Oncology 6.
Epidural	<ul style="list-style-type: none"> √ standard infusion type, if applicable; otherwise enter specific infusion type. Enter basal rate. If its and epidural PCA enter lock out interval time and one hour dose limit.
Yesterday's Weight	<ul style="list-style-type: none"> Enter weight from the previous days flowsheet
Today's Weight	<ul style="list-style-type: none"> Enter the weight taken today
Weight Change	<ul style="list-style-type: none"> Enter the amount, either + or - of the change between yesterdays and today's weight (Subtract the larger number from the smaller number to get the difference, and identify it as a loss or gain with the + or - symbols.
Vital Signs	<ul style="list-style-type: none"> Enter values for T (temperature), HR (heart rate), BP (blood pressure), and RR (respiratory rate)
Pulse Ox (SpO2) and Oxygen Delivery	<ul style="list-style-type: none"> Enter pulse ox value if patient is on pulse oximetry, and oxygen delivery/flow rate, if applicable
Pain Score	<ul style="list-style-type: none"> A numeric pain rating value of range 0-10 (0=no pain, 10=worst pain imaginable) should be entered whenever possible (all scales, have a 1-10 correlation) , along with a Y (yes) or N (no) indicating whether or not the patient finds the pain level acceptable to him/her

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PCA	<ul style="list-style-type: none"> Document the number of injected doses of medication and the number of attempts for patients on a PCA pump
Sedation Score, Sensory Check, Motor Check	<ul style="list-style-type: none"> Enter values using the legend at top of page.
Epidural Rate/Site Check	<ul style="list-style-type: none"> Enter the rate that the epidural is running at. Rate changes are captured here Epidural site check must be performed every 12 hours. The site should be assessed for redness, bruising, swelling and leakage. The check mark indicates the check was done, if any of the above are present, document in the nursing note and notify anesthesia.
Pulses	<ul style="list-style-type: none"> Document strength of blood flow of the RRAD (right radial), LRAD (left radial), RDP (right dorsalis pedis) and LDP (left dorsalis pedis) by indicating if the palpable pulses or Doppler pulse is 0 (absent), 1 (diminished/weak), 2 (as expected), 3 (full/increased), or 4 (bounding), or if the doppler measurement is audible (DA) or inaudible (DI)
Comments/Meds	<ul style="list-style-type: none"> Use this column for any medications you want to include on the Flowsheet (perhaps in response to an elevated VS or FSG or pain) or any other comments that may be helpful. Refer to MAR for documentation of any medications administered
Fingerstick glucose (FSG)	<ul style="list-style-type: none"> Enter any decentralized lab testing values and sliding scale insulin coverage if applicable; refer to MAR for documentation of all drugs administered in response to the value

** A significant deterioration in any vital sign or other objective measure of patient status indicates the need to report the condition to the House Officer (HO).

PAGE 2: 24 HOUR FLUID INTAKE

IV Sites	<ul style="list-style-type: none"> Document the location(s) of each IV site. There is space to include 3(three) IV sites as well as 1 (one) central line. Be sure to specify insertion date. If the dressing is intact, changed or the IV is discontinued, check the appropriate box.
Infusions	<ul style="list-style-type: none"> A column is provided for up to 5 (Five) separate infusions. Each infusion should have the intravenous fluid (IVF) being administered identified along with the corresponding site number (#). Solutions infused must be documented with the corresponding column/IV site, as well as the hourly rate Phlebitis and infiltration scores should be documented every 8 hours under the corresponding IV site
IV Medications/Flush	<ul style="list-style-type: none"> document the volume of intermittent medications administered, when applicable
Epidural Rate	<ul style="list-style-type: none"> Document the rate of the epidural in this column, this is where a rate change can be identified
Tube Feeds	<ul style="list-style-type: none"> Document the type of tube feeding product being used, as well as the hourly infusion rate

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Residual/Placement	<ul style="list-style-type: none"> Document the volume of residual aspirated as well as the placement of the tube (+ for positive placement - for negative placement, if placement is negative, nothing should be placed in the tube, and the LIP contacted
PO Fluid	<ul style="list-style-type: none"> All oral fluids must be included in the cumulative 24-hour intake Calculation
PO Solid (%) Diet	<ul style="list-style-type: none"> Document the percentage of each meal consumed, especially for patients on calorie counts. Document the patients current diet order
Intake Hourly Cumulative	<ul style="list-style-type: none"> If needed, this column can be used to keep track of all intake on an hourly basis
8 Hour Total	<ul style="list-style-type: none"> At eight hour intervals, record the 8-hour intake for each column
24 Hour Total	<ul style="list-style-type: none"> At the bottom of the page, record the 24-hour intake for each column

PAGE 3: 24 HOUR FLUID OUTPUT

Top Left Box	Check the appropriate box to indicate how the patient voids, and if they have a colostomy or ileostomy. If they do have an appliance, indicate when the change was done and the date
Top Right Box	<p><i>Hemodialysis</i>- check the box if they are a hemodylasis patient</p> <p><i>CAPD</i>- check the box if the patient is a CAPD patient- this will indicate a separate CAPD flowsheet</p> <p>Due to Void (DTV): check the box and enter the time that the patient is due to void in this space.</p> <p>EBL: enter the estimated blood loss in this column.</p>
Tubes 1-5	Enter type of tube at top of column, and the hourly output, if applicable Make certain that tube 2, tube 3 and tube 4 are clearly labeled on the Flowsheet and correspond to the same tube on the patient.
CBI: Continuous bladder irrigation	Enter the type of continuous bladder irrigation fluid being used. Record amounts for solution hung, amount infused each hour, and amount of output each hour. Then calculate the true urine output by subtracting amount infused from the output.
Urine Output	Enter volume of output corresponding to the appropriate time of day
Post Void Residual (PVR):	Enter volume of urine obtained after patient voids
Stool/Heme	<ul style="list-style-type: none"> LBM = last bowel movement; enter the date of the last bowel movement Indicate the volume of stool produced, as appropriate. For hemacult testing use + if positive or - if negative- sticker may be used.
Emesis	<ul style="list-style-type: none"> Enter amount produced, as appropriate
8 Hour Total	<ul style="list-style-type: none"> At three, 8 hour intervals, record the 8-hour output for each column
24 Hour Total	<ul style="list-style-type: none"> At the bottom of the page, record the 24-hour output for

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	each column
Cumulative Values	<ul style="list-style-type: none"> At bottom of page 3, record the 24-hour cumulative total intake from the previous page and the total output from the current page in the dark-outlined box Subtract the two values to determine the 24-hour net balance, and record on the Flowsheet

PAGE 4: NURSING ASSESSMENT

	Eye Opening	<ul style="list-style-type: none"> Using the legend at the top of the page, document the patients eye opening response: <ul style="list-style-type: none"> 4 - spontaneously 3 - to speech 2 - to pain 1 - no opening
	Motor Response	<ul style="list-style-type: none"> Using the legend at the top of the page, document the patients motor response: <ul style="list-style-type: none"> 6 - observes commands 5 - localizes pain 4 - withdraws from pain 3 - flexion to pain 2 - extension to pain 1 - none
	Verbal Response	<ul style="list-style-type: none"> Using the legend at the top of the page, document verbal response: <ul style="list-style-type: none"> 5 - oriented 4 - confused 3 - inappropriate 2 - incomprehensible 1 - none
	Motor Function	<ul style="list-style-type: none"> Assess motor function of the left and right upper and lower extremities as: <ul style="list-style-type: none"> 5-full strength 4-less than normal strength 3-can raise extremity, but not against resistance 2-can move extremity, but not lift it 1-slight movement 0-no movement
	Pupils	<ul style="list-style-type: none"> Document size and reaction for left and right eye accordingly
Respiratory Assessment	Suction	<ul style="list-style-type: none"> Place a check mark in the appropriate box corresponding to the time that each of these tasks was performed by the nurse or patient
	Incentive Spirometer	
	Trach Care	
	Breath Sounds	<p>Document auscultated breath sounds according to the legend at the top of the page, corresponding to the time of the assessment</p> <p>Boxes are labeled as LUL (left upper lobe), LLL (left lower lobe), RUL (right upper lobe) and RLL (right lower lobe)</p> <p>Breath sounds are identified as N (normal), W (wheeze), C (crackles), A (absent), or ↓ (decreased)</p>
	Sputum	<p>The color (clear, white, tan, yellow, green, hemoptysis) and amount of sputum (small, medium, large/copious) is documented</p>

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		in the corresponding boxes and under the appropriate time frame
GI Assessment	Bowel Sounds	Using the legend at the top of page 4, document the patients' abdominal exam. Bowel sounds are assessed in each of the four quadrants: RUQ (right upper quadrant), RLQ (right lower quadrant), LUQ (left upper quadrant), and LLQ (left lower quadrant) as positive, negative hypoactive or hyperactive.
	Flatus	Flatus is documented as either positive or negative
	Edema	Edema is documented according to the legend at the top of the page for right and left, upper and lower extremities (RUE, RLE, LUE, LLE)

**PAGE 5: FALL PREVENTION TREATMENT PLAN
 FALL PREVENTION TREATMENT PLAN**

Fall Prevention Treatment Plan is incorporated into the medical 4/ Med Stepdown and Med/Surg/Onc Flowsheet as its own form. It now incorporates both the fall score as well as various potential or actual interventions put into place for a given patient.

The Fall Risk Assessment Screening Tool is located on the left side of the document, and is divided into 5 categories - fall history; confusion/disorientation; mobility impaired/change of position; elimination, altered; and medications.

The next column provides an overview of the patient descriptors (i.e. indicators for point values) for each fall risk category.

The Shift/Time boxes should be filled in for the shift/time that the fall risk screening was completed. The number of points the patient scores for each given category (from 4 points to 2 points) should be filled in for each category. The fall risk score should be totaled at the bottom of this column.

The Interventions/Guidelines column provides the nurse the opportunity to document interventions put into place for a given shift/time of day. The Shift/Time box needs to be completed at the time of documenting interventions. Universal Risk is located at the top of the form and includes pre-determined interventions to maintain the safety of all patients regardless of what their fall score is determined to be. They should be implemented and signed off for all patients by all nurses in the appropriate column corresponding to the shift/time.

The Fall risk assessment screening categories are scored according to whether the patient meets any of the patient descriptors in the second column. The point value (2 or 4 pts) should be written in the column corresponding to the shift/time of screening. If the patient scores any points for any given fall risk, then any interventions put into place for that given risk should be signed off. Please note that some interventions are required interventions (noted with an asterisk [*]) for a given fall risk. For example, if a patient earns 2 or 4 points for the fall history category, then the required interventions that should be initiated/implemented and signed off include "PT consult ordered" and "encourage patient to call for assistance." Other interventions listed next to fall history are optional and should be based on additional patient factors.

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PAGE 6: SKIN AND WOUND ASSESSMENTS

Scoring of the Braden Scale Pressure Ulcer Risk Reduction Tool, interventions, and documentation of skin or wound breakdown documentation is located page 6, in the section called Skin and Wound Assessments.

There are 3 outlined areas to complete in this form:

I. Outlined area 1: Braden Scale

All adult inpatients should have this form completed using the following guidelines:

The Braden Scale will be performed:

- o On hospital admission
- o Every 24 hours
- o Upon patient transfer (by the nurse accepting the patient on the new unit)
- o With any change of condition

Time	Enter the military time the Braden Scale is done
Initials	Place your initials in the box
Sensory Perception	Place a numerical score in the subset box (from 1-4). The score is based on the nurse's patient assessment of the following: 1. completely limited sensory perception 2. very limited sensory perception 3. slightly limited sensory perception 4. no impairment
Moisture	Place a numerical score in the subset box (from 1-4). The score is based on the nurse's patient assessment of the following: 1. constantly moist 2. very moist 3. occasionally moist 4. rarely moist
Activity	Place a numerical score in the subset box (from 1-4). The score is based on the nurse's patient assessment of the following: 1. bedfast 2. chairfast 3. walks occasionally 4. walks frequently
Mobility	Place a numerical score in the subset box (from 1-4). The score is based on the nurse's patient assessment of the following: 1. completely immobile 2. very limited mobility 3. slightly limited mobility 4. no mobility limitation
Nutrition	Place a numerical score in the subset box (from 1-4). The score is based on the nurse's patient assessment of the following: 1. very poor nutritional status 2. probably inadequate nutrition status 3. adequate nutrition 4. excellent nutrition

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	transferring patient
Box 4 Outline of body (front and back) Outline of plantar surface of feet Outline of dorsal surface of feet	Circle and number any areas of skin breakdown on the anatomical outline to correspond to the descriptors located below in Outline Area #3.
Box 5 Is this the Admission Assessment?	Question is posed to prompt nurse to check off either "yes" or "no" : Yes - this is done only one time at the initial hospital admission No - this is checked every time after the hospital admission

III. Outlined area 3: Skin or Wound Breakdown Areas Documentation

- When the nurse determines that the patient does not have any areas of skin breakdown following the performance a skin assessment, the nurse checks off the box "No Skin Breakdown". No further documentation is needed on this form.
- However, when a patient has skin breakdown or wounds, this space documents wound descriptors for pressure ulcer wounds or non-pressure ulcer wounds (arterial ulcers, venous stasis ulcers, skin tears, presence of a rash, wound dehiscence, fistulas, an open postop surgical incision, etc.) using these parameters:
 - o Within 24 hours of hospital admission
 - o Weekly (every Wednesday)
 - o With change in patient or wound condition
- Page 6 supplements the overall Skin Assessment Section located on page 7 of the Med/Surg/Onc Flowsheet The one exception to completion of this part of the wounds flow sheet for wounds is a surgical incision that is well-approximated and closed, and the patient has no additional skin or wound breakdowns to describe. In that case, the documentation on page 7 is sufficient, and notes the surgical incision's location, and whether it is clean ©, dry (D), dressing intact (I), and approximated (A).

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Location	Columns #1, #2, #3, #4 1. List each location of skin breakdown or wound location, up to 4 sites. 2. Should correspond to circled and number areas of the body outline. 3. If there are additional columns needed for additional areas, please use a second flow sheet and label "second sheet".
Wound Type	Under appropriate column, fill in the wound type using the abbreviations: NPU non-pressure ulcer (such as arterial, venous, diabetic) OSI open surgical wound (dehiscd, post-op) ST skin tear PU pressure ulcer R rash O other (purpura, hematoma, etc.)
Pressure Ulcer Stage or NA	Pressure ulcer (skin breakdown over bony prominence from pressure, friction, shear) Stage 1 Stage 2 Stage 3 Stage 4 DTI Deep Tissue Injury US Unstageable N/A No Applicable - not a pressure ulcer
Length	Measurement of length of wound in centimeters (head to toe)
Width	Measurement of width of wound in centimeters (hip to hip)
Depth	Measurement of depth of wound in centimeters (deepest area)
Tunneling	In presence of wound tunneling, describe in centimeters location using clock method, such as "1.5 cm at 9 o'clock" Leave blank or draw line through box if tunneling is not present.
Undermining	In presence of wound undermining, describe in centimeters location using clock method, such as "2.5 cm at 2 to 4 o'clock" Leave blank or draw line through box if undermining is not present.
Wound Appearance	In percentages, describe wound bed, based on appearance. R= red wound bed, represents granulation Y = yellow wound bed, represents slough B = Black or brown wound bed, represents necrotic tissue
Drainage Type	Under appropriate column for each corresponding wound, document drainage type: N= none (no drainage) S= serous SA= sanguinous P= purulent

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Drainage Amount	Under appropriate column for each corresponding wound, document drainage amount: N= none (no drainage) M= minimal (scant) MO= moderate L=large
Surrounding Tissue	Describe surrounding wound tissue (periwound): I= intact P=purple EX= excoriated M=macerated R= red or erythema O=other
Odor	Does the wound have an odor? Y= yes N= no
Treatment code	Allows documentation of up to three daily dressing changes for each wound with time of change and initials under the appropriate wound column using treatment codes: <ul style="list-style-type: none"> • Category I = Place I in column for dressing changed, wound unchanged • Category II= Place II in column for a dressing changed, wound appears changed → further documentation to support change is written in the columns above • Category III= Place III in column when dressing remains intact, and is not changed or not due to be changed
TX	Documentation of treatment or dressings with time and initials under the corresponding columns matched to sequence of dressing changes (1,2, or 3): H= hydrocolloid (duoderm) DSD= dry sterile dressing Vac= wound vac BS= barrier spray (i.e. cavilon spray) HB= hydrofera blue HG= hydrogel WD= wet to dry HF= hydrofiber (Aquacel) HFAG= hydrofiber with silver (aquacel AG) OTA= open to air O= other Describe _____ (examples - Dakin's solution, mepilex, mesalt)

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PAGE 7: CARE GIVEN

The nurse performing the nursing assessment and/or collecting data must enter the shift that the identified nursing care is given. Care needs are divided into two different columns and categorized on the left hand side of each column. Categories are hygiene, activity, skin assessment, safety, cardiac and chest tubes. Next to each category are various check boxes and/or interventions with bolded codes. When care is provided to a patient, the nurse writes his/her initials or the code next to the nursing care under his/her corresponding shift column.

Hygiene	<ul style="list-style-type: none"> • Initial one or more boxes appropriate for the care which was provided: <ul style="list-style-type: none"> ▪ Shower (S), Sponge bath (SB) ▪ Self/Assist/Total (S, A or T) ▪ Pericare/Foley care (P or F) ▪ Bedside Commode ▪ Oral Care ▪ Other
Activity	<ul style="list-style-type: none"> • Initial and/or check the appropriate box(es) applicable to the patient's activity level: <ul style="list-style-type: none"> ▪ Bedrest ▪ Out of Bed (OOB): with assist or without assist ▪ Ambulate: with assist or without assist ▪ Turn/Reposition q ____ hours ▪ Bed: Versacare, Advanta or Other ▪ H.O.B. ____degrees ▪ Traction and/or CPM and/or Foot/Leg pumps ▪ Immobilizer: Identify type of immobilizer used and which side (left, right or bilateral) it is being used on as appropriate. ▪ Other
Skin Assessment	<ul style="list-style-type: none"> • Document whether the patient has no skin breakdown. • Document whether the patient's skin is pink (P), warm (W), dusky(D) and/or Jaundice (J). If other- describe (such as pale) • If there is a surgical incision, document the location, and if it is clean (C), dry (D), dressing intact (I) and approximated (A). There is space for two surgical incisions. • Other wounds or Skin breakdown: initial to indicate that the skin and wound assessment page has been utilized
Safety	<ul style="list-style-type: none"> • Initial appropriate boxes for: <ul style="list-style-type: none"> ▪ side rails up (2-3 rails may be up, 4 side rails up are considered a restraint). ▪ call light in reach ▪ ID bracelet is on ▪ Allergy bracelet is on ▪ Fall Risk bracelet is on ▪ Bed Alarm (B) or Chair Alarm (C) is on ▪ isolation precautions

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	<ul style="list-style-type: none"> ▪ Restraints ▪ constant observation/1:1 ▪ seizure precautions ▪ Aspiration precautions ▪ Other (such as radiation) ▪ Visual impairment or deaf/hard of hearing ▪ If interpreter services are needed, and if so what language
Cardiac	<ul style="list-style-type: none"> • Indicate type of monitoring used (if any): Telemetry, Hardwire or continuous pulse oximetry • Permanent Pacemaker • AICD (automated implantable cardioverter-defibrillator)
Chest Tubes	<ul style="list-style-type: none"> • Left and/or Right Pleural chest tube • Indicate if chest tube is on continuous low wall suction (S) or to water seal (W) by placing a S or W in the corresponding time column. • Presence of an air leak: Y= Yes N= No, enter Y or N in column • Presence of crepitus : Y= Yes N= No, enter Y or N in column
Initials/Signature	<ul style="list-style-type: none"> • EVERY person documenting on the Flowsheet must have their initials, signature and title documented on the bottom of page 7

PAGES 8 and 9 are for Medicine 4 and Medical Stepdown ONLY:

Page 8: Arrhythmia Strips

Arrhythmia Strips	<p>Page 8 of the flowsheet includes space for four different arrhythmia strips. It is important that the strip does not exceed the space of the box outlined on the page. To the left the date and time should be recorded along with the rate, PRI, QRS, QT and interpretation. A signature should accompany each strip. The person recording the strip must also sign, initial and title the bottom of page 7 on the flowsheet. The frequency of obtaining and interpreting strips is outlined in the policy: Cardiac Monitoring: Care of the Patient on Cardiac Monitoring.</p>
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Page 9: Frequent Vital Signs

Frequent Vital Signs	For vitals signs that are obtained more frequently than once an hour, record the following: Date, time, temperature, heart rate/rythm), respiratory rate, blood pressure, SpO2 (pulse oximetry), any applicable comments and initials. Initials must have corresponding signature, initials and title on page 7 of the flow sheet.
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Important Documentation Reminders:

1. A progress note is required a minimum of every 24 hours, and in accordance with the "Documentation: Progress Notes" procedure located in the Nursing Practice Manual.
2. All nursing progress notes will be written using DAR (focus) format, and labeled using a nursing diagnosis, an event or symptom, a variance, or an active problem on the patient care plan.

D (Data): Subjective and/or objective information, which supports the problem or describes observations at the time of a significant event in therapy

A (Action): Past, present or future actions based on the assessment/evaluation of the patient's condition. The action also includes evaluation of the present care plan, any changes required, and the plan for future care

R (Response): Description of patient responses/outcomes to care

3. All med/surg patients will have an individualized patient care plan initiated by the nurse either in the medical record or attached to the bedside flowsheet. The patient care plan will serve as a communication and documentation tool for clinical staff as they work with the patient, family and interdisciplinary team to:
 - a. plan the patient's care based on clinical, psychosocial, teaching/learning, spiritual and cultural needs
 - b. set outcomes based goals
 - c. identify interventions to be implemented for attaining goals
4. Problems on the patient care plan will be reviewed and prioritized at least once daily by the nurse. Data supporting the patient's specific focus/problem, interventions (including assessments and monitoring), and

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patient response will be reflected through the use of unit-specific flowsheets, and focus/DAR notes in the medical record.

5. All patient and family teaching must be documented on the appropriate Patient and Family Teaching Record.

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