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.

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

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
Peripheral Pulses: ☐ LUE ☐ LLE ☐ RUE ☐ FILE
☐ 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:_____

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:_____

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:_____

PM System 305.818.5940 SAMPLE

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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:_____

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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

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M/D Y E A R	T I M E A/PM	V E P N R L T E I S M S I T	T I V D O A L L U M E	I M V	I-E R A T I O	S Y P S R T E E S M S (PIP)	F L O W	F I 0_2	C A T S E C M A P D E	0_2 S A T	P U L S E	R E S p I R A				

Patient _____

Week Beginning _____

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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

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PEDIATRIC NURSING PROGRESS NOTES CONTINUATION

Client's Name:_____ SHIFT: _____

TIME	

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Name:

Signature/ Title: _____ Report Given to:_____ Date:_____

PEDIATRIC HOME HEALTH DISCHARGE SUMMARY

Patient and discharge details

1. Agency and Patient Information

Agency Name
Your Agency Name

Branch/Office

Agency Phone

Patient Full Name

DOB

MRN/Chart #

Parent/Legal Guardian

Guardian Phone

Preferred Language
__ English __ Spanish __ Other:_____

Address

City/State/ZIP

Primary Physician/PCP

PCP Phone/Fax

Payer/Insurance

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2. Admission and Discharge Details

SOC/Admission Date

Discharge Date

Last Visit Date

Discipline Completing Form
__ SN __PT __ OT __ ST __ MSW

Discharge Status

- ☐ Stable
- ☐ Improved
- ☐ Unchanged
- ☐ Declined
- ☐ Transferred
- ☐ Expired

Discharge Disposition

- ☐ Home/Self-care
- ☐ Physician care
- ☐ Outpatient therapy
- ☐ Hospital
- ☐ SNF
- ☐ Another agency
- ☐ Other _____

Visit Frequency at Discharge

Reason for Discharge (select all that apply)

- ☐ Goals met
- ☐ Max benefit
- ☐ Physician order
- ☐ Caregiver request
- ☐ Transfer agency
- ☐ Hospitalized
- ☐ No longer homebound
- ☐ Non-compliance

Other reason/comments

Diagnoses and ICD-10 codes

3. Clinical Summary and Skilled Services Provided

Summary of skilled care provided, response to treatment, and progress toward goals

_____

_____

Skilled Services Provided

- ☐ Skilled nursing
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medical social work
- ☐ Home health aide

Condition at Discharge

- ○ Stable
- ○ Improved
- ○ Unchanged
- ○ Declined

Goal Status:

- ☐ All goals met
- ☐ Most goals met
- ☐ Partially met
- ☐ Not met
- ☐ Unable to assess

Risk Level
__ Low __ Moderate __ High

PEDIATRIC HOME HEALTH DISCHARGE SUMMARY

Clinical assessment

4. Discharge Clinical Assessment

Your Agency Name

Vital Signs at/near Discharge

Date	Temp	HR	RR	BP	SpO2	Weight

Respiratory Status
- ☐ WNL
- ☐ Stable chronic needs
- ☐ Oxygen dependent
- ☐ Vent/trach
- ☐ Distress/concern

Cardiac Status
- ☐ WNL
- ☐ Stable
- ☐ Edema
- ☐ Abnormal findings
- ☐ Concern

Nutrition/Hydration
- ☐ PO adequate
- ☐ Tube feeding
- ☐ TPN
- ☐ Poor intake
- ☐ Concern

Skin/Wound Status
- ☐ Intact
- ☐ Wound improving
- ☐ Wound unchanged
- ☐ New breakdown
- ☐ Concern

Pain Status
- ☐ No pain
- ☐ Controlled
- ☐ Intermittent
- ☐ Uncontrolled
- ☐ Unable to assess _____

Neuro/Development
- ☐ Baseline
- ☐ Improving
- ☐ Delayed
- ☐ Changed status
- ☐ Concern

Pertinent clinical findings, unresolved problems, and recommendations

5. Equipment, Supplies, and Technology

Equipment in Home

- ☐ Oxygen
- ☐ Nebulizer
- ☐ Suction
- ☐ Enteral pump
- ☐ Ventilator
- ☐ Trach supplies
- ☐ Glucometer
- ☐ Other

Equipment Vendor

Vendor Phone

Supplies Remaining/Ordered

Equipment / supply instructions and troubleshooting reviewed

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PEDIATRIC HOME HEALTH DISCHARGE SUMMARY

Medication reconciliation and caregiver teaching

6. Medication Reconciliation at Discharge

Your Agency Name

Medication list reviewed with caregiver? ○ Yes ○ No ○ N/A **Discrepancies resolved?** ○ Yes ○ No

Medication	Dose/Route	Frequency	Purpose	Instructions/Notes

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7. Caregiver Education and Return Demonstration

Education Provided To **Relationship** **Interpreter Used** ○ No ○ Yes

Topics Covered (select all that apply)

- ☐ Medication administration
- ☐ Equipment use
- ☐ G-tube/enteral feeds
- ☐ Fall prevention
- ☐ Infection control
- ☐ Trach care
- ☐ Wound/skin care
- ☐ Nutrition/hydration
- ☐ Emergency plan/911
- ☐ Ventilator
- ☐ Seizure precautions
- ☐ Other

Caregiver Understanding

- ☐ Verbalized understanding
- ☐ Return demonstration complete
- ☐ Needs reinforcement
- ☐ Unable to demonstrate
- ☐ N/A

Written Instructions Yes ○ No ○ N/A ○

Education notes, barriers, and caregiver response

Home exercise/program, diet, activity, wound care, respiratory care, or other ongoing instructions

PEDIATRIC HOME HEALTH DISCHARGE SUMMARY

Referrals, safety plan, and checklist

8. Referrals, Follow-up, and Notifications

Your Agency Name

Follow-up Appointment Date/Time | **Provider/Clinic** | **Phone**

Referrals Made

- ☐ PT
- ☐ OT
- ☐ ST
- ☐ MSW
- ☐ DME/Supplies
- ☐ Specialist
- ☐ School nurse/IEP
- ☐ Other

Referral details and contact information

Physician/PCP notified: date, time, method, response

9. Emergency and Safety Plan at Discharge

Emergency Plan Reviewed ○ Yes ○ No ○ N/A

High-risk instructions needed ○ No ○ Yes

Emergency instructions: symptoms requiring provider call, 911 criteria, after-hours number, equipment failure plan

10. Required Attachments / Document Checklist

- ☐ Medication list
- ☐ Discharge instructions
- ☐ Plan of care summary
- ☐ Discharge Summary
- ☐ Final visit note
- ☐ Referral documentation

Records Sent To | **Sent Date** | **Method** __ Fax __ email __ courier

11. Signatures and Attestation

I certify that the information documented on this discharge summary is accurate to the best of my knowledge and that discharge instructions were reviewed with the patient caregiver/legal guardian as applicable.

Discharging Clinician

Printed Name/Title

Signature

Date

Parent/Legal Guardian

Printed Name

Signature

Date

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