

Patient Name: _____

Date: _____

PATIENT CARE AND SAFETY																								
TIME ⇨	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
PERSONAL CARE																								
Bath Complete																								
Assist																								
Self																								
Shower																								
Oral Care																								
Hair Care																								
Shave																								
Foot Care																								
Peri Care																								
Urinary Catheter Care																								
PM Care																								
Linen Change																								
ACTIVITY																								
Bed Rest	P	A																						
Position R L S																								
Positions Self																								
COB to Chair w/Assist																								
Return to Bed w/Assist																								
Dist Amb in Rm																								
Dist Amb in Hall																								
BRP																								
Sleeping																								
FLUIDS																								
Encourage																								
Restrict																								
SAFETY																								
ID Band																								
Allergy Band																								
Code Status Verified																								
Side Rails Up X _____																								
Call Light in Reach																								
Bed Alarm																								
Bed Low Position																								
Safety Checks / Q hr																								
HOB <input type="checkbox"/> Up																								
Brakes Locked																								
DEVICES																								
Podus Boots on / off																								
Ted Hose on / off																								
CPM																								
Other:																								
EQUIPMENT IN USE																								
SPECIAL BEDS	ORTHOPEDIC EQUIPMENT					ASSIST DEVICES					INFUSION DEVICES					OTHER ITEMS*								
<input type="checkbox"/> Accucaire Overlay	<input type="checkbox"/> CPM Machine @ _____					<input type="checkbox"/> K-Thermia Pad					<input type="checkbox"/> IV Pump X _____					<input type="checkbox"/> Pulse Oximetry								
<input type="checkbox"/> Zonaire Bed	<input type="checkbox"/> Overhead Trapeze					<input type="checkbox"/> Plexipulse / SCDS					<input type="checkbox"/> Feeding Pump					<input type="checkbox"/> Thermo/Hemo Monitoring								
<input type="checkbox"/> Flexcaire											<input type="checkbox"/> PCA Pump					<input type="checkbox"/> Pressure Lines								
<input type="checkbox"/> Other																<input type="checkbox"/> Wound Vac								

7A Signature/Title: **X** _____

7P Signature/Title: **X** _____