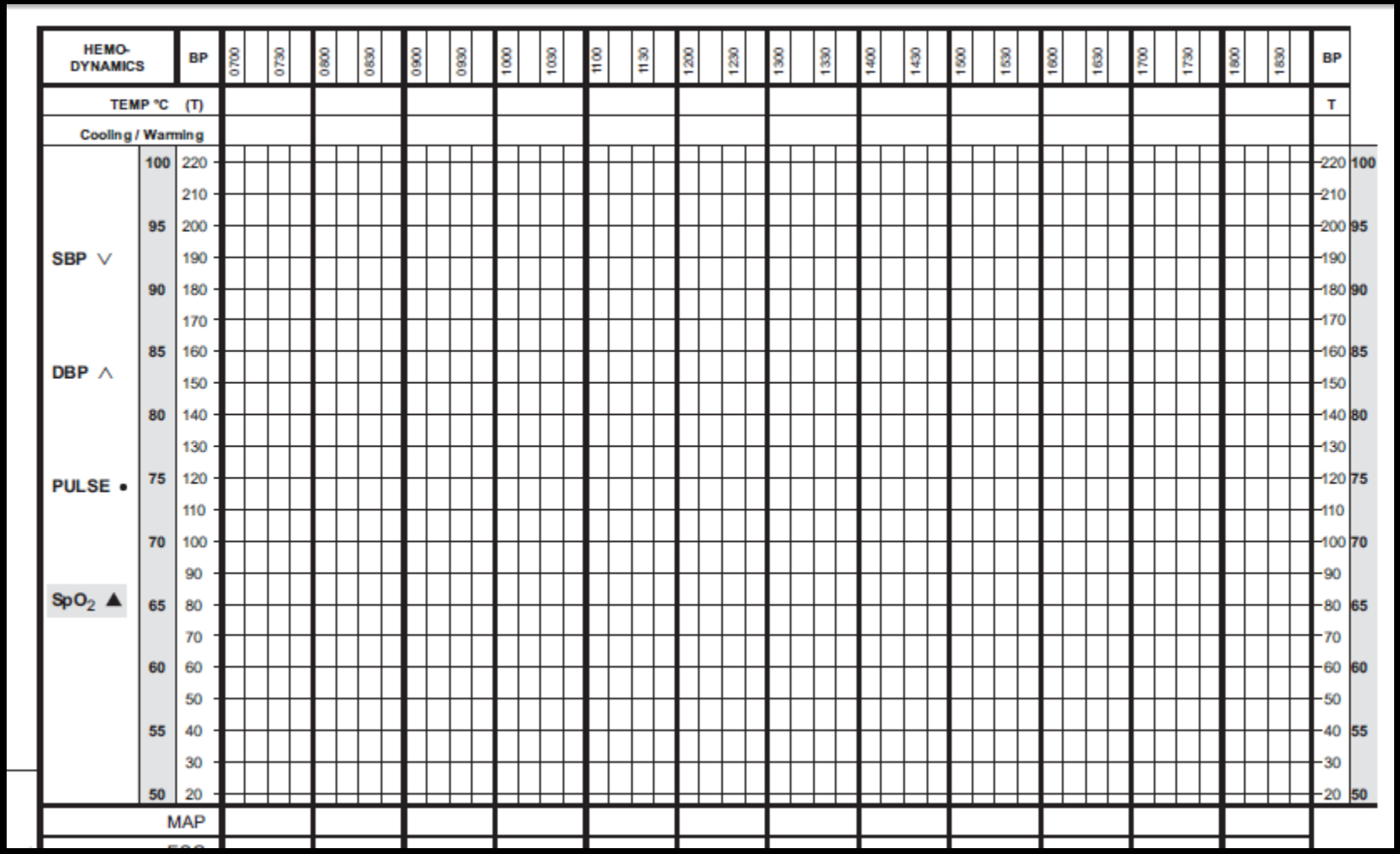
Flow Sheet
Updated May 2014
CCTC

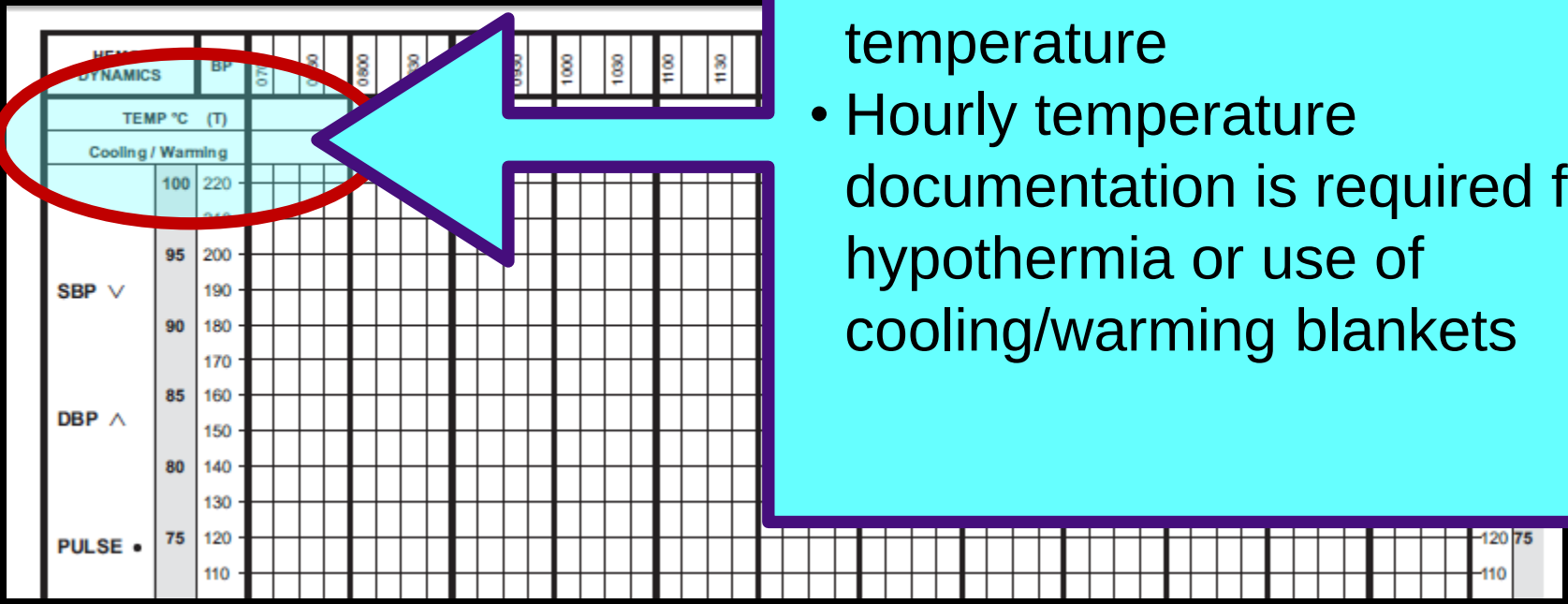
For information on CCTC Procedures, Nursing Standards, Protocols or Bedside Assessment tools, refer to CCTC Website

Cardiorespiratory Sections (Panels 1 and 3)

BP-HR-Temperature



BP-HR-Temperature



Key Points:

- Add cooling or warming blanket on/off under temperature
- Hourly temperature documentation is required for hypothermia or use of cooling/warming blankets

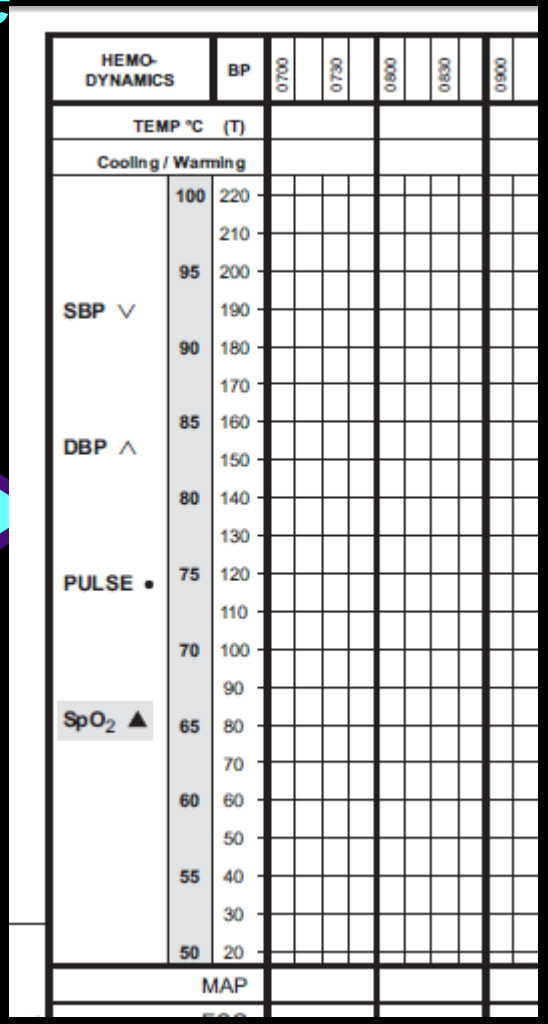
BP-HR-Temperature

Key Points:

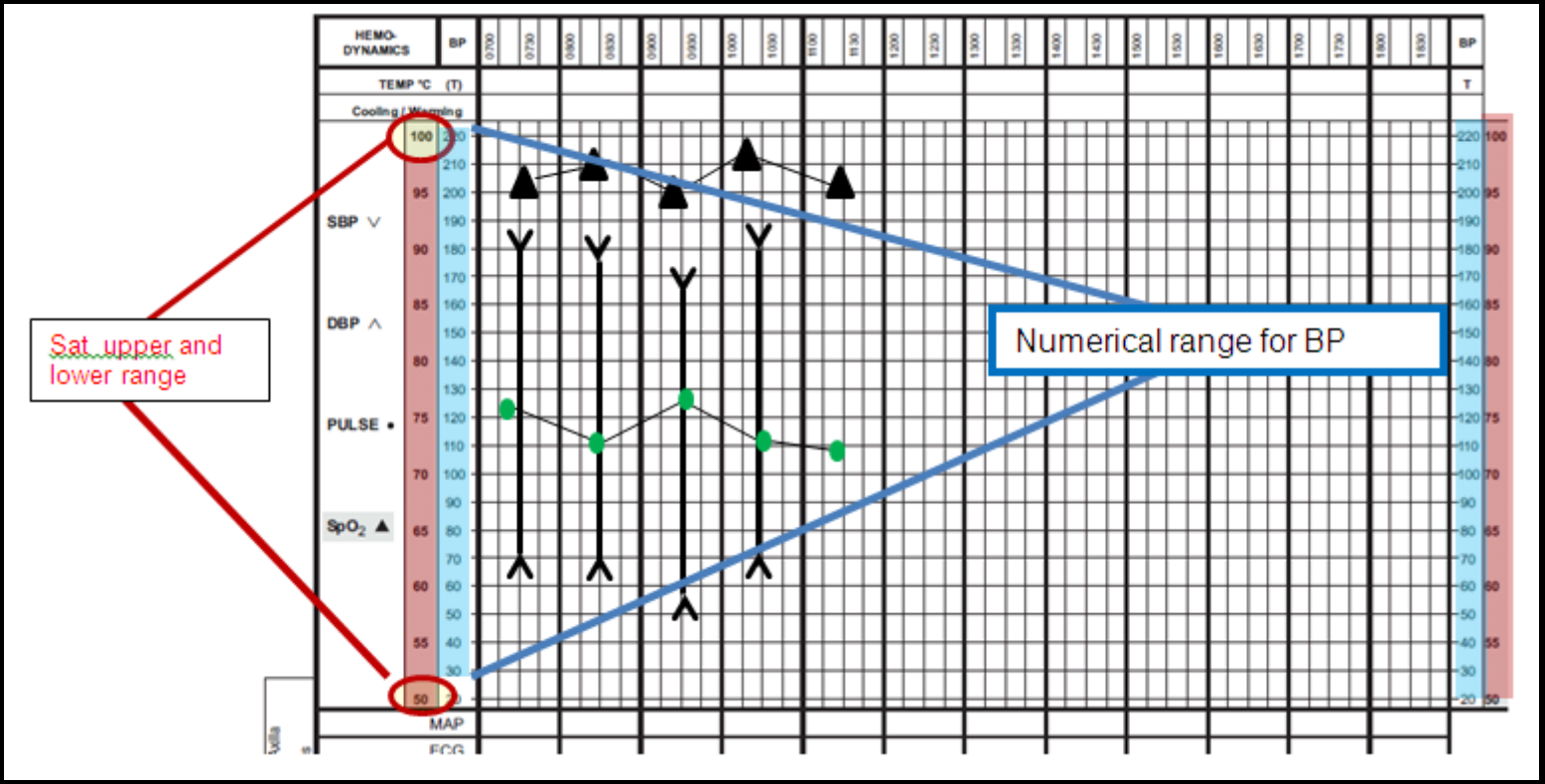
- Temperature is numeric
- Chart in blue/black
- WNL is now called WDL (Within Defined Limits)

Standards:

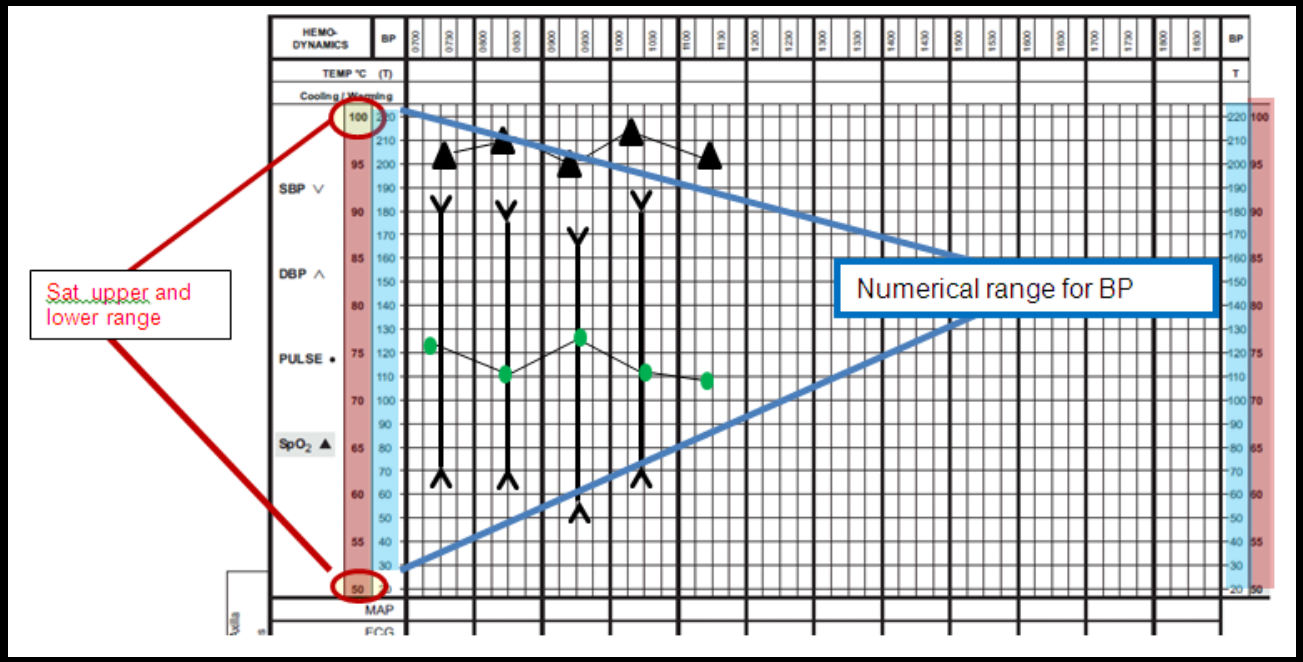
- Chart abnormal results more frequently to reflect change
- If not WDL, there must be a DAR note



How to Chart SpO_2

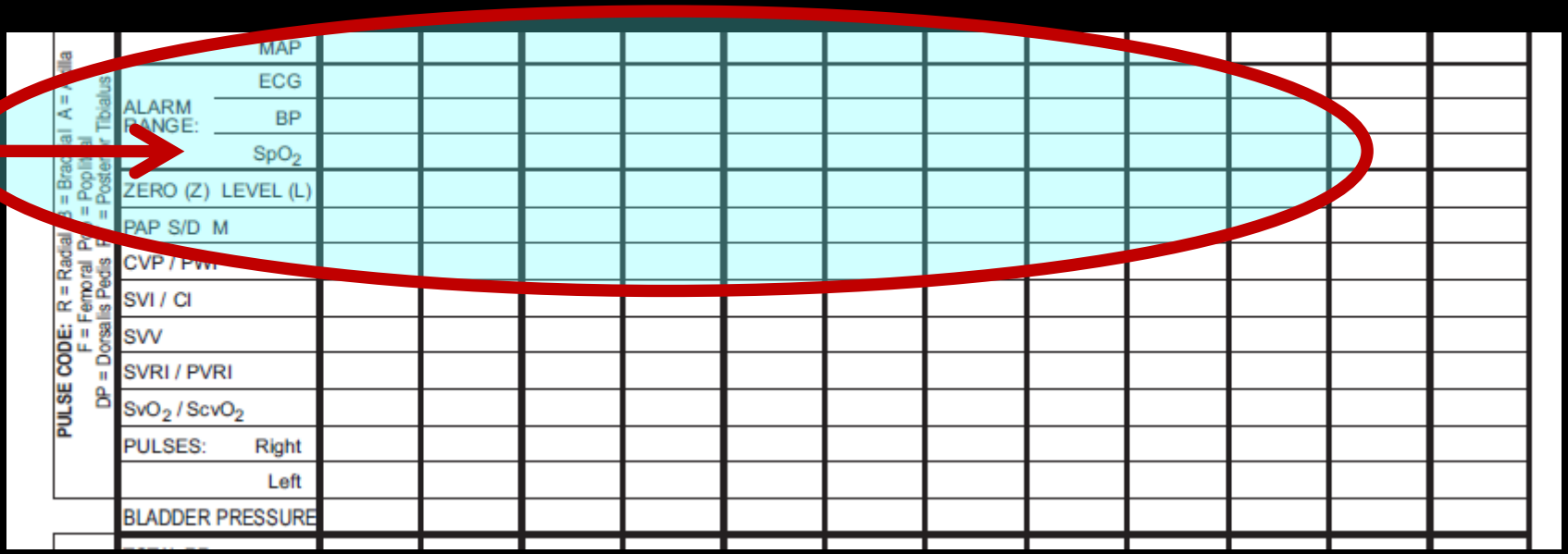


Remember: Brief episode of tachycardia or desaturation should be documented to display graphical variation



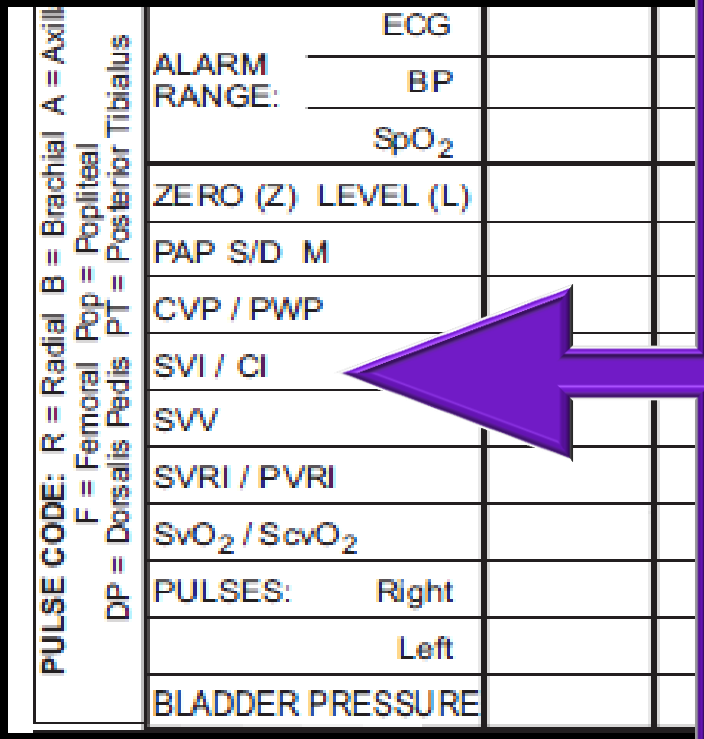
- The scale for SpO_2 is shaded
- Use a triangle to record SpO_2
- The scale for BP is unshaded; use a chevron to identify upper and lower levels (mean in box below)
- Pulse is identified by round dot points
- Link pulse dots and SpO_2 triangles to create graphic
- Include brief episodes of abnormal HR and SpO_2 in graphic

Cardiac Output/Hemodynamic Pressures



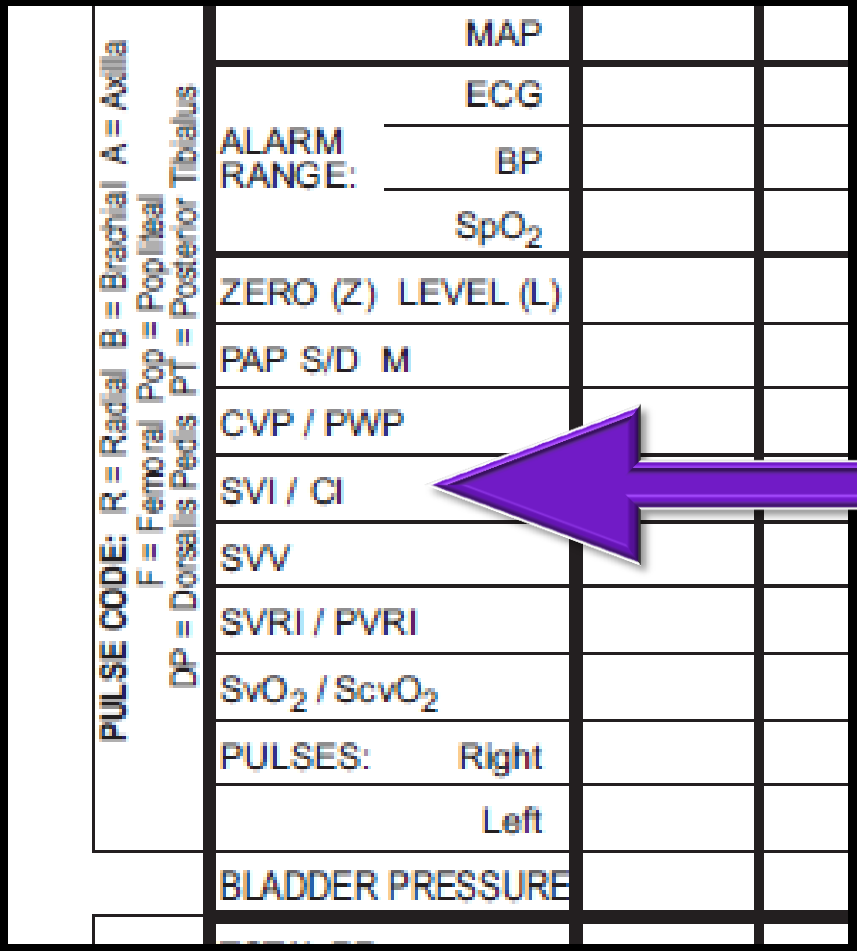
SpO_2 alarm range is new

Cardiac Output/Hemodynamic Pressures



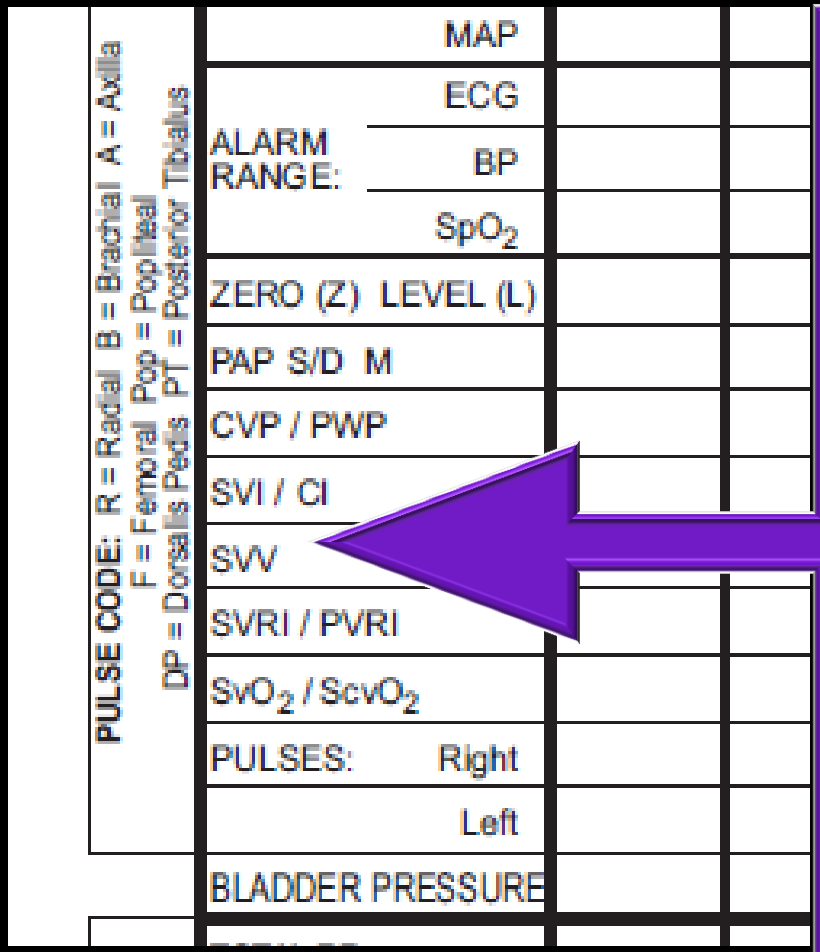
- CI (cardiac index): volume of blood pumped in one minute/BSA
- Normal 2.5-4.2 L/M^2/beat
- Higher than normal may be required if hypermetabolic/ septic
- If CI is inadequate, extraction will increase as first compensation
- If extraction is inadequate, lactic acidosis occurs
- CI with Flotrac is still accurate during A fib

Cardiac Output/Hemodynamic Pressures



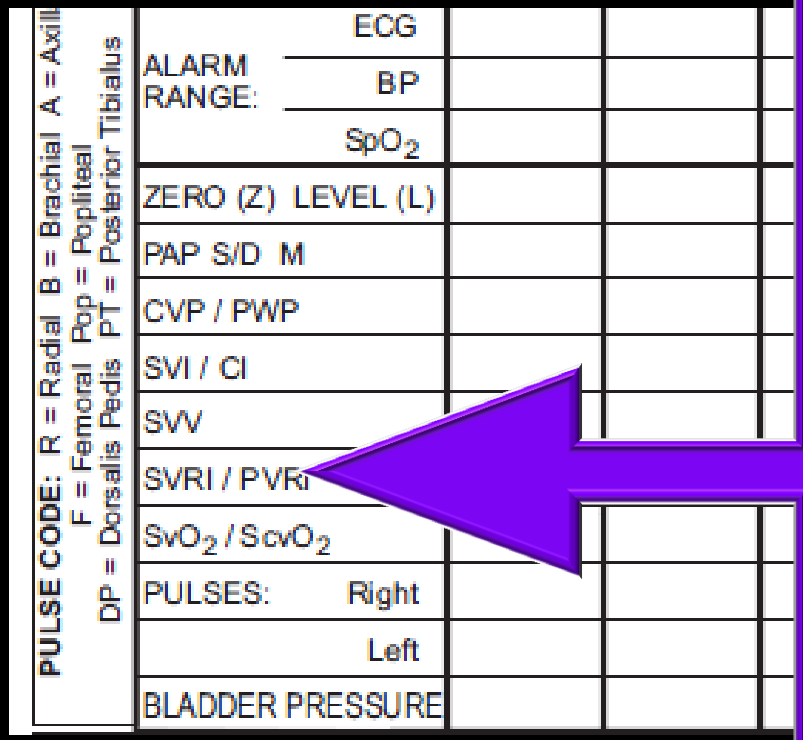
- SVI (stroke volume index): volume of blood pumped with each systole/BSA
- Normal 35-45 mL/M^2/beat
- Stroke volume index X heart rate = cardiac index
- SVI will fall earlier than CI (HR initially rises to maintain CI)

Cardiac Output/Hemodynamic Pressures



- Stroke volume variation is the % of variation in the stroke volume between inspiration and expiration
- Normal SVV = 10-15%
- SVV < 13% may indicate that a patient is volume depleted
- You can pretest responsiveness to fluid by performing bilateral leg lift (cautiously) while monitoring for decrease in SVV and increase in SVI
- Afib and irregular heart rhythms add stroke volume variability to the respiratory variability

Cardiac Output/Hemodynamic Pressures



- Systemic Vascular Resistance Index (SVRI) is calculated as:

  (MAP-CVP)/CI X 79.9

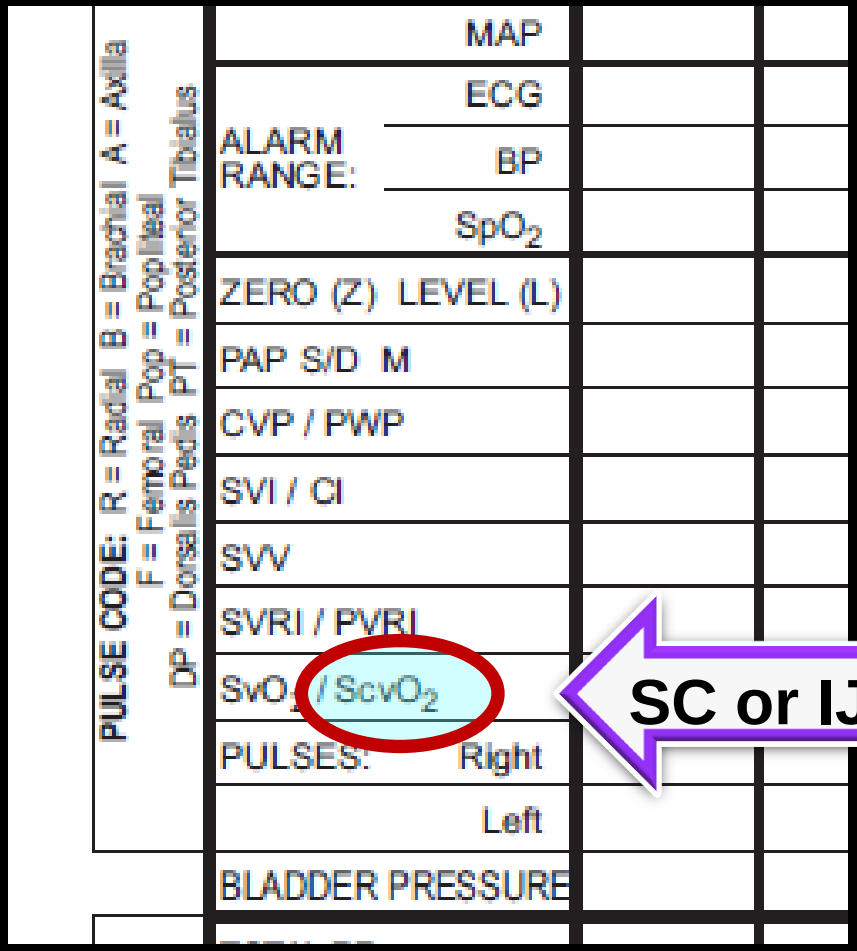
- You can calculate SVRI by entering the CVP into the derived values with Flotrac

- Pulmonary Vascular Resistance Index (PRVI) is calculate as:

  (PAP – PWP/CI) X 79.9

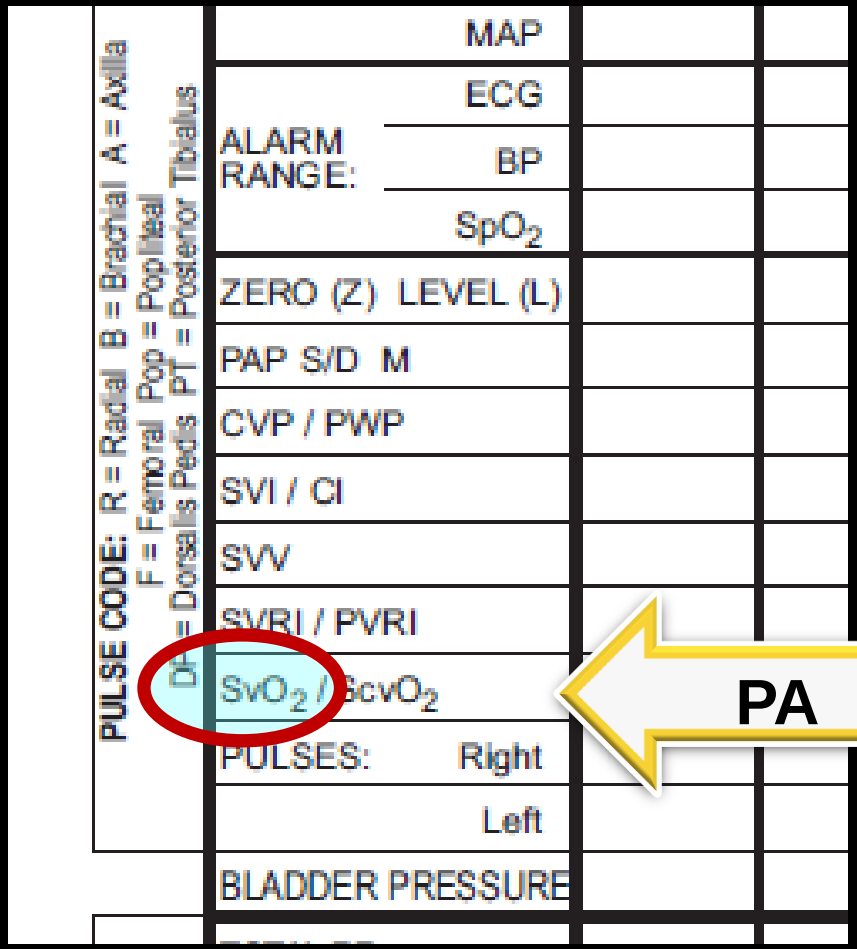
- Both SVRI and PVRI are calculated in Critbase when SwanGanz values entered

Cardiac Output/Hemodynamic Pressures



- For venous gases, circle the correct option for $ScvO_2$ (right atrial sample) or SVO_2 (pulmonary artery sample)
- If femoral vein blood gas drawn for trending or venous confirmation, indicate sample location with “femoral”

Cardiac Output/Hemodynamic Pressures



- Just prior to removal of a PA catheter, measure the SvO_2 (from PA distal) and $ScvO_2$ (from PA proximal)
- After removal, this will enable you to interpret the significance of any change in the value obtained

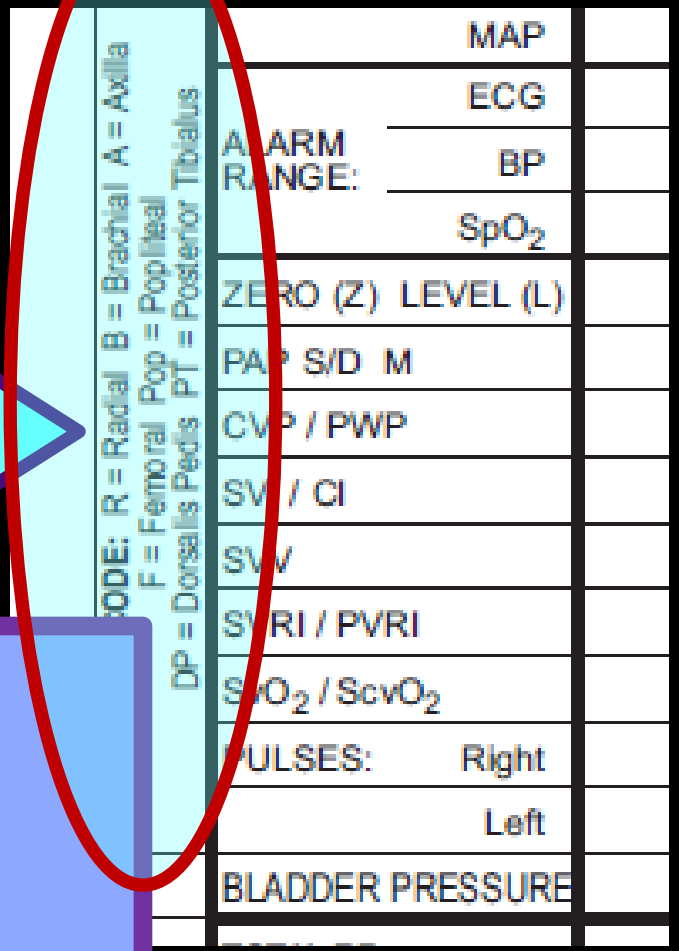
Cardiac Output/Hemodynamic Pressures

Key Points:

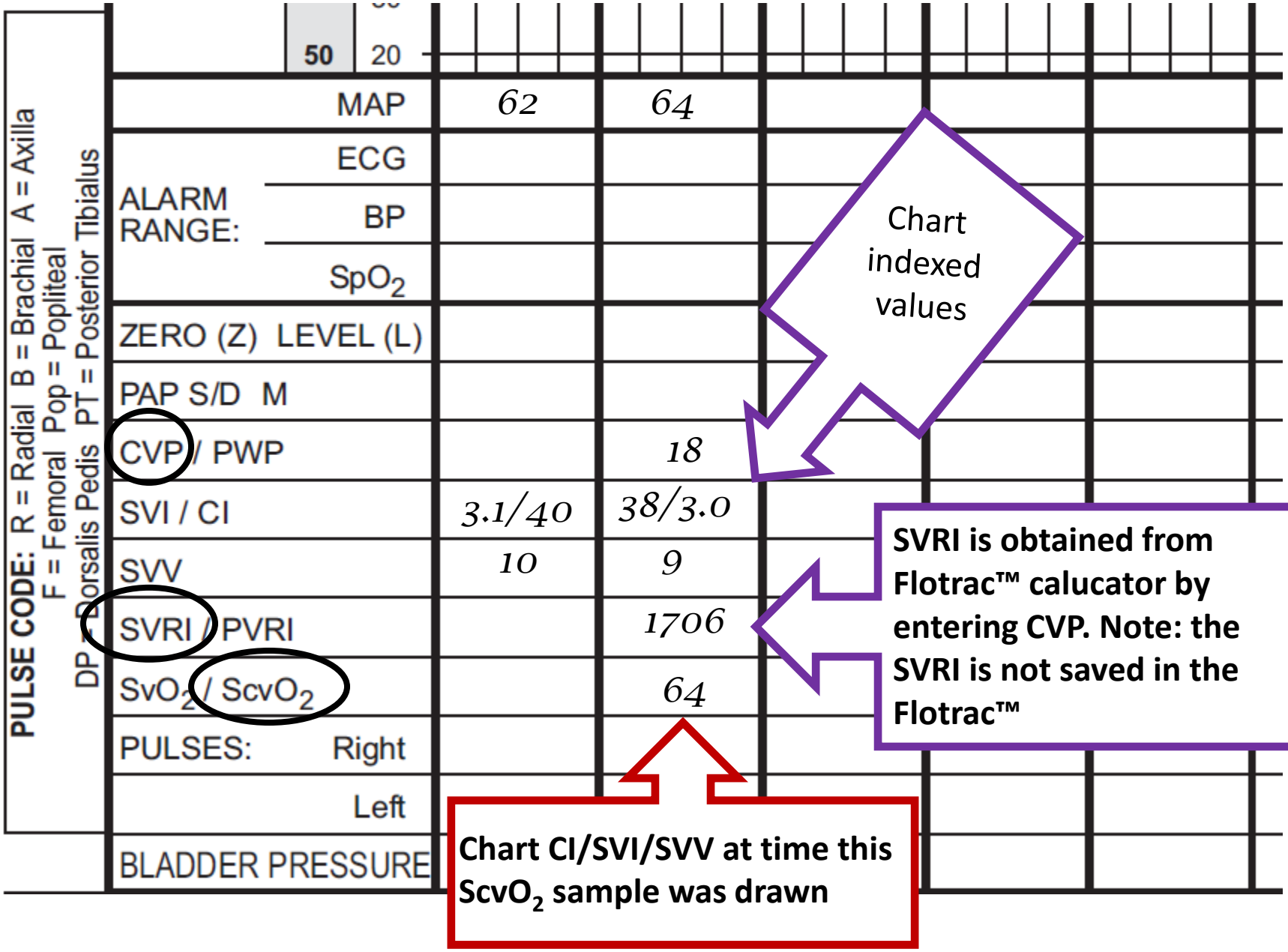
- Pulse options have been added to facilitate charting

Standards:

- Assess for anyone with potential for vascular compromise (e.g., central or arterial line in extremity, vascular Sx, trauma)



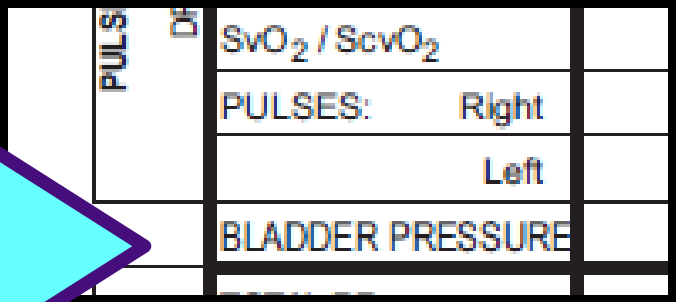
Charting data derived from Flotrac™



Cardiac Output/Hemodynamic Pressures

Key Points:

- A nurse can measure without an order if patient has a bladder catheter and there is concern regarding expanding abdomen



Standards:

- Set on an individual patient basis

Respiratory Section

CODE: 1 = Small 2 = Mod 3 = Copious M = Mucous P = Purulent B = Blood													
	OTAL RR												
	ENT. PRESSURES												
	NUTE VOLUME												
	/ SIMV												
	/ PAV / BI-LEVEL												
	/ VC												
	FIO_2 / PEEP												
	ASK / NP												
	UCTION: ETT / TRACH												
	SUCTION: NT / OT												

Respiratory Section

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M = Mucous P = Purulent B = Blood	TOTAL RR													
	VENT. PRESSURES													
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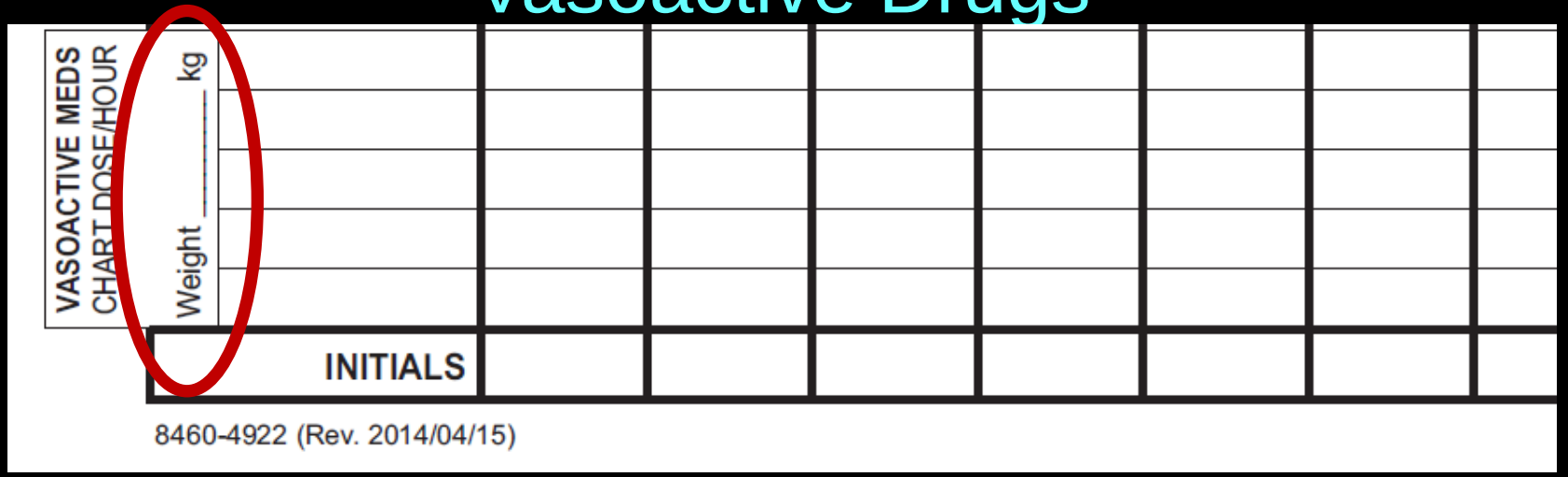
	AC / SIMV													
	PS / PAV / BI-LEVEL													
	PC / VC													
	FiO_2 / PEEP													
	MASK / NP													
	OSCILLATOR - Wiggle													
	[illegible]													
	SUCTION: NT / OT													

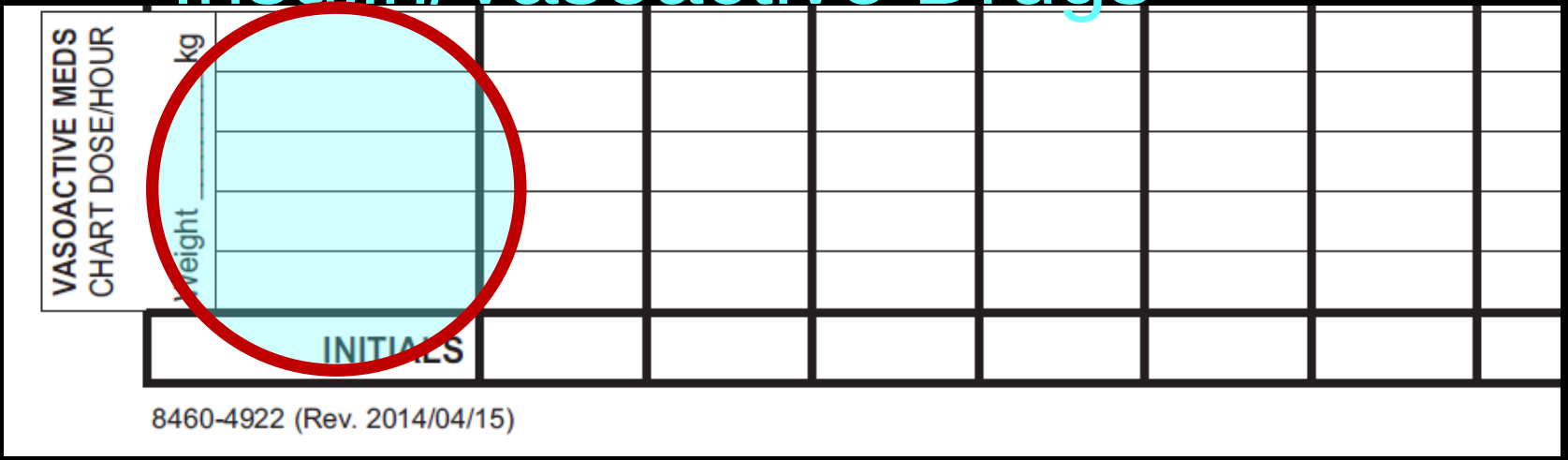
Vasoactive Drugs



Enter the weight that is being used to determine dose/kg/hr. This weight should be the same as entered in Power Chart. Update Power Chart as required to ensure both weights match. Power Chart weight will be used by providers for medication orders.

A 5th line has been added for infusions (other than comfort meds which are charted in the neurological section).

Insulin/Vasoactive Drugs



- This section is ONLY for continuous medications that may impact hemodynamic or respiratory status (e.g., vasopressors, Flolan) or require titration
- Chart drugs that effect neuro status in neuro section.
- DO NOT chart volume/hr; ***chart only the dose per hour or dose per kg per hour*** (volume is documented on I/O)
- Medications still must be signed off on the MAR

Place to Track Dextrose Bolus

GLUCOSE	10	2.8	
INSULIN u/hr or DEXTROSE	4	↓1 D 25 ml	

Insulin or dextrose administration can be added to the tracking line to enhance the evaluation of glycemic response. You either enter the dose in u/hr or record “D” to indicate 50% dextrose bolus was given. Continue to sign for drugs on MAR.

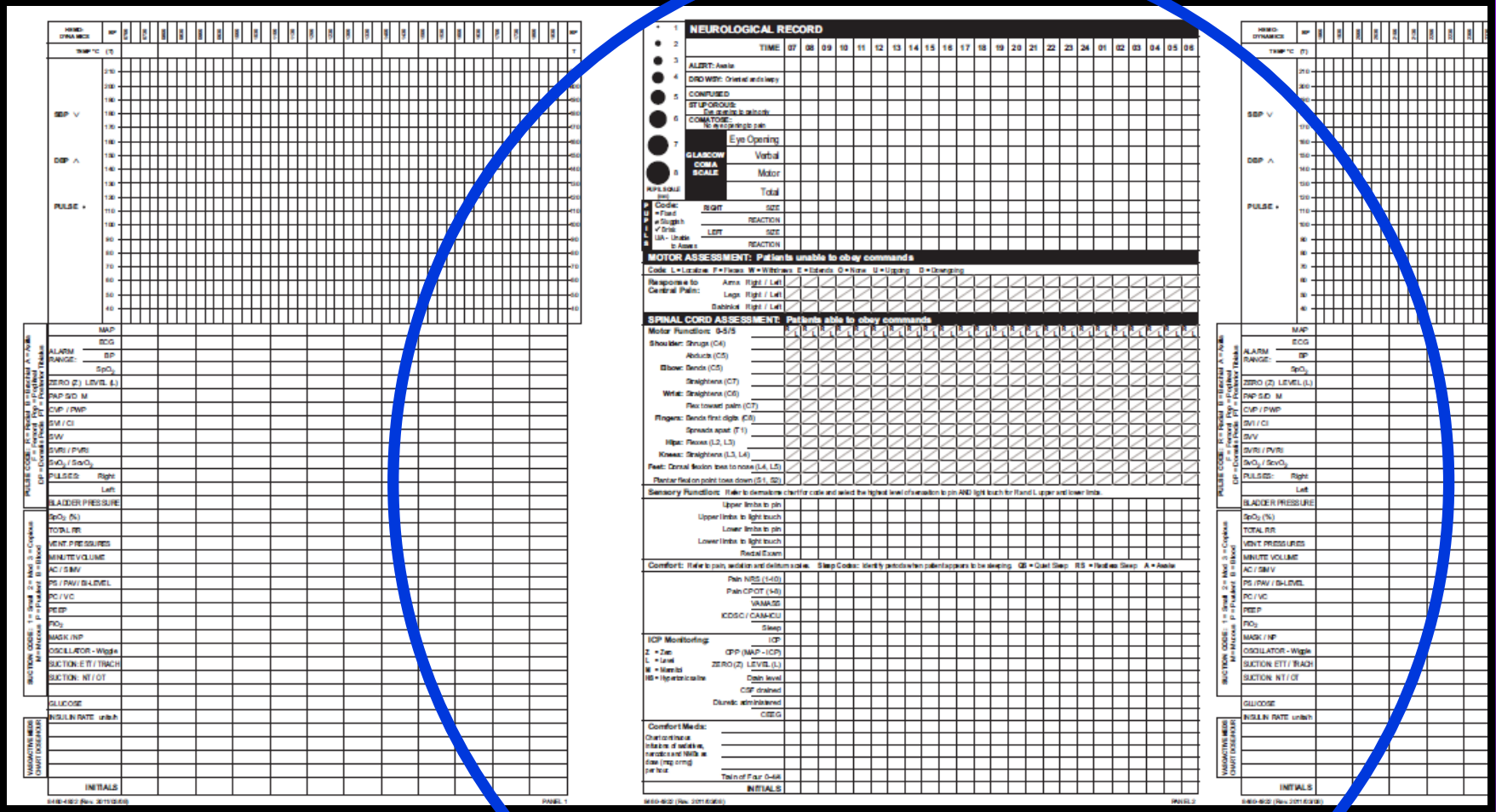
Practice Reminder

Always consider/rule out hypoglycemia for any change in neurological status including seizure.

Any low blood glucose reading by lab or glucometer should always be treated STAT. A confirmation sample should be sent to the lab to verify that the glucose was truly low, however, the confirmation sample should not delay treatment. A single low blood glucose value ***should be presumed accurate*** and treatment instituted immediately ***while awaiting the lab result***.

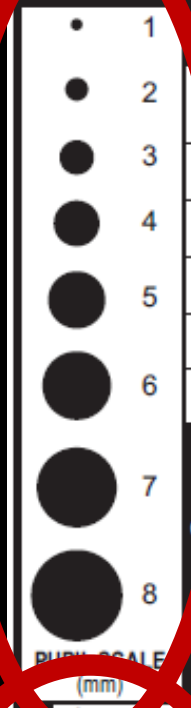
Administration of a bolus of dextrose will not cause harm even if the low reading was erroneous or the patient was in DKA.
Delay in the treatment of a truly low glucose (e.g., while awaiting confirmation results) can lead to irreversible neurological injury.

Neurological Assessment
Spinal Cord Testing
Pain and Sedation
(Panel 2)



24-hour Neuro
+ Spinal Cord Record

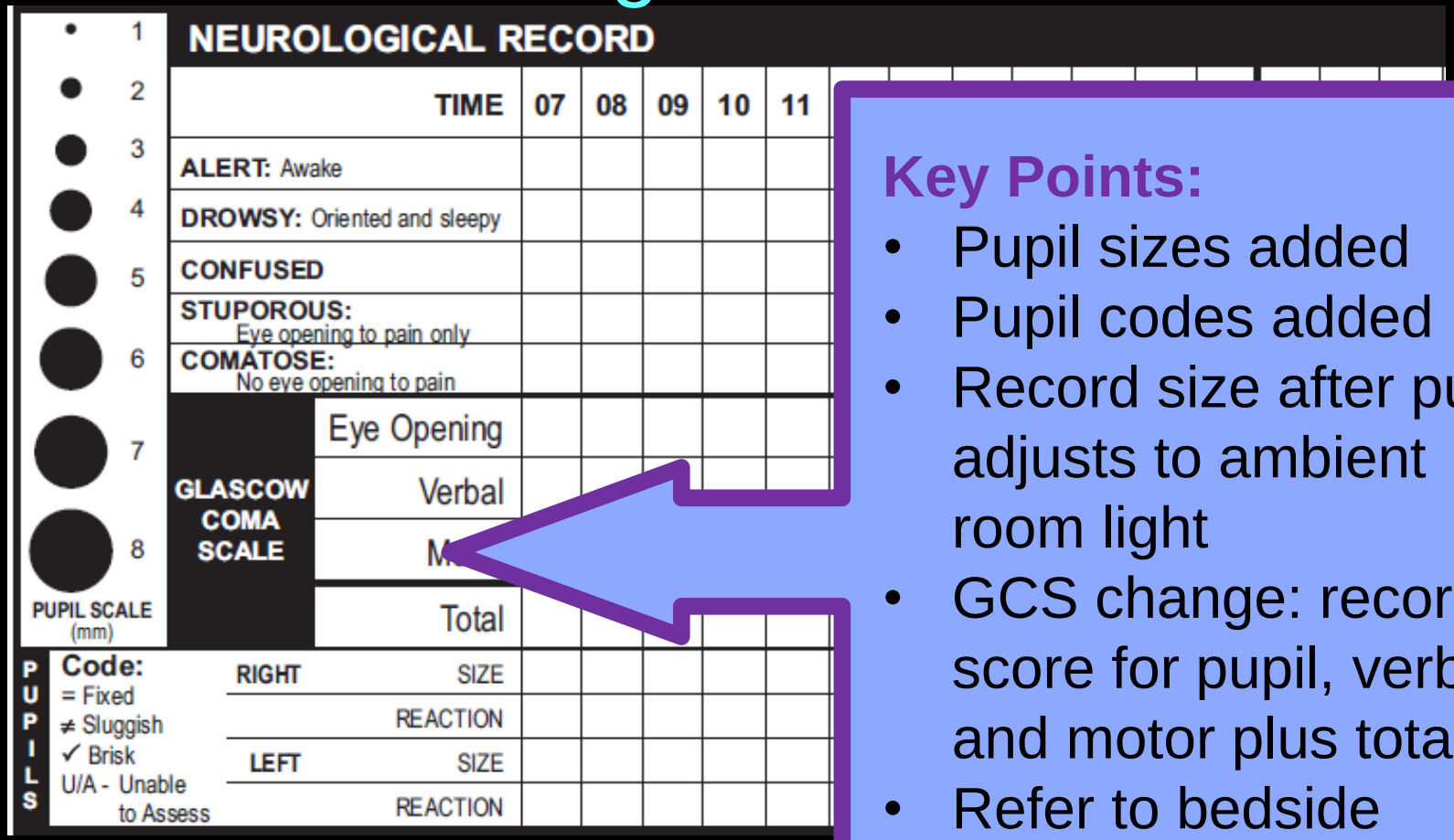
Neurological Assessment



NEUROLOGICAL RECORD

		TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
		A ERT: Awake															
		D OWSY: Oriented and sleepy															
		C NFUSED															
		ST UPOROUS: Eye opening to pain only															
		C MATOSE: No eye o ing to pain															
G ASCOW COMA CALE		Eye Opening															
		Verbal															
		Motor															
		Total															
P U P I L S	**Cod :** = Fixed ≠ Sluggish ✓ Brisk U/A - Unable to Asse	**RIGHT** SIZE															
		REACTION															
		LEFT SIZE															
		REACTION															

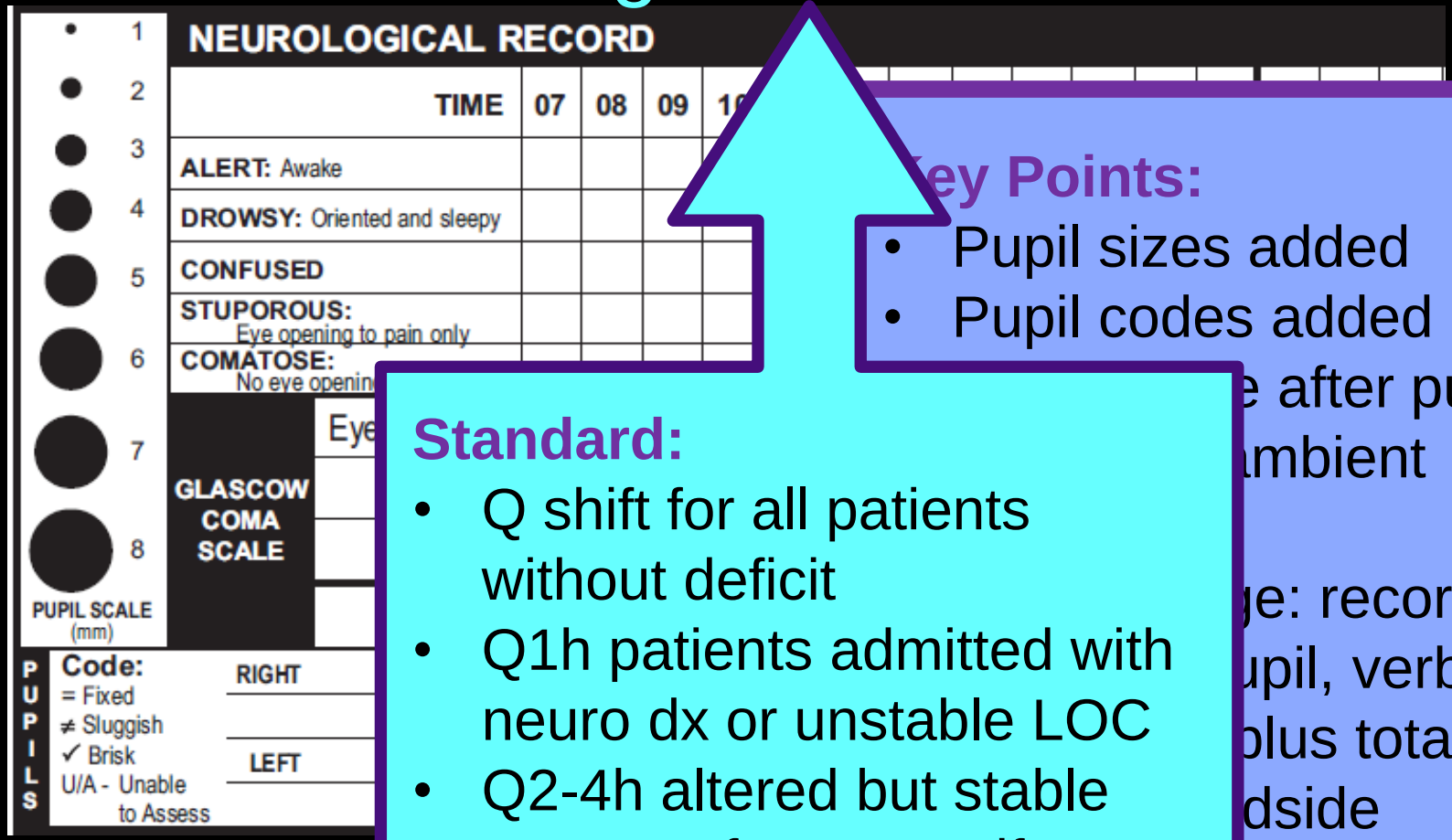
Neurological Assessment



Key Points:

- Pupil sizes added
- Pupil codes added
- Record size after pupil adjusts to ambient room light
- GCS change: record score for pupil, verbal and motor plus total
- Refer to bedside

Neurological Assessment



Standard:

- Q shift for all patients without deficit
- Q1h patients admitted with neuro dx or unstable LOC
- Q2-4h altered but stable
- Increase frequency if deterioration

ey Points:

- Pupil sizes added
- Pupil codes added

e after pupil

mbient

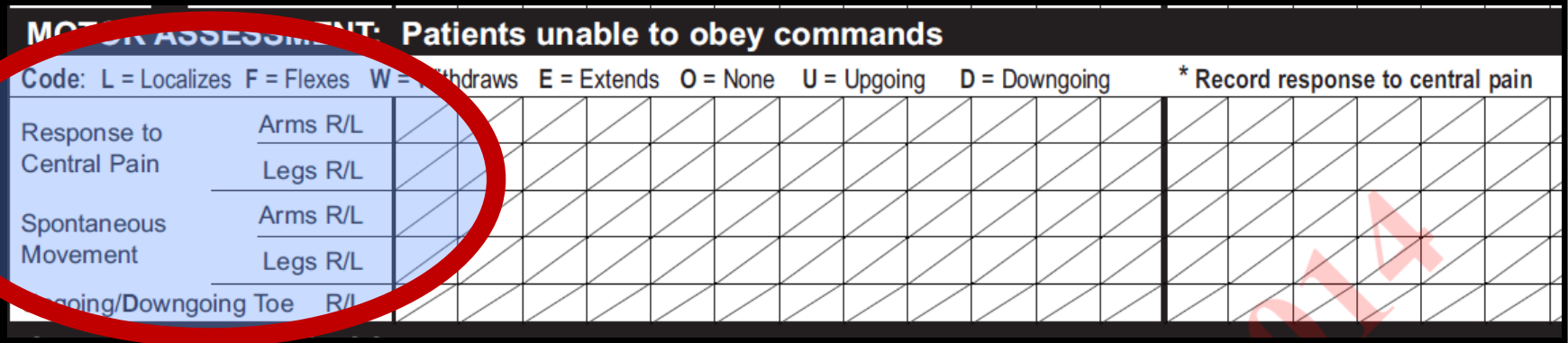
ge: record

upil, verbal

lus total

dside

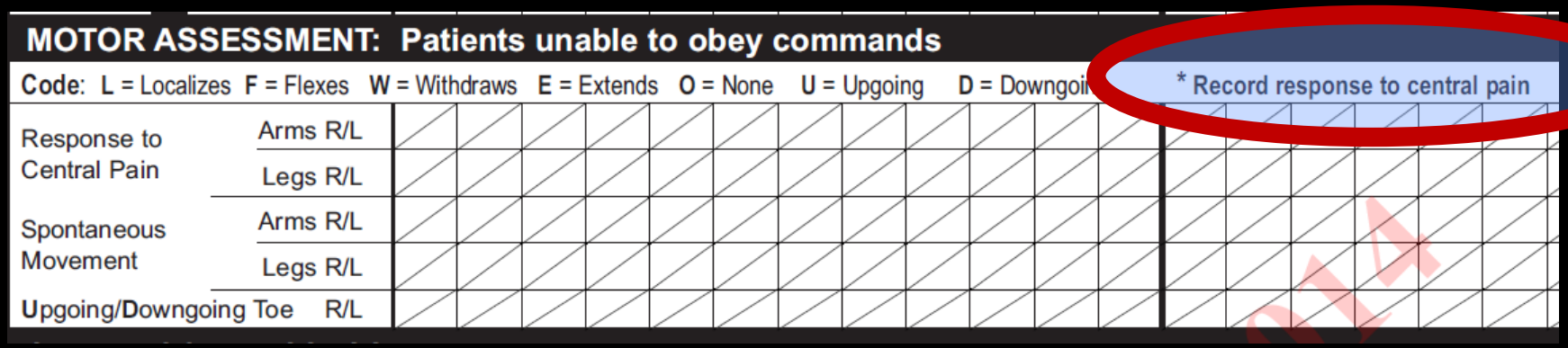
Motor Assessment:
Patients Unable to Obey Commands



Motor assessment for the patient UNABLE to obey commands has been divided into response to central pain AND spontaneous response.

This will help to describe those patients who do not respond to pain but do have spontaneous movement.

Practice Reminder



MOTOR ASSESSMENT: Patients unable to obey commands														
Code: L = Localizes F = Flexes W = Withdraws E = Extends O = None U = Upgoing D = Downgoi													* Record response to central pain	
Response to Central Pain	Arms R/L													
	Legs R/L													
Spontaneous Movement	Arms R/L													
	Legs R/L													
Upgoing/Downgoing Toe	R/L													

Always assess the patient for response to:

1. Normal voice first
2. Loud voice (if no response to normal voice)
3. Light touch (if no response to voice)
4. Pain (only if no response to voice or light touch)

Painful stimulation should always be central first.

Practice Reminder

Central pain provides an opportunity to assess for symmetry of response and reduces likelihood that response may be due to spinal reflex.

More than one method can be used for assessment of central pain. Try more than one method if the patient does not respond to your first attempt.

Practice Reminder

Clinical notes (DAR) that clearly describe the patient's response to specific neurological assessment tests provides more meaningful information that assessment tools such as the GCS.

Change from the previous assessment is the most important finding.

Neurological assessment should be performed together between incoming and outcoming nurses.

Central Pain Testing

While sternal rub does not specifically test the central nerves, it does provide an opportunity to observe for symmetrical response to a noxious stimulus.

Central nerves can be assessed using the trapezius squeeze, supraorbital pressure or mandibular pressure. Overuse of any one method may lead to bruising or soft tissue injury.

Supraorbital pressure is not recommended if raised ICP is a concern and facial or orbital trauma may be a contraindication for supraorbital or mandibular pressure.

High spinal cord injury above T4 may limit the use of sternal rub or trapezius squeeze.

Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																	
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
Shoulder: Shrugs (C4)																	
Abducts (C5)																	
Elbow: Bends (C5)																	
Straightens (C7)																	
Wrist: Straightens (C6)																	
Flex toward palm (C7)																	
Fingers: Bends first digits (C8)																	
Spreads apart (T1)																	
Hips: Flexes (L2, L3)																	
Knees: Straightens (L3, L4)																	
Feet: Dorsal flexion toes to nose (L4, L5)																	
Plantar flexion point toes down (S1, S2)																	

Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands

Motor Function: 0-5/5		R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
Shoulder:	Shrugs (C4)															
	Abducts (C5)															
Elbow:	Bends (C5)															
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Wrist:	Straightens (C6)															
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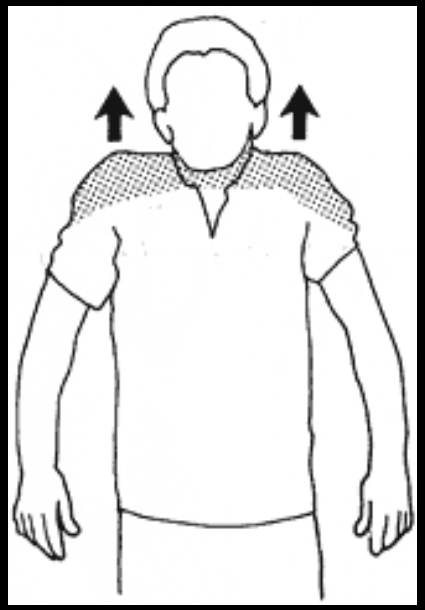
Fingers:	Bends first digits (C8)															
	Spreads apart (T1)															
Hips:	Flexes (L2, L3)															
Knees:	Straightens (L3, L4)															
Feet:	Dorsal flexion toes to nose (L4, L5)															
	Plantar flexion point toes down (S1, S2)															

- Assess motor in all patients at least once per shift
- Test all muscle groups in patients with potential brain or cord injury
- For low risk patients, choose 3 or 4 major muscle groups to test

Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands										
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Shoulder: Shrugs (C4)										
Abducts (C5)										



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SPINAL CORD ASSESSMENT: Patients able to obey commands											
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Shoulder: Shrugs (C4)											
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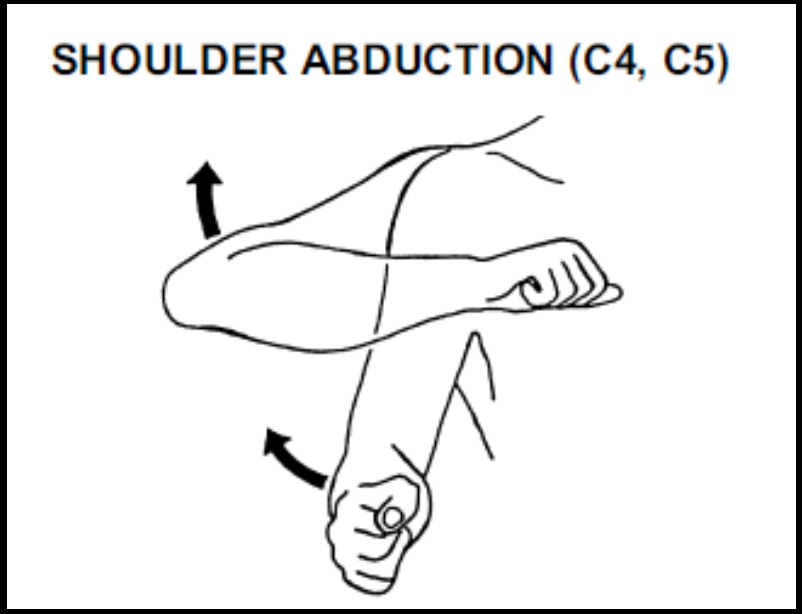
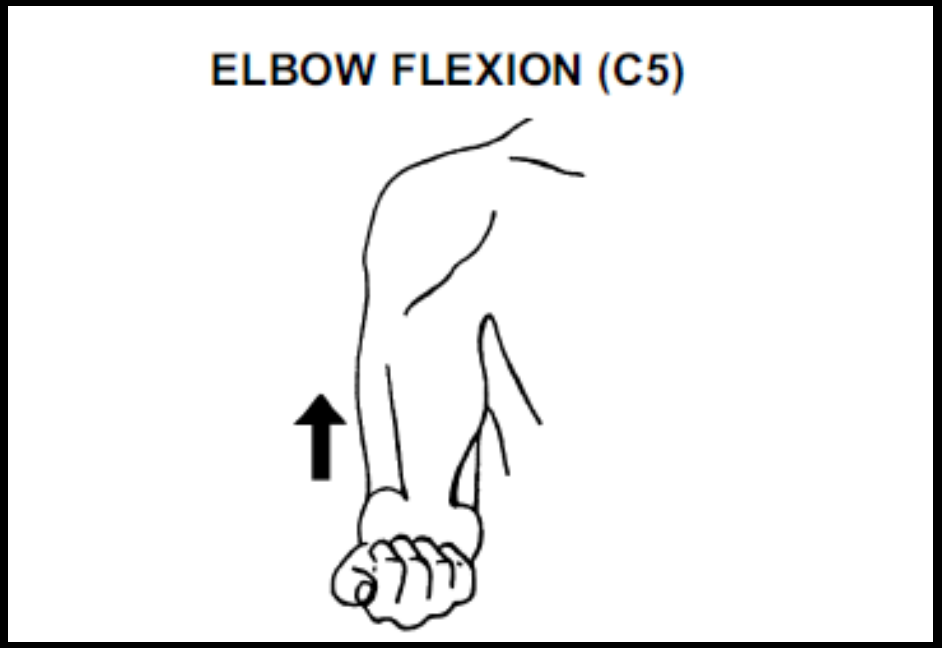


Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Elbow: Bends (C5)																			
Straightens (C7)																			



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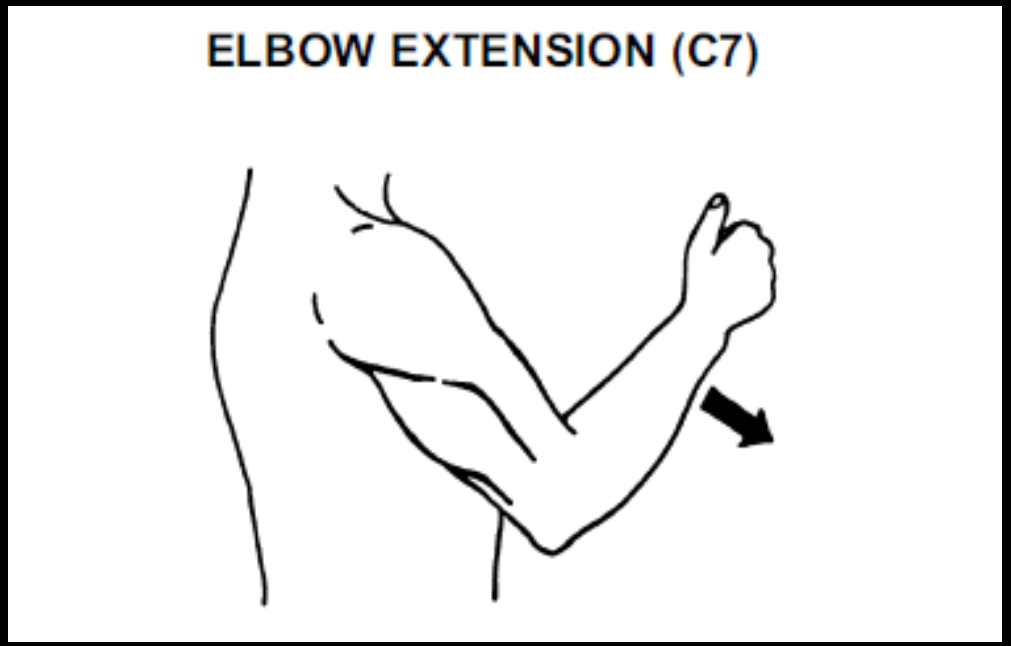
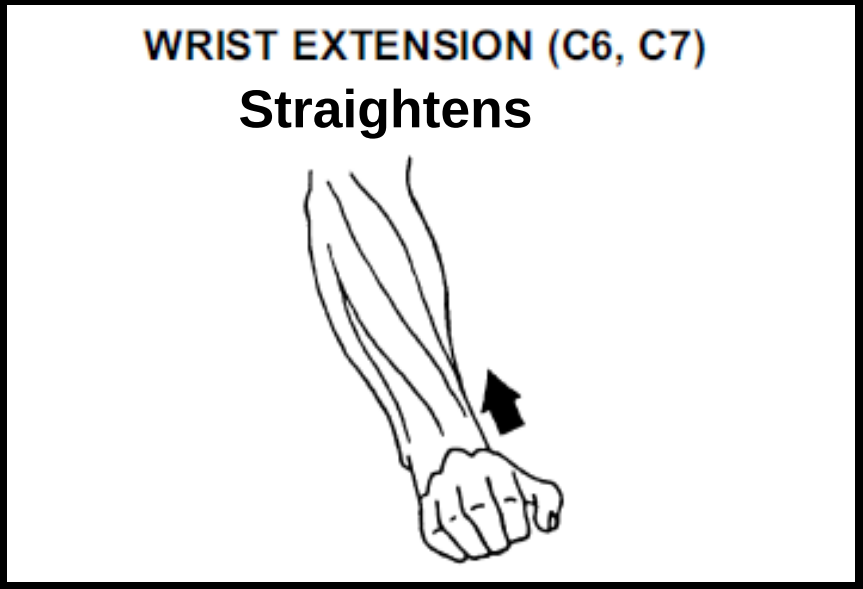
SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Elbow: Bends (C5)																			
Straightens (C7)																			



Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Wrist: Straightens (C6)																			
Flex toward palm (C7)																			



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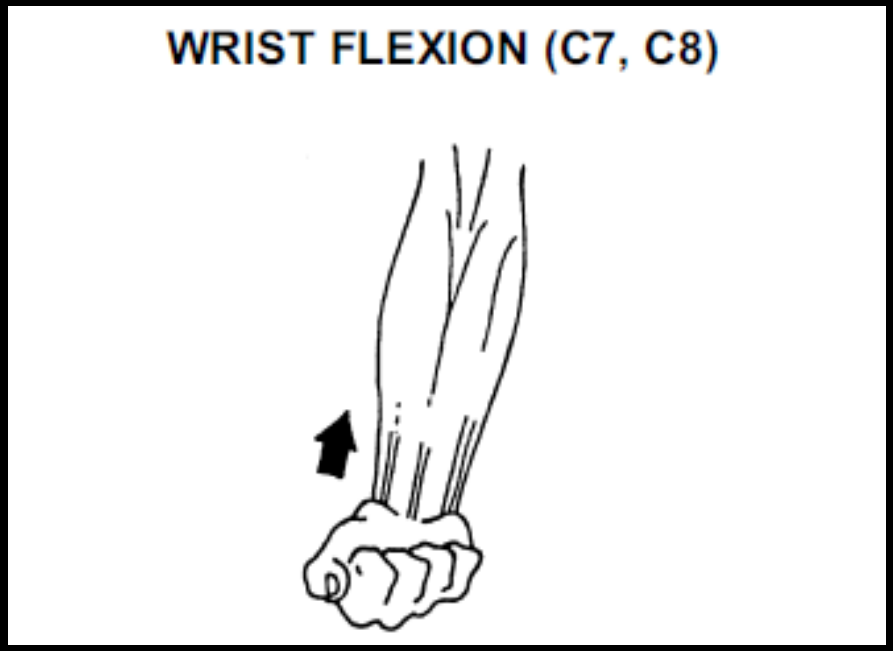
SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Elbow: Bends (C5)																			
Straightens (C7)																			



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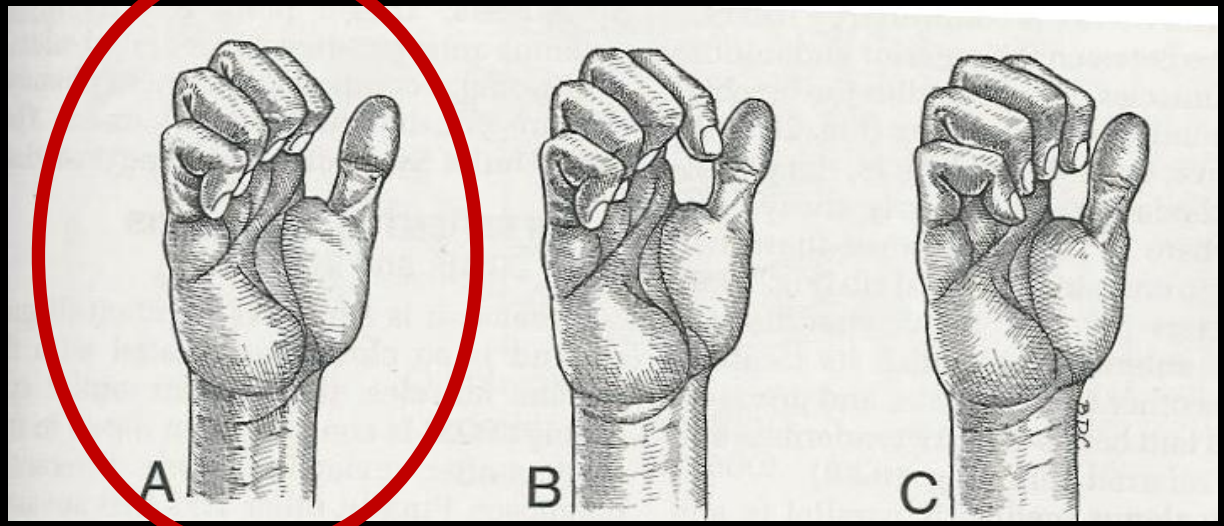
SPINAL CORD ASSESSMENT: Patients able to obey commands																							
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
Fingers: Bends first digits (C8)																							
Spreads apart (T1)																							



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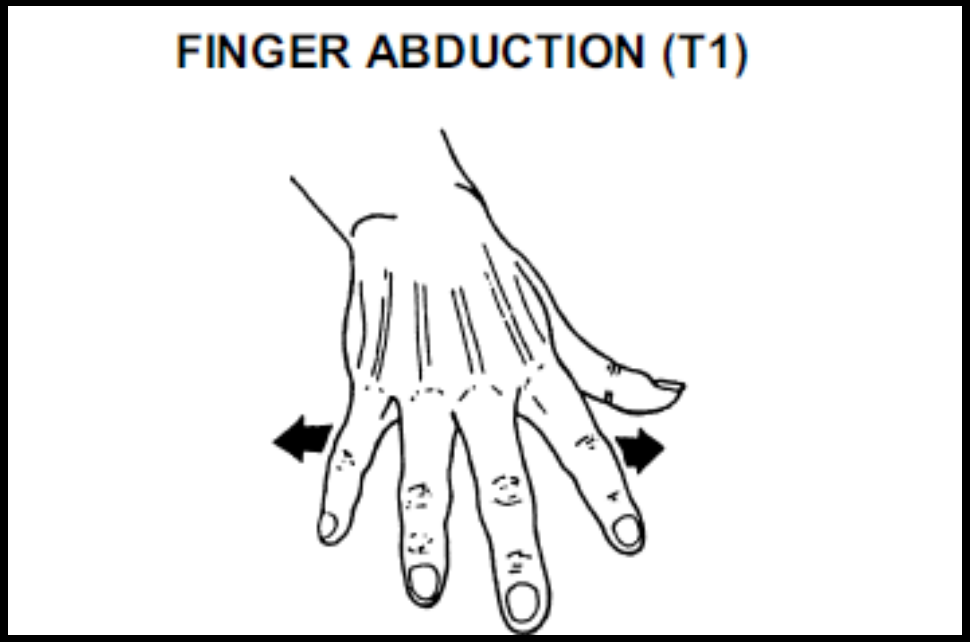
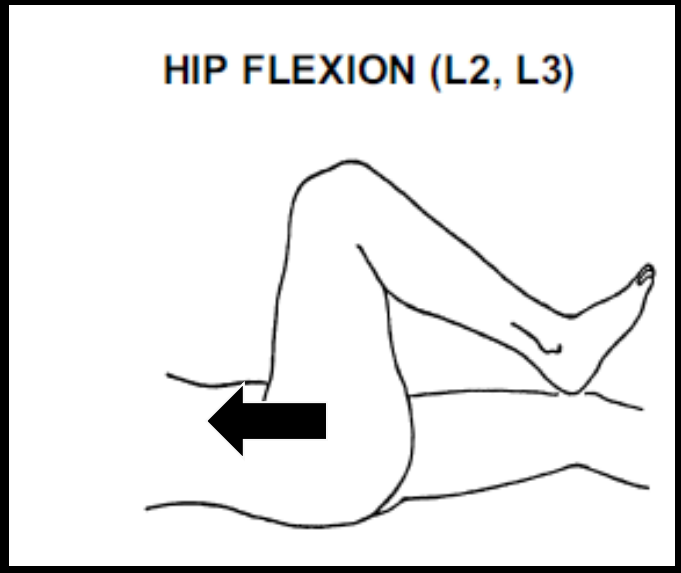
SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Fingers: Bends first digits (C8)																			
Spreads apart (T1)																			



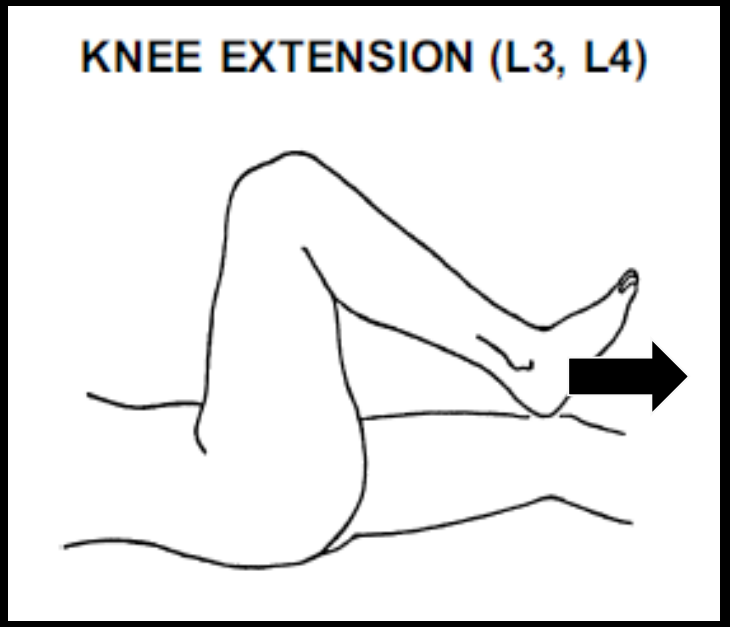
Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																							
Motor Function: 0-5/5	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R
Hips: Flexes (L2, L3)																							
Knees: Straightens (L3, L4)																							
Feet: Dorsal flexion toes to nose (L4, L5)																							
Plantar flexion point toes down (S1, S2)																							



Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																						
Motor Function: 0-5/5	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Hips: Flexes (L2, L3)																						
Knees: Straightens (L3, L4)																						
Feet: Dorsal flexion toes to nose (L4, L5)																						
Plantar flexion point toes down (S1, S2)																						



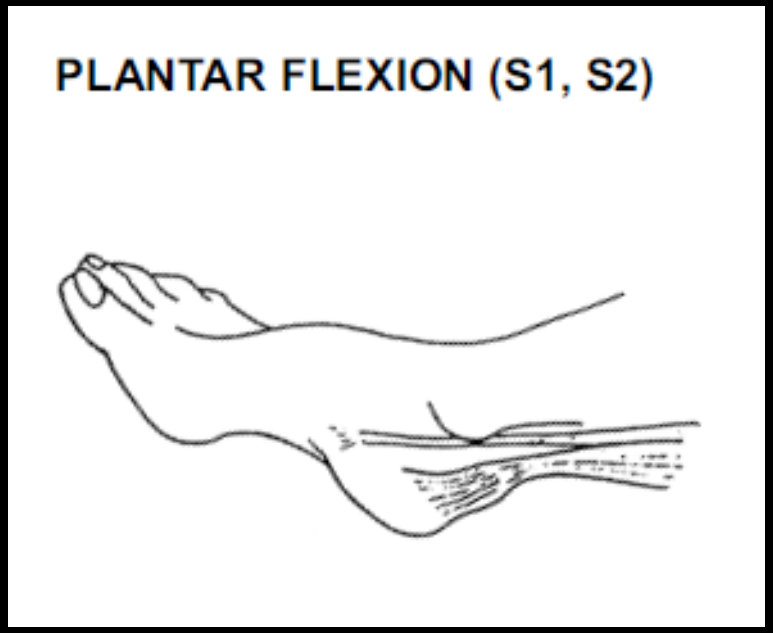
Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R
Hips: Flexes (L2, L3)																			
Knees: Straightens (L3, L4)																			
Feet: Dorsal flexion toes to nose (L4, L5)																			
Plantar flexion point toes down (S1, S2)																			

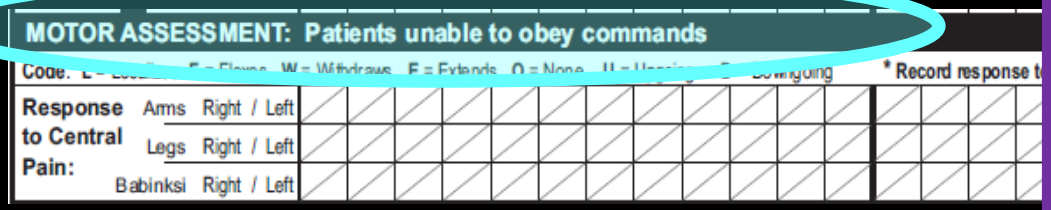
DORSI FLEXION (L4, L5)

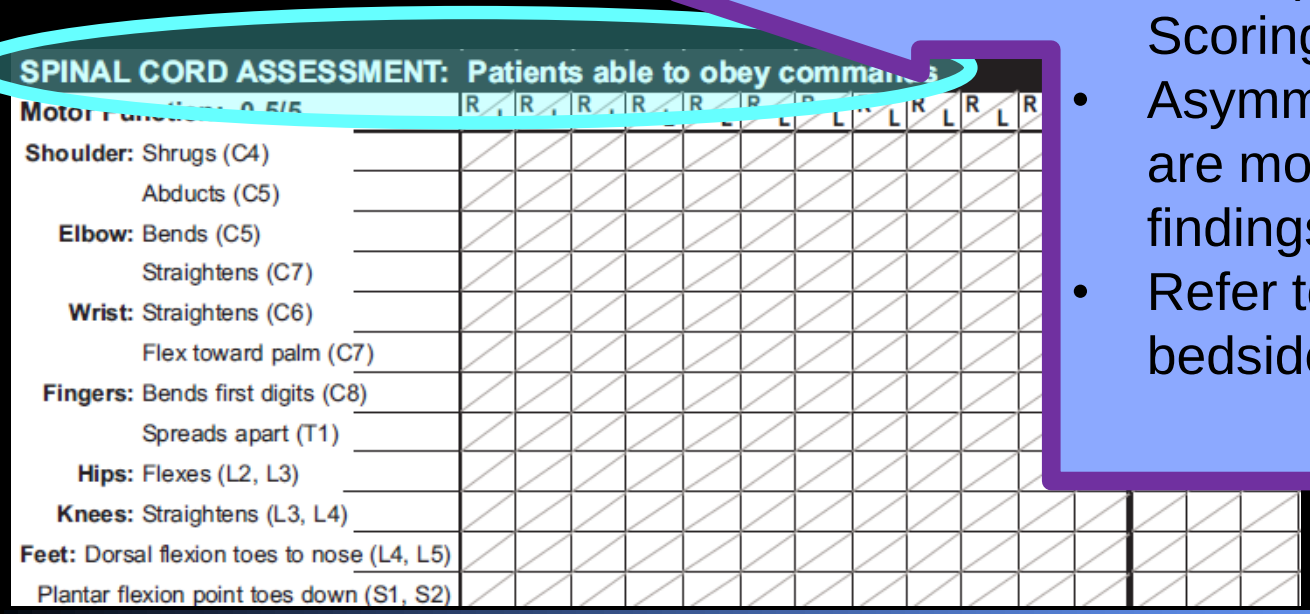
Motor Assessment: Patients able to Obey

SPINAL CORD ASSESSMENT: Patients able to obey commands																			
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R
Hips: Flexes (L2, L3)																			
Knees: Straightens (L3, L4)																			
Feet: Dorsal flexion toes to nose (L4, L5)																			
Plantar flexion point toes down (S1, S2)																			



Motor Assessment:
Using either “unable” or “able” to obey

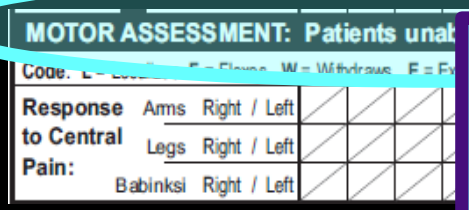


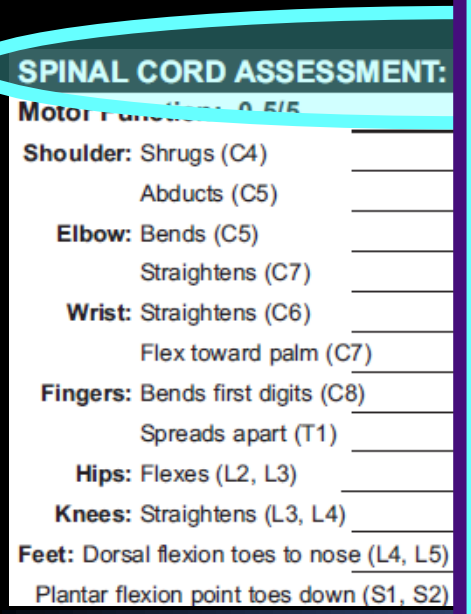


Key Points:

- Use correct motor section (unable or able to obey)
- If able to obey, record motor strength as 0-5/5 (using Motor Scoring Scale)
- Asymmetry and change are most important findings
- Refer to scoring tools at bedside

Motor Assessment: Using either "unable" or "unable" to obey





Minimum Motor Assessment:

- Q1-2h and prn following trauma, uncleared CTL spines, thoracic aneurysm, postop spinal surgery or following any neurological deterioration X 24 hrs
- For above, Q2-4H after initial 24 hours if no deterioration
- With each neurological assessment
- Minimum Q shift for all patients until awake and findings normal (symmetrical and 4-5/5) for at least 4 days
- Increase monitoring for any neurological change

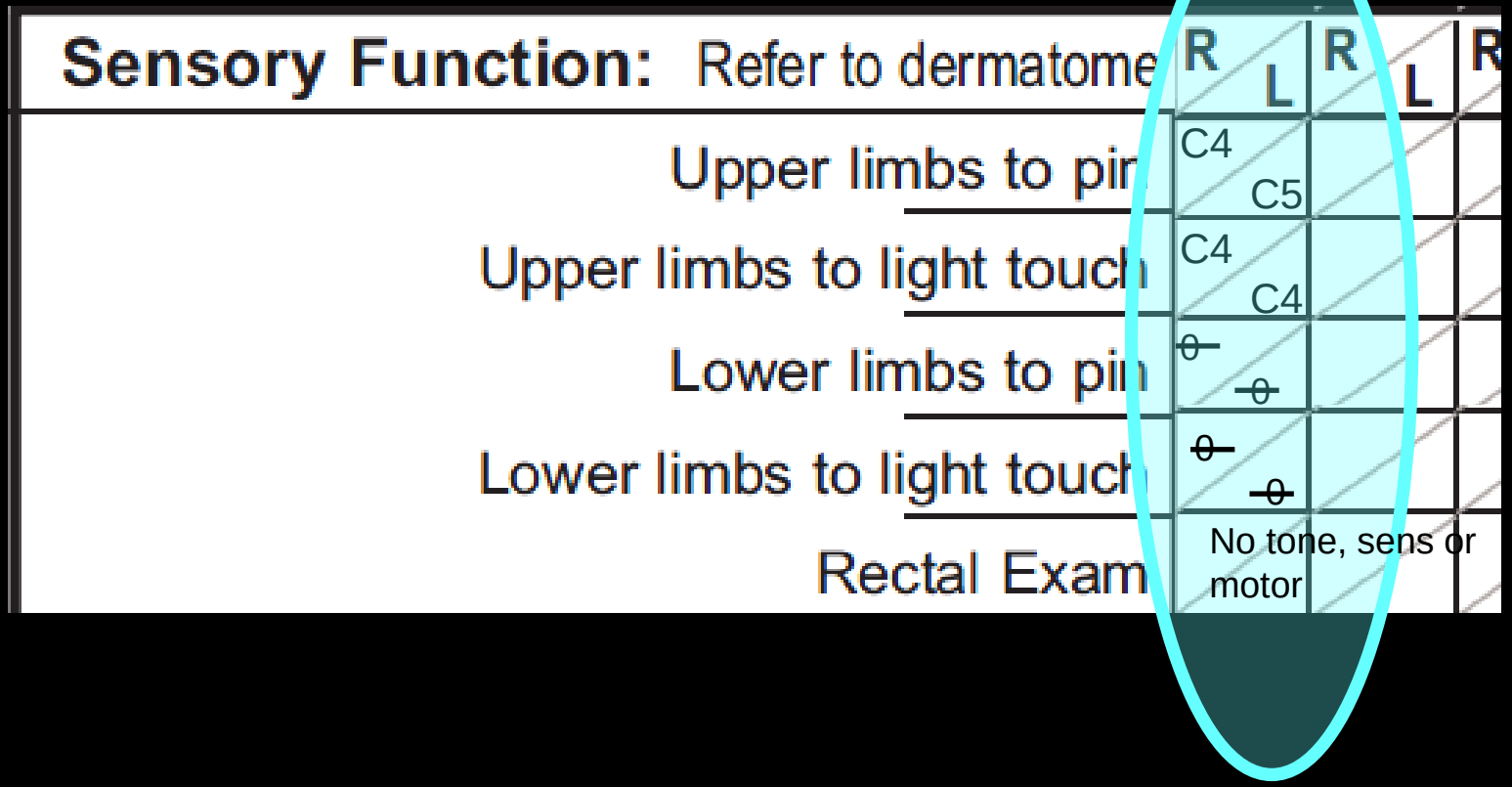
Sensory Testing

Sensory Function: Refer to dermatome chart for code and select the best (lowest) level of sensation to pin AND light touch for R and L upper and lower limbs.

[illegible] to pin																					
Upper limbs to light touch																					
Lower limbs to pin																					
Lower limbs to light touch																					
Rectal Exam																					

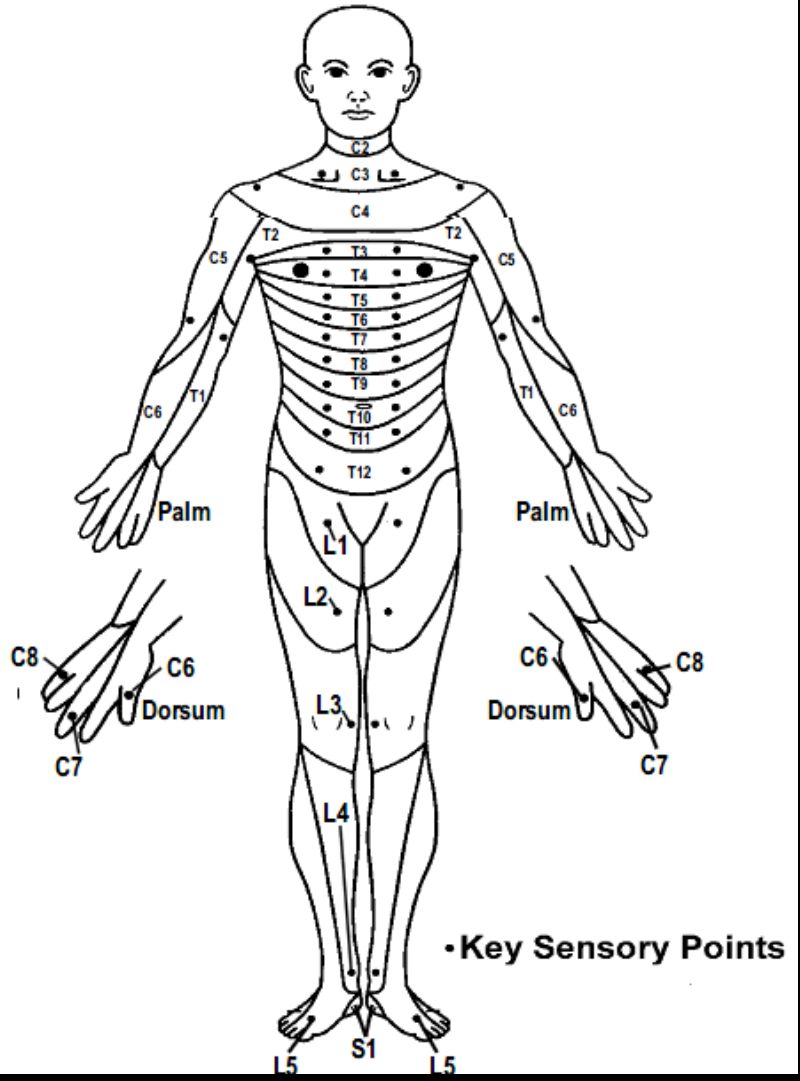
Refer to Bedside Assessment Sheets for dermatome diagram

Sensory Testing

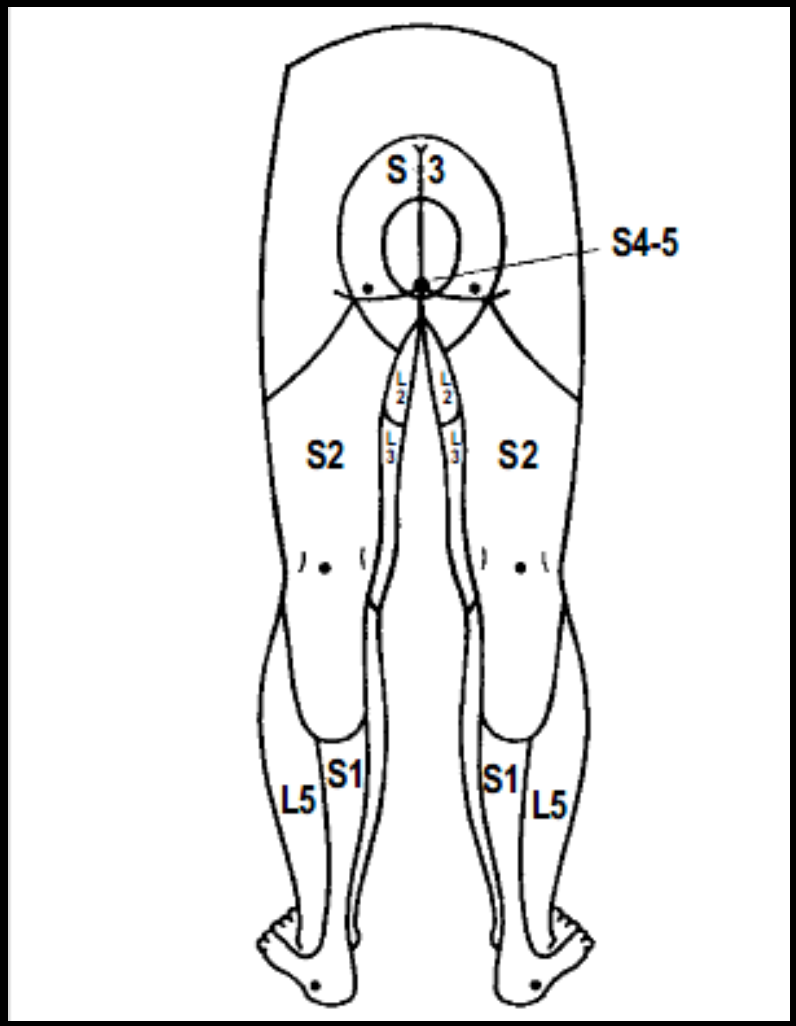


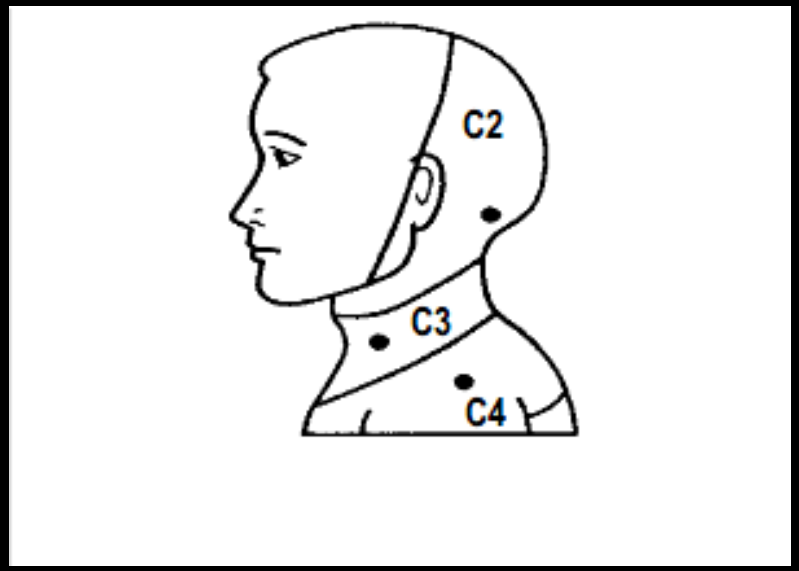
Sensory Levels

To test sensory function: apply pin prick to each dermatome in anatomical descending order.



Sensory Levels

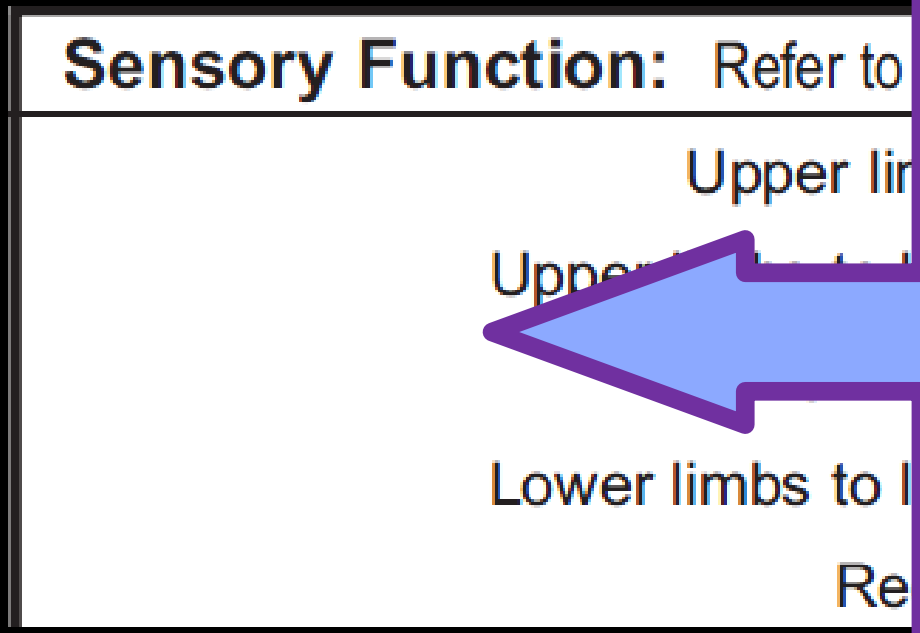




Sensory Assessment: Patients able to Obey

Sensory Function: Refer to dermatome chart for code			
Upper limbs to pin			
Upper limbs to light touch			
Lower limbs to pin			
Lower limbs to light touch			
Rectal Exam			

Sensory Assessment: Patients able to Obey



Key Points:

- Patient must be able to obey/nod
- Refer to scoring tools at bedside

Sensory Assess ment:
Patients able t bey

Sensory Fun

Minimum Sensory Assessment:

- Q1-2h and prn following trauma, uncleared CTL spines, thoracic aneurysm, postop spinal surgery or following any neurological deterioration X 24 hrs
- For above, Q2-4H after initial 24 hours if no deterioration
- If patient is not awake/able to obey and meets above criteria, document q shift recent for lack of assessment

Neuro Section: Comfort Section

Comfort: Refer to pain, sedation and delirium scales.	**Sleep Codes:** Identify periods when patient appears to be sle												
NSR (0-10) or CPOT (0-8)													
VAMAAS													
SWAP Pass/Fail													
EPS/NMS (+* or -)													
SLEEP													

Note: Delirium is charted once per shift in neuro section of AI record

Delirium assessment requires:

- Pain assessment
- Sedation assessment
- Delirium screening

Steps to Pain, Sedation and Delirium Screening

First Step: Assess pain

- Self-report first
- CPOT if unable to self-report
- Q shift, Q4H and prn
- Reassess with procedures and following analgesia
- Rx pain or assess ability to reduce narcotic unless contraindicated

Second Step: Assess sedation

- Q shift, Q4H and prn
- VAMAAS if ventilated, MAAS is unventilated
- Rx anxiety or assess ability to reduce sedatives unless contraindicated

Third Step: Screen for delirium

- Screen all patients during second half of shift
- Record time of assessment and document in neuro section of AI record
- If MAAS < 2, document “unable to screen” and document reason
- If MAAS $\geq$ 2, complete ICDSC

Pain Assessment

- Determine pre-admission medication for pain, sedation, anxiety or mental health issues
- Assess pain and comfort level
  - Self-report of pain is the priority for assessment
  - Use CPOT to screen for pain if patient unable to self-report

Neuro Section: Pain Assessment

Comfort: Refer to pain, sedation and delirium scales. **Sleep Codes:** Identify periods when patient appears to be sle

NSR (0-10) or CPOT (0-8)												
VAMAAS												
SWAP Pass/Fail												
EPS/NMS (+* or -)												
SLEEP												

Self-Report (Subjective Pain):

- NRS (Numeric Rating Scale) :
  - Verbal report (rate pain on a scale of 0-10/10)
  - Visual analogue scale
  - Refer to Bedside Assessment tools for prompts to pain assessment (PQRST)

Use CPOT for Patients Unable to Self-Report:

- CPOT (Critical Care Pain Observation Tool)

Critical Care Pain Observation Tool

Response	Strength	Score
Facial Expressions	Relaxed Tense Grimacing	0 1 2
Body Movements	None Protection Restlessness	0 1 2
Muscle Tension	Relaxed Tense/Rigid Very Tense	0 1 2
Ventilator Compliance ***OR*** Vocalization	Tolerating ventilator or talking in normal tone Coughing against ventilator or Sighing/Moaning Fighting the ventilator or crying or Sobbing	0 1 2
TOTAL		**/8**

Neuro Section: Comfort Section

Comfort: Refer to pain, sedation and delirium scales.					**Sleep Codes:** Identify periods when patient appears to be sle								
NSR (0-10) or CPOT (0-8)													
VAMAAS													
SWAP Pass/Fail													
EPS/NMS (+* or -)													
SLEEP													

Pain scores are on a single line. Circle the tool that you are using and enter the number.

Neuro Section: Comfort Section

Comfort: Refer to pain, sedation and delirium scales.	**Sleep Codes:** Identify periods when patient appears to be sle											
NSR (0-10) or CPOT (0-8)												
VAMAAS												
SWAP Pass/Fail												
EPS/NMS (+* or -)												
SLEEP												

All tools including VAMAAS are on bedside laminated cards and on the CCTC website (What's New or Standards links)

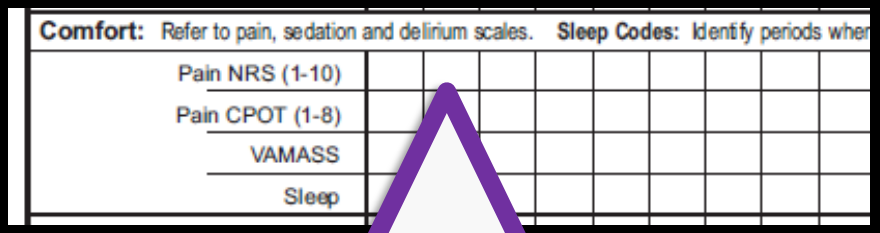
Neuro Section: Sedation

Comfort: Refer to pain, sedation and delirium scales.	**Sleep Codes:** Identify periods when patient appears to be sle											
NSR (0-10) or CPOT (0-8)												
VAMAAS												
SWAP Pass/Fail												
EPS/NMS (+* or -)												
SLEEP												

- ❑ Screen all patients at start of shift
  - VAMAAS if ventilated.
  - MAAS if unventilated
- ❑ Q4h and prn with each neuro assessment unless sleeping
- ❑ Reassess following administration of sedatives
- ❑ Document on MAR to support reason for prn sedative

Neuro Section: Pain and Sedation

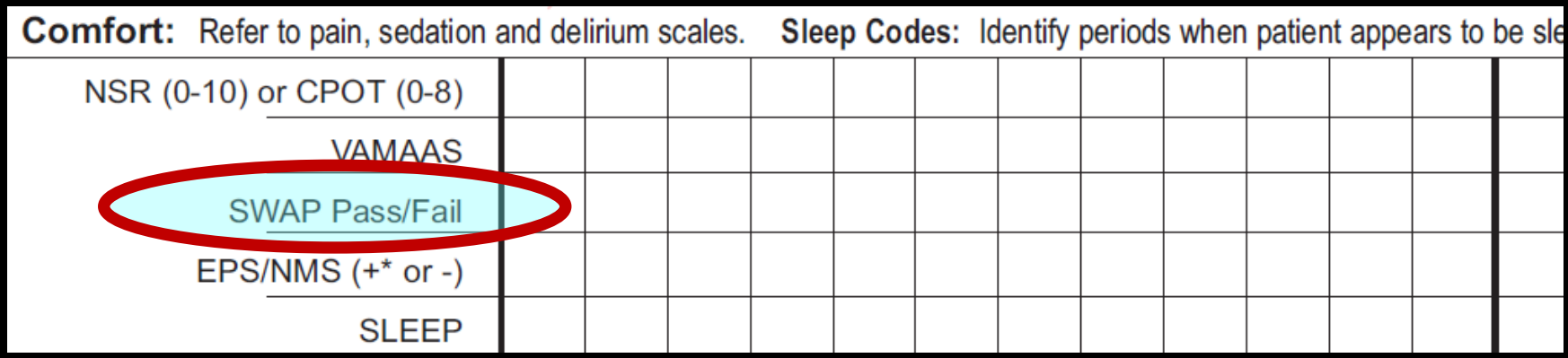
- If you give a prn, you are required to * and DAR rationale and response
- It is acceptable to write a summary note to describe, pain, sedation and delirium assessment/interventions q4-12h
- Document Pain or VAMAAS score pre/post medication



STANDARD:

- Chart q shift, q4h (while awake) and PRN
- Chart MAAS if unventilated
- Chart VAMAAS on MAR at time prn dose given

Sedation Weaning Assessment Protocol (SWAP)



Comfort: Refer to pain, sedation and delirium scales.	**Sleep Codes:** Identify periods when patient appears to be sle											
NSR (0-10) or CPOT (0-8)												
VAMAAS												
SWAP Pass/Fail												
EPS/NMS (+* or -)												
SLEEP												

The analgesia and sedation orders require each patient to be SCREENED at least once per shift for his/her readiness for automatic sedation weaning trials. The screening tool is called the SWAP (Sedation Weaning Assessment Protocol).

The results of the SWAP are entered as Pass/Fail

Daily Sedation Weaning Assessment Protocol (SWAP)

- ✓ **CONTRAINDICATED in patients requiring deep sedation (e.g., 0-1A)**
- ✓ RN/RRT to collaborate at the start of each shift to review SWAP/SBT goals
- ✓ Document assessment and weaning plan in 24 hour assessment record
- ✓ Record response to sedation weaning in AI record under "comfort/sedation" parameter

Is the patient's reason for ventilation resolved or partially resolved?

Is the PaO_2/FiO_2 > 200 on $FiO_2 \leq .5$ and PEEP $\leq$ 10 cm H_20?

Is the patient hemodynamically stable?
(may be on stable doses of vasoactive drugs)

Is the patient's VAMASS score $\leq$ 3A?

Is the patient on continuous analgesic or sedative infusions?

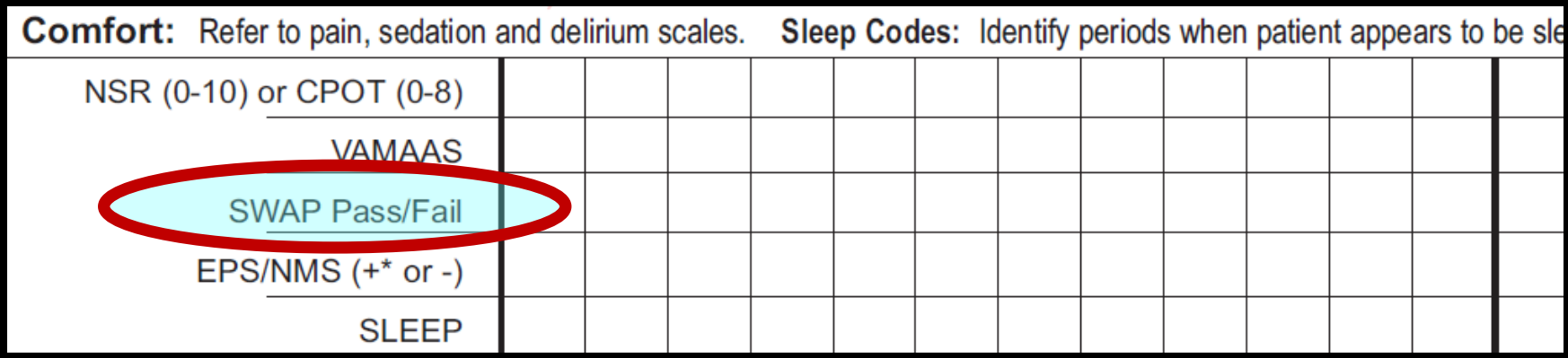
If *YES* to all of these questions:

- Wean sedation and narcotic as per weaning orders
- Document response to weaning in AI record

If *No* to any of these questions:

- Review sedation goals during morning rounds
- Document reason why sedation weaning is contraindicated
- Use the lowest dose of sedation required to achieve pain and MAAS targets

Sedation Weaning Assessment Protocol (SWAP)



Comfort: Refer to pain, sedation and delirium scales.	**Sleep Codes:** Identify periods when patient appears to be sle											
NSR (0-10) or CPOT (0-8)												
VAMAAS												
SWAP Pass/Fail												
EPS/NMS (+* or -)												
SLEEP												

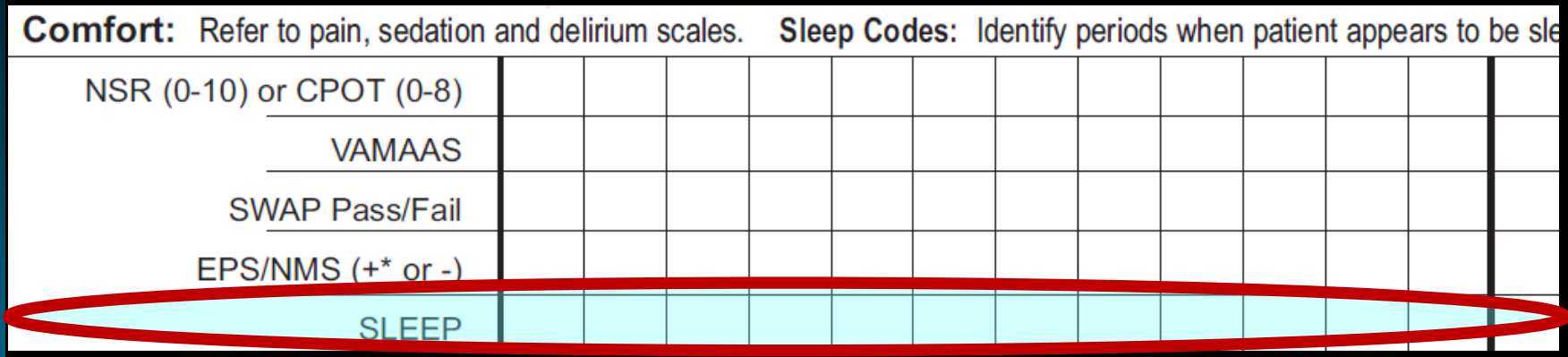
If a patient passes the screen, weaning attempts (as per the analgesia and sedation orders) are initiated automatically by the RN. Sedation weaning attempts should be coordinated with the RRT SBT.

If a patient fails the screen, analgesia and sedation plans should be discussed during morning rounds. Weaning trials or medication reductions may still be ordered.

Practice Reminder

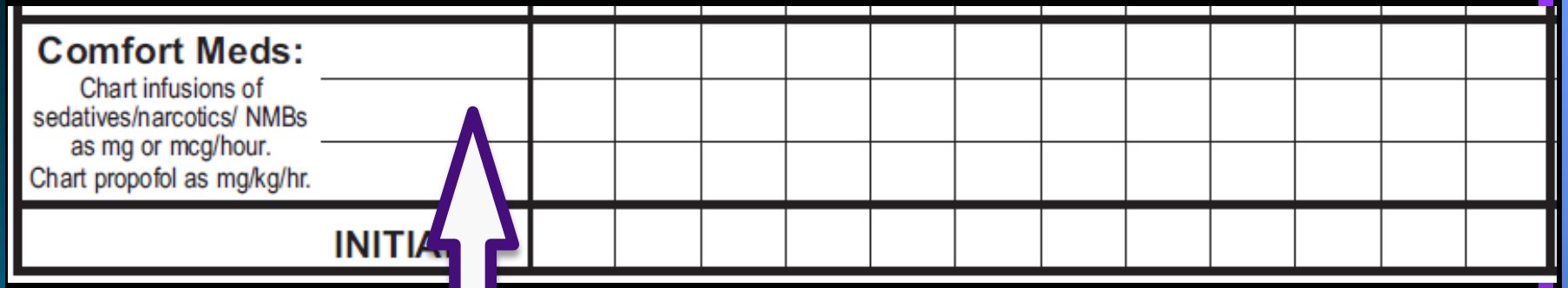
Every patient is expected to have at least one DAR note each shift that outlines their response to comfort medications, any weaning attempts/response to weaning and or reasons why weaning is contraindicated.

Neuro Section: Sleep



- Use code to identify periods of quite sleep or wakefulness
- Arrow over to highlight periods of sleep and wakefulness
- Sleep disruption and/or day-night confusion is often the first marker of delirium

Neuro Section: Pain and Sedation



Key Points:

- Sedatives, narcotics and NMB infusions documented here
- Chart dose per hour only (volume on fluid balance)

Fluid Balance
(Panel 4)

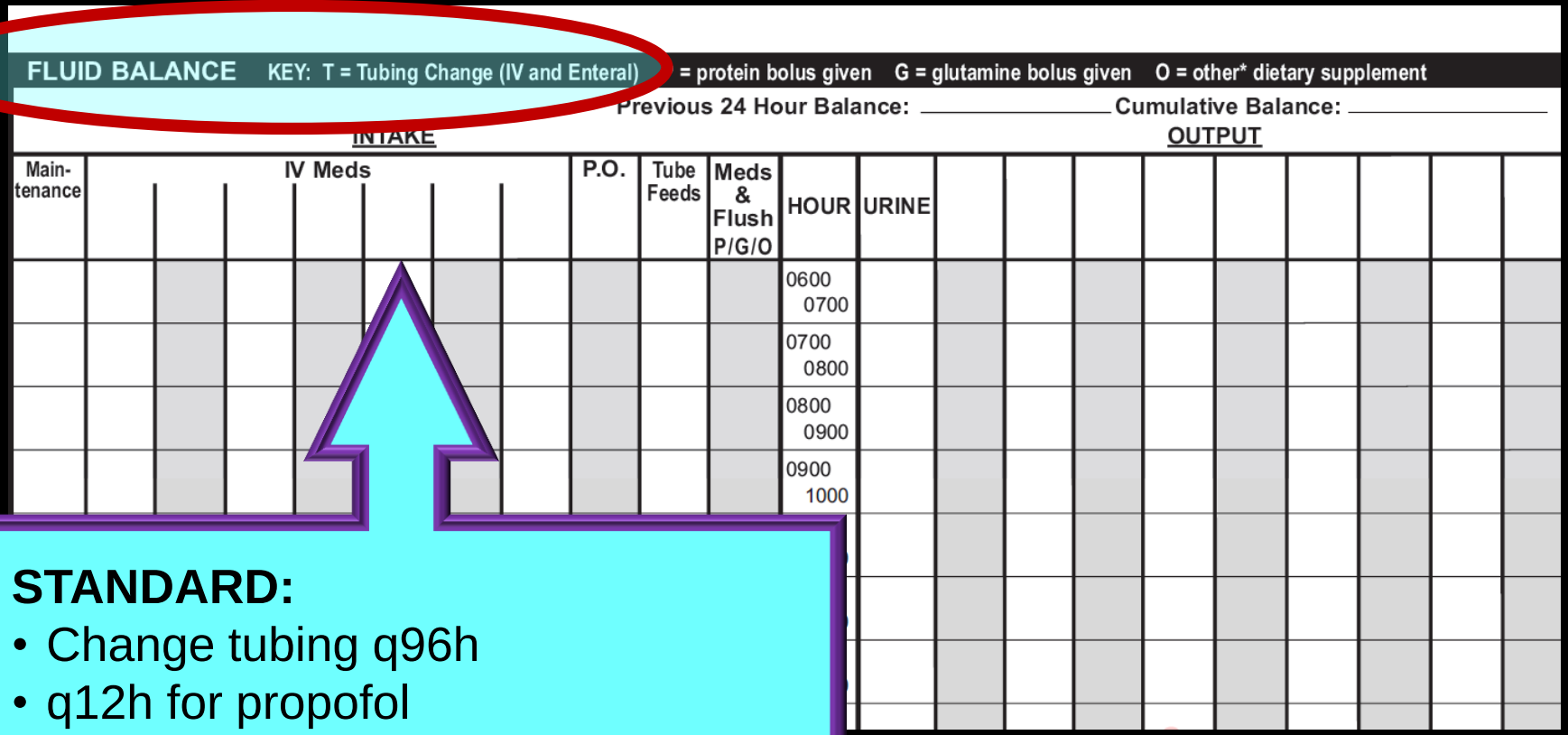
Fluid Balance

FLUID BALANCE KEY: T = Tubing Change (IV and Enteral) P = protein bolus given G = glutamine bolus given O = other* dietary supplement

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE												OUTPUT									
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300										

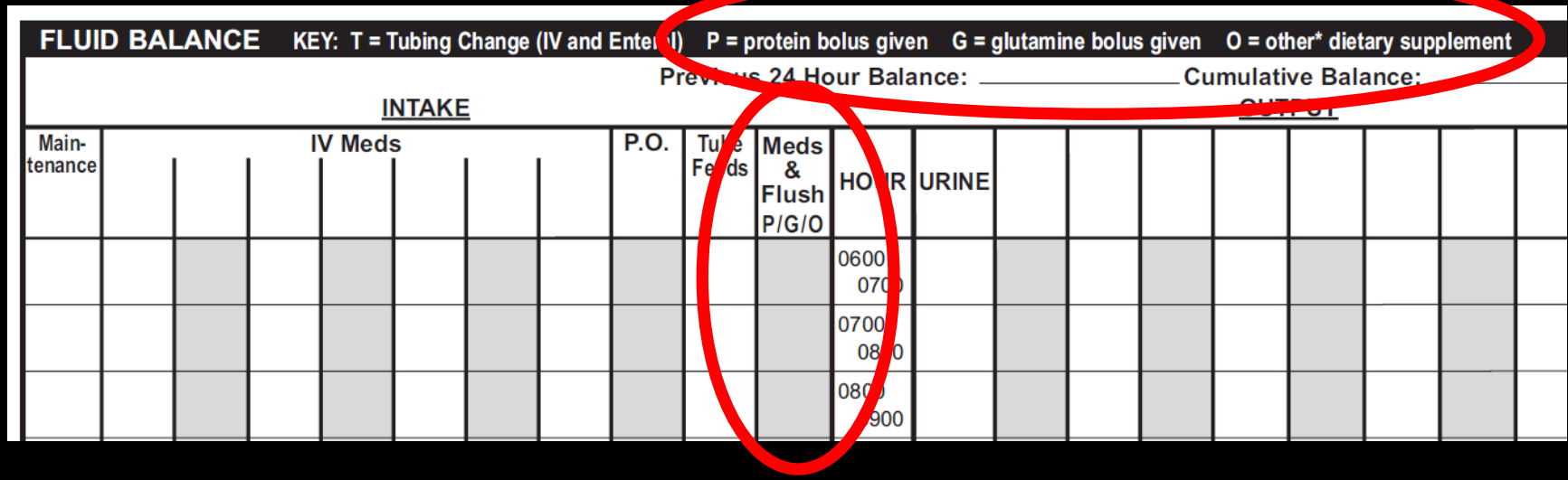
Fluid Balance



STANDARD:

- Change tubing q96h
- q12h for propofol
- q24h for TPN or lipids
- after 2 units or q4h for blood tubing
- Remove peripheral IVs q 96 hrs

Fluid Balance



FLUID BALANCE KEY: T = Tubing Change (IV and Enteral) P = protein bolus given G = glutamine bolus given O = other* dietary supplement

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE											OUTPUT								
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE							
											0600 0700								
											0700 0800								
											0800 0900								

We can no longer enter enteral feeding supplements onto the MAR in the electronic world.

Revision:

Record enteral feeding flushes in the medication/flush column as P (protein), G (glutamine) or O (other dietary supplement). If other is chosen, describe the supplement being used.

Fluid Balance

FLUID BALANCE KEY: T = Tubing Change (IV and Enteral) P = protein bolus given G = glutamine bolus given O = other* dietary supplement

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE												OUTPUT									
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300										

Fluid Balance

FLUID BALANCE KEY: T = Tubing Change (IV and Enteral) P = protein bolus given G = glutamine bolus given O = other* dietary supplement

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE											OUTPUT									
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE								
											0600 0700									
											0700 0800									
											0800 0900									
											0900 1000									
											1000 1100									
											1100 1200									
											1200 1300									
											1300									

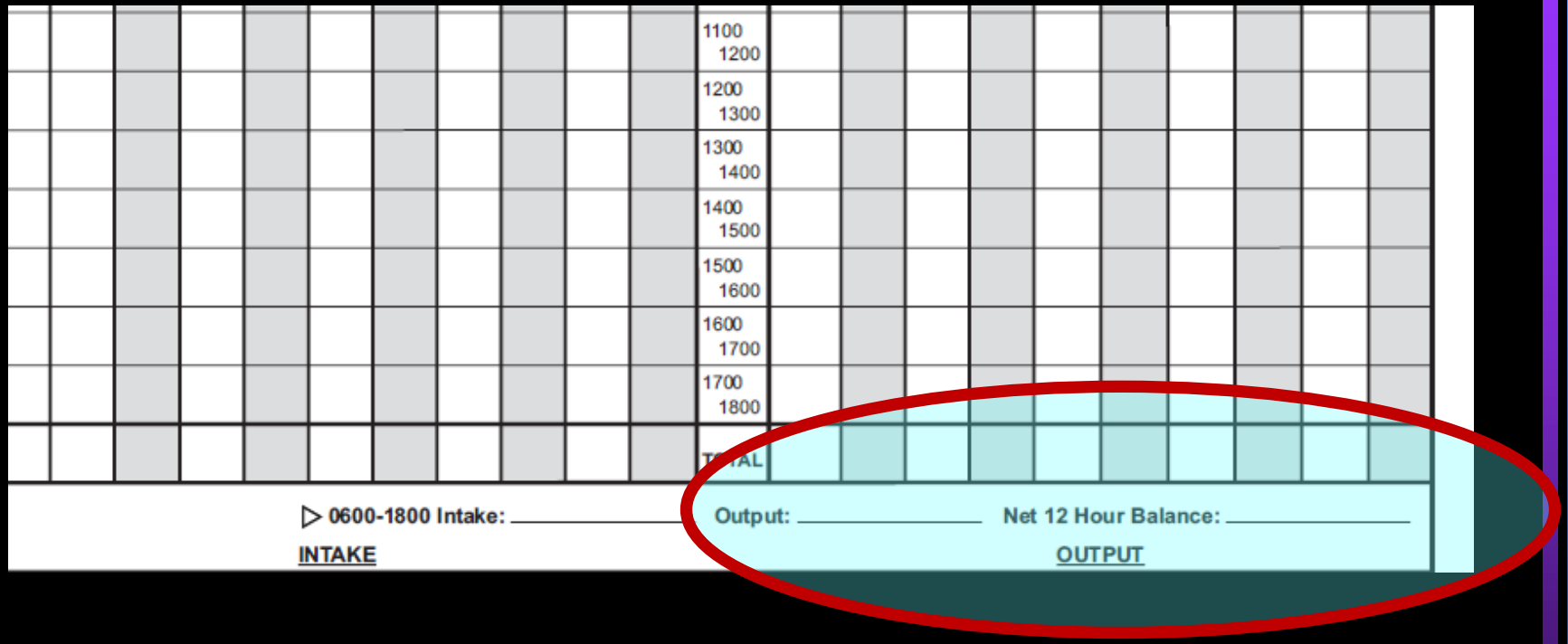
Fluid Balance

FLUID BALANCE KEY: T = Tubing Change (IV and Enteral) P = protein bolus given G = glutamine bolus given O = other* dietary supplement

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE												OUTPUT									
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300										

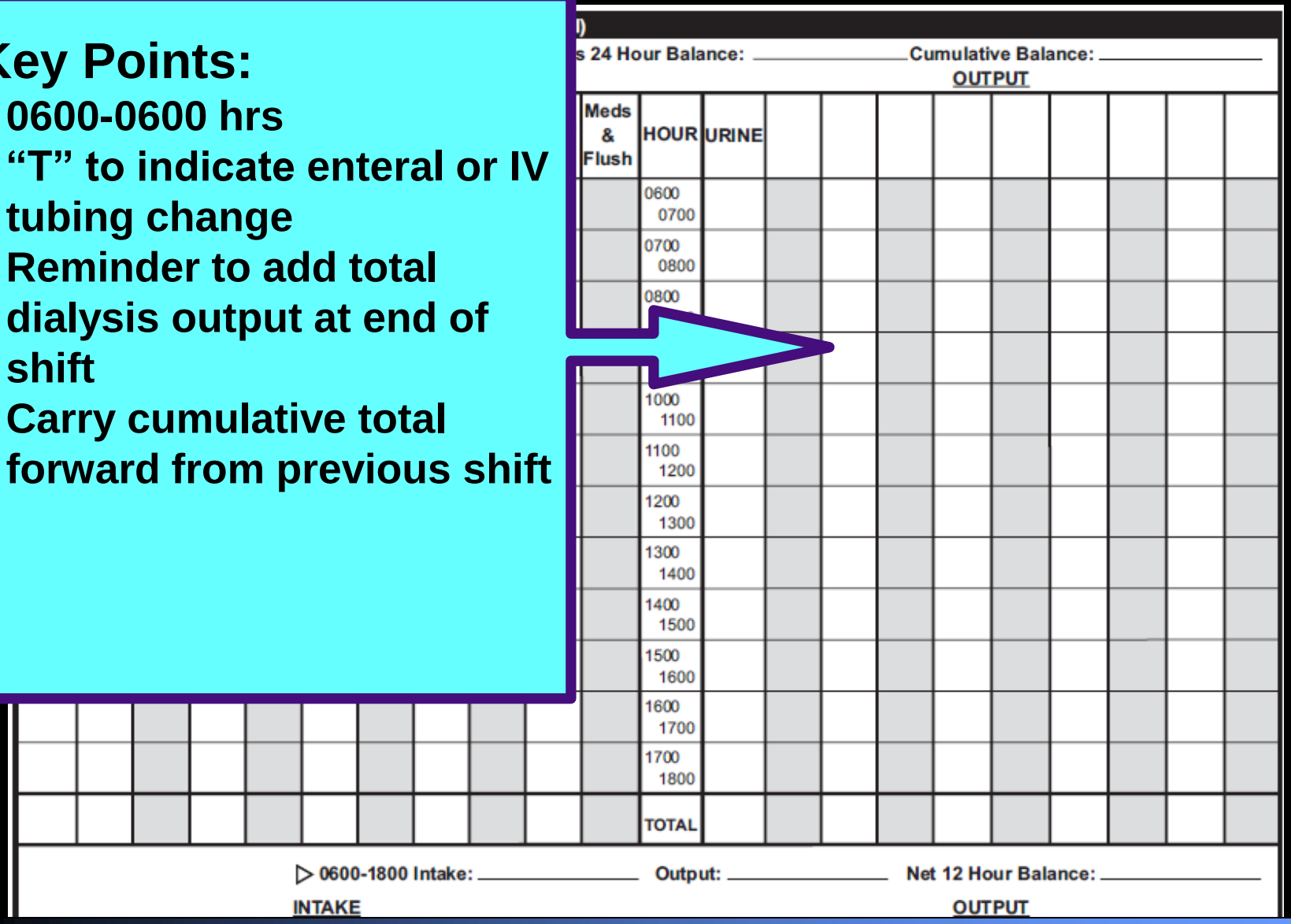
Fluid Balance



Fluid Balance

Key Points:

- 0600-0600 hrs
- “T” to indicate enteral or IV tubing change
- Reminder to add total dialysis output at end of shift
- Carry cumulative total forward from previous shift

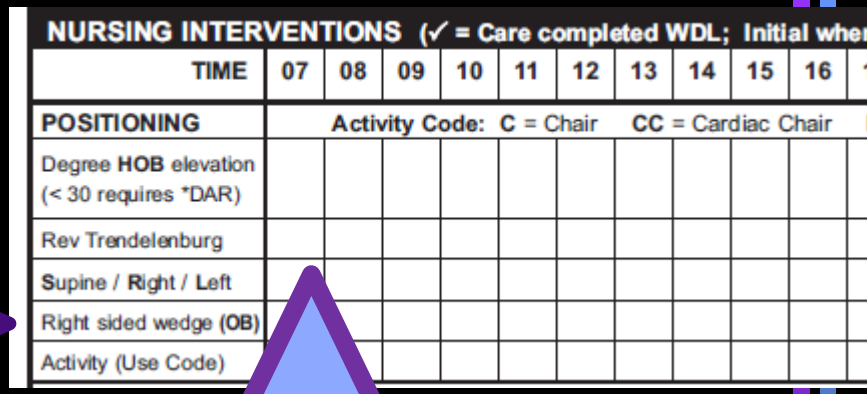


Nursing Care Interventions (Panel 5)

Nursing Care Documentation

STANDARD:

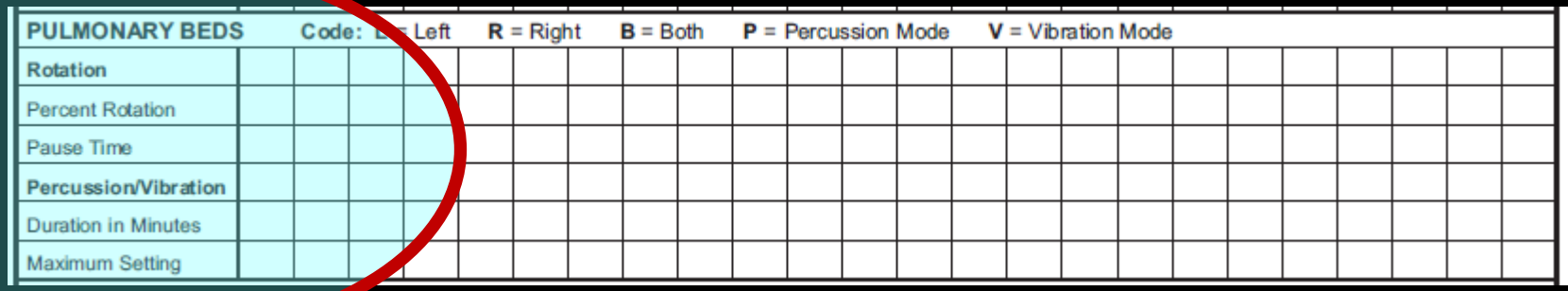
- **HOB ≥30 degrees documented q1h**
- *** and DAR if other than 30 degrees**
- **Reposition at least q2h**
- **Be sure to document activity**



NURSING INTERVENTIONS (✓ = Care completed WDL; Initial when											
TIME	07	08	09	10	11	12	13	14	15	16	
POSITIONING	Activity Code: C = Chair CC = Cardiac Chair										
Degree HOB elevation (< 30 requires *DAR)											
Rev Trendelenburg											
Supine / Right / Left											
Right sided wedge (OB)											
Activity (Use Code)											

***If you cannot meet the standard (e.g., HOB to 30 degrees), * and DAR rationale**
Refer to bedside tools for contraindications

Nursing Care Documentation



PULMONARY BEDS	Code: L = Left	R = Right	B = Both	P = Percussion Mode	V = Vibration Mode
Rotation					
Percent Rotation					
Pause Time					
Percussion/Vibration					
Duration in Minutes					
Maximum Setting					

- Documentation in the AI record must include reason for starting, continued use of, and discontinuation of CLRT q 4 h

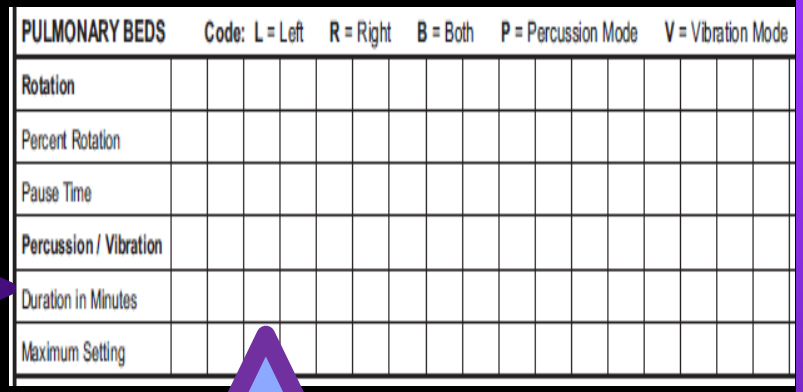
Continuous Lateral Rotational Therapy

- Only indicated for patients with impaired gas exchange due to pneumonia or atelectasis
- Obesity and prevention of skin breakdown are not indications for use

Nursing Care Documentation

Rotation:

- Indicate left, right or both for turn, percent of rotation, and pause time
- Percuss/Vibrate:
- Indicate duration and max setting



PULMONARY BEDS	Code: L = Left	R = Right	B = Both	P = Percussion Mode	V = Vibration Mode
Rotation					
Percent Rotation					
Pause Time					
Percussion / Vibration					
Duration in Minutes					
Maximum Setting					

- Chart on flow sheet q1h
- Reassess use for q4h and chart in AI
- Monitor for tolerance in vital signs and n/v

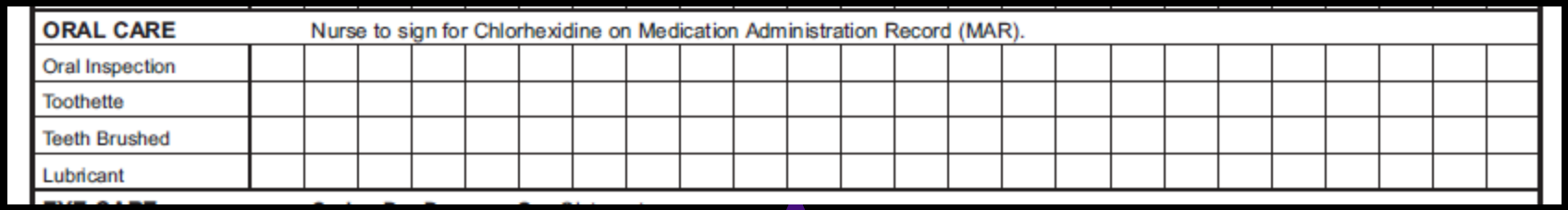
Nursing Care Documentation

HYGIENE	Bath Code: C = Complete P = Partial Nurse to sign for Chlorhexidine on Medication Administration Record (MAR).																							
Skin Inspection																								
Bath																								
Shower																								
Hair Wash																								
Pericare																								
Linen Change																								
Facial Shave																								
Collar Care																								

Documentation:

- Chlorhexidine baths q shift; place on MAR
- Spot for linen change added; should be prn

Nursing Care Documentation



ORAL CARE	Nurse to sign for Chlorhexidine on Medication Administration Record (MAR).
Oral Inspection	
Toothette	
Teeth Brushed	
Lubricant	

Documentation:

- Oral inspection q shift
- Toothette q2-4h and prn
- Teeth brushed q shift
- If patient has no teeth, document at start of shift on teeth brushing line

Nursing Care Documentation

EYE CARE	Code: D = Drops O = Ointments																							
Lubricant																								

Documentation:

- Obtain lubricant order and apply q4h and prn for unconscious patient or those with impaired eye closure including neuromuscular blocking agent

Nursing Care Documentation

BOWEL ROUTINE	Stool Code: - = Small + = Large S = Soft D= Diarrhea H = Hard														Impaction Code: H = Hard S = Soft N = None									
Stool Record																								
Impaction ✓																								
Fecal Incontinence System Flush																								
Fecal Incontinence System Irrigation																								

- Flushing is the rinsing of the drainage tube. It should be done q 8 h
- Irrigation can only be done with specific products that have an irrigation port
- Irrigation is the administration of a saline infusion/ bolus into the rectum
  - Can either be retained by inflating the luminal cuff, or allowed to run in and out
  - Should be done q 8 h for fecal diversion strategies (patients who do not have diarrhea as their indication for use)

Nursing Care Documentation

RESPIRATORY	Identify **L** = Left or **R** = Right and drainage tube number **AT** = Adhesive Tape **AF** = Anchor Fast **TT** = Trach Ties																							
Trach/ETT Securement change																								
Trach Dressing																								
Chest Tube Dressing																								
Chest Drainage Unit Change																								
DB&C/Breath Stacking																								
SpO_2 Monitor Site Change																								
Preoxygenated / Hyperoxygenated																								
INITIALS																								

- Trach ties/ETT securement are responsibility of the RRT; RN is encouraged to notify when a change is needed
- Trach dressing is changed daily and prn
- Chest tube dressings are changed q 2 days and prn
- Document preoxygenation (100% oxygen) and hyperventilation (extra breaths) pre suctioning as indicated
- Findings not WDL are documented in AI record, which is most dressings unless wound is dry and healed
- Chest Drainage Unit Change done q7days and when filled and/or tipped over

Nursing Care Documentation

RESPIRATORY	Identify L = Left or R = Right and drainage tube number AT = Adhesive Tape AF = Anchor Fast TT = Trach Ties																							
Trach/ETT Securement change																								
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Chest Tube Dressing																								
Chest Drainage Unit Change																								
DB&C/Breath Stacking																								
SpO_2 Monitor Site Change																								
Hyperoxygenated																								
INITIALS																								

- SpO2 monitor site change performed q 2 hours
- Change the placement to a different digit, and indicate any abnormal findings in the AI record

Nursing Care Documentation

RESPIRATORY	Identify L = Left or R = Right and drainage tube number AT = Adhesive Tape AF = Anchor Fast TT = Trach Ties																							
Trach/ETT Securement change																								
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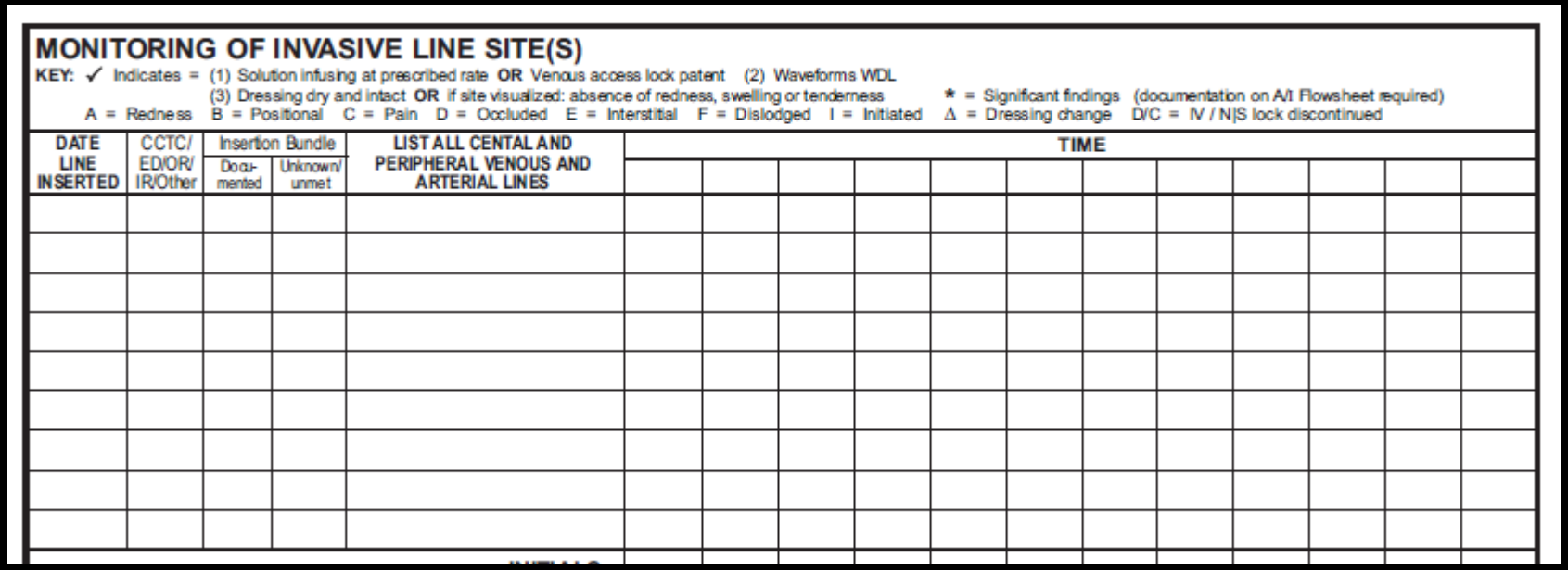
Chest Drainage Unit Change																								
DB&C/Breath Stacking																								
SpO_2 Monitor Site Change																								
Preoxygenated / Hyperoxygenated																								
INITIALS																								

STANDARD:

- **Ties/Tapes prn**
- **Trach drsg qshift**
- **Chest Tube drsg q2days**
- **CT Unit q7days and prn**
- **SpO2 site change q2h**

Line Tracking
Nursing Care Interventions
(Panel 6)

Line Tracking

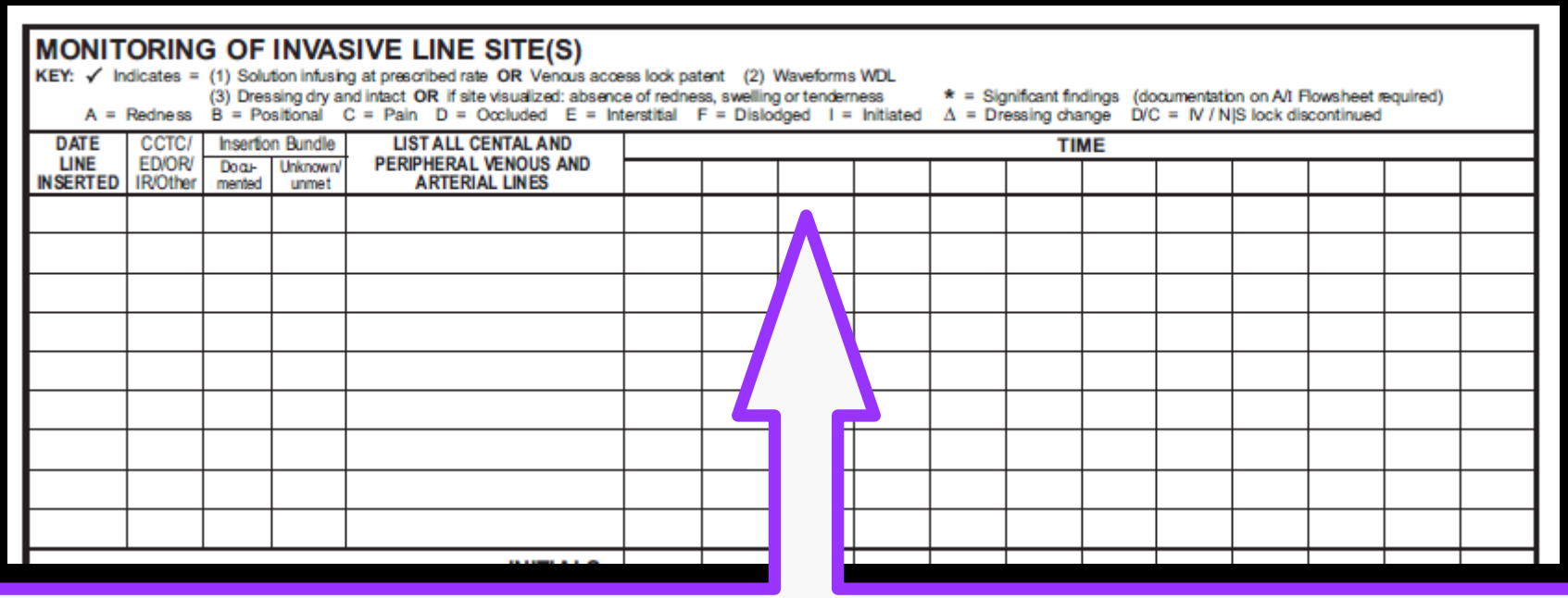


MONITORING OF INVASIVE LINE SITE(S)

KEY: ✓ Indicates = (1) Solution infusing at prescribed rate **OR** Venous access lock patent (2) Waveforms WDL
(3) Dressing dry and intact **OR** if site visualized: absence of redness, swelling or tenderness * = Significant findings (documentation on A/I Flowsheet required)
A = Redness B = Positional C = Pain D = Occluded E = Interstitial F = Dislodged I = Initiated Δ = Dressing change D/C = IV / N|S lock discontinued

DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle		LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES	TIME											
		Documented	Unknown/ unmet													

Line Tracking



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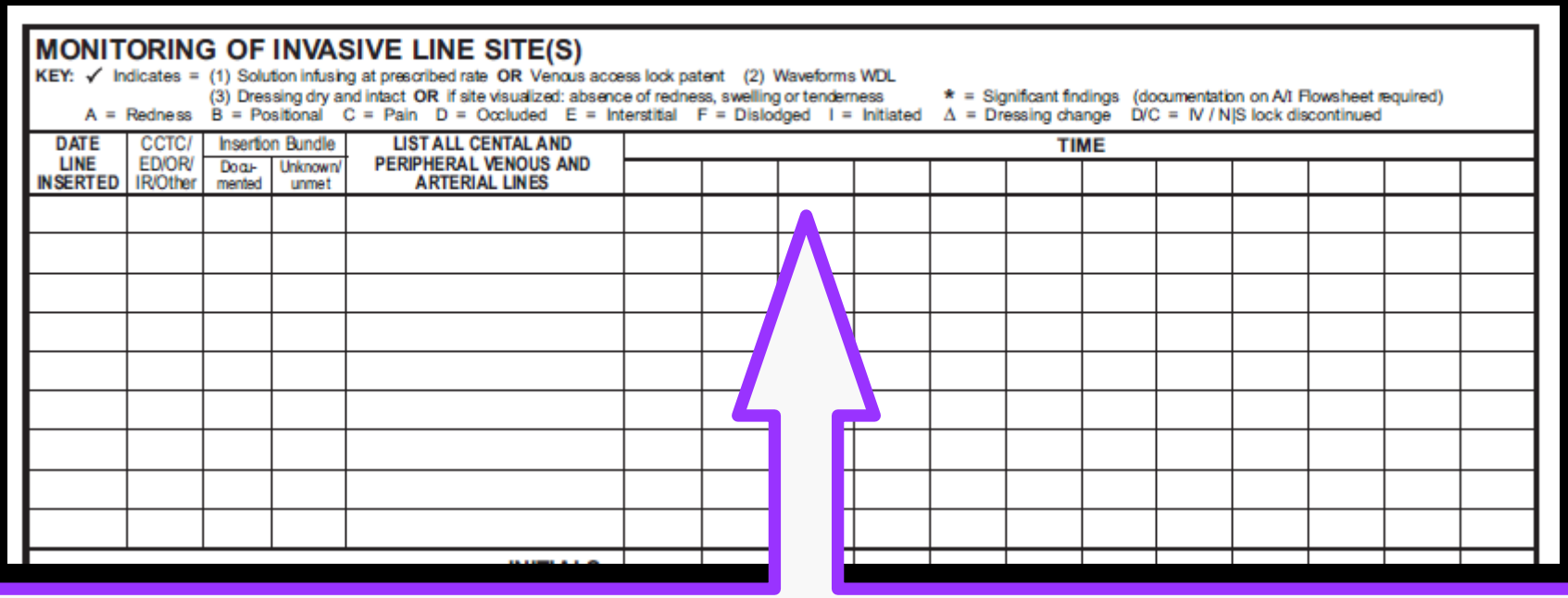
A = Redness B = Positional C = Pain D = Occluded E = Interstitial F = Dislodged I = Initiated Δ = Dressing change D/C = IV / N|S lock discontinued

DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle: Documented	Insertion Bundle: Unknown/ unmet	LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES	TIME

- Enter the date AND location of all lines upon insertion or admission
- Speak with the team who put the line in to find out if it was placed during an emergency
- Unless there is documentation that the line was placed according to central line insertion standards, choose “unknown/unmet” for insertion bundle.

- If unknown or unmet, report to the medical team and document in the

Line Tracking



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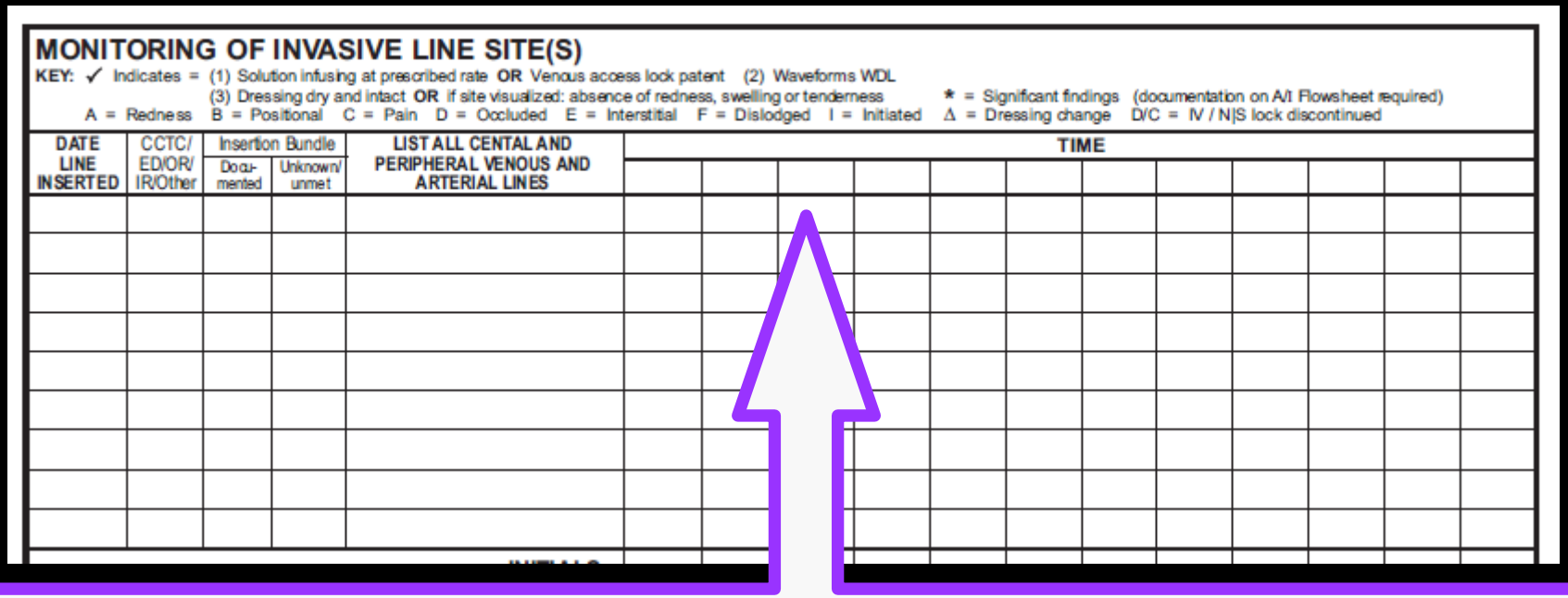
DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle: Documented	Insertion Bundle: Unknown/ unmet	LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES	TIME											

- Unless there is documentation that the line was placed according to central line insertion standards, choose “unknown/unmet” for insertion bundle

Line Tracking



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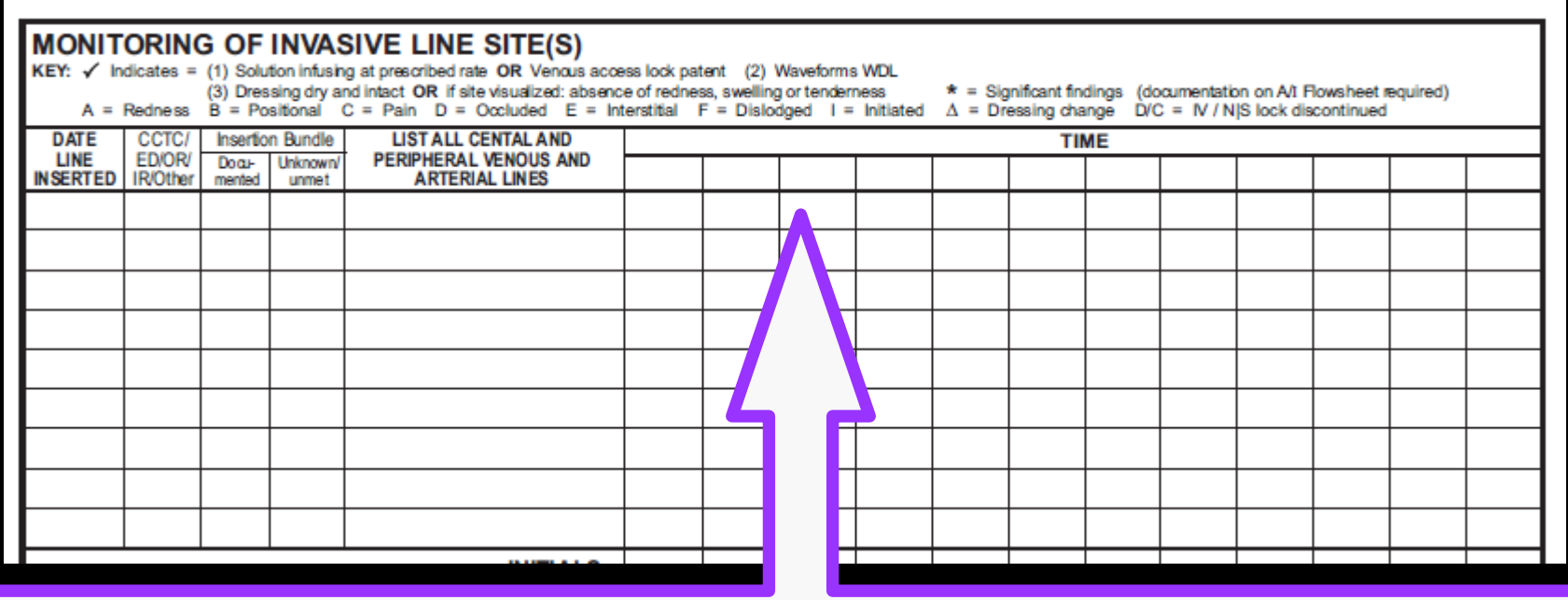
DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle		LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES	TIME											
		Documented	Unknown/ unmet													

- If the line insertion bundle was not met or is unknown, the medical team must be notified
- Document your report and the line plan in the AI record
- If the line is not changed on your shift, report information to oncoming shift

Line Tracking



MONITORING OF INVASIVE LINE SITE(S)

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A = Redness B = Positional C = Pain D = Occluded E = Interstitial F = Dislodged I = Initiated Δ = Dressing change D/C = IV / N|S lock discontinued

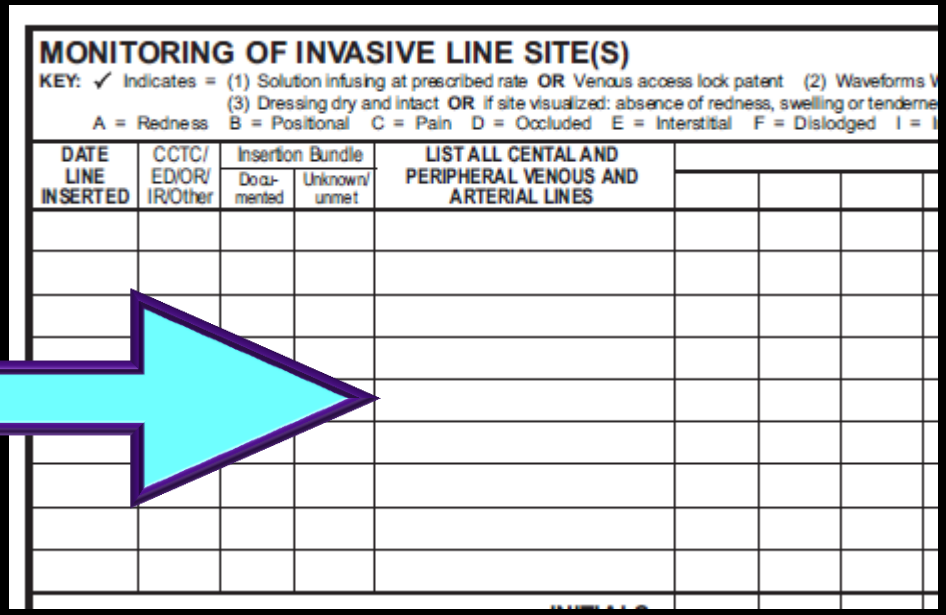
DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle		LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES	TIME											
		Documented	Unknown/ unmet													

- Remember to document when dressings are changed and if there are issues with any line (e.g., positional, blocked, dressing adherence)
- All line issues require a DAR note and should be reported during rounds
- The issue, discussion and plan must be documented in the DAR

Nursing Care Documentation

STANDARD:

- Central line and arterial line dressings are changed q 2 days and prn (tape/gauze), or q 7 days and prn (transparent)
- Use KEY to indicate findings and changes
- * and DAR if not WDL
- Be sure to document leaks, positional and blocked lines
- D/c peripheral IVs q96h



MONITORING OF INVASIVE LINE SITE(S)

KEY: ✓ Indicates = (1) Solution infusing at prescribed rate **OR** Venous access lock patent (2) Waveforms W
(3) Dressing dry and intact **OR** if site visualized: absence of redness, swelling or tenderne
A = Redness B = Positional C = Pain D = Occluded E = Interstitial F = Dislodged I = I

DATE LINE INSERTED	CCTC/ ED/OR/ IR/Other	Insertion Bundle		LIST ALL CENTAL AND PERIPHERAL VENOUS AND ARTERIAL LINES			
		Docu-mented	Unknown/ unmet				

Nursing Care Documentation

NURSING INTERVENTIONS (initial when completed/assessed; *significant findings and document on A/I Flowsheet)																								
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
RESTRAINTS	Code: + = On - = Off																							
R Wrist Restraint																								
✓ CSM																								
L Wrist Restraint																								
✓ CSM																								
R Ankle Restraint																								
✓ CSM																								
L Ankle Restraint																								
✓ CSM																								
Magnetic Restraint																								

Document consent on AI record; this is both a hospital policy and Ontario law.

* DAR the following:

- the behaviour that necessitated the use of the restraint
- the date and time of initial application
- the type of restraint used
- the discussion with the Family/Substitute Decision-Maker
- the verbal consent or refusal
- observations regarding the effect of the restraint on patient's behaviour
- *refusal requires completion of the consent for refusal

Nursing Care Documentation

NURSING INTERVENTIONS (initial when completed/assessed; *significant findings and document on A/I Flowsheet)																							
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
RESTRAINTS	Code: + = On − = Off																							
R Wrist Restraint																								
✓ CSM																								
L Wrist Restraint																								
✓ CSM																								
R Ankle Restraint																								
✓ CSM																								
L Ankle Restraint																								
✓ CSM																								
Magnetic Restraint																								

STANDARD:

- Assess CSM q15X4, then q1h
- Remove/reapply and chart q2h
- ROM q12h
- Reassess need q shift and document in A/I reason for ongoing use; document consent on AI

Nursing Care Documentation

VTE PROPHYLAXIS	Code: + = On	- = Off																						
TEDS																								
*Skin ✓ Legs																								
IPC																								

STANDARD:
- TEDS/IPC off for ~20-30 minutes for bathing and skin assessment q12h and prn

IPC stands for:
Intermittent Pneumatic Compression (AKA SCD)

Nursing Care Documentation

MUSCULOSKELETAL		Code: + = On − = Off																					
Splints	Upper Extremities																						
	Lower Extremities																						
ROM	Leg																						
	Arm																						

STANDARD:

- Splints on/off q2h, assess CSM
- ROM q12h

Nursing Care Documentation

STANDARD:

- Change regular foley q7days to a silastic then leave until removed
- Change drainage bag with any catheter changes

CATHETER CHANGE	Code: R = Regular Foley		S = Silicone		T = Thermistor									
Catheter Change														
Drainage Bag Change														

Changes only needed if:

- regular to silastic
- UTI (review with team)
- break in the system
- requirement of different type of catheter (ie: 3way)

Obstetrical Section

OBSTETRICAL CARE (refer to postpartum checklist for WDL definitions) * if not WDL (requires DAR note)																
Lochia (✓ if WDL, or * and DAR)																
Fundal Height (✓ if WDL, or * and DAR)																
Perineum (✓ if WDL, or * and DAR)																
Abdominal Incision																
Pre Eclampsia/Eclampsia Assess (headache, vision, epigastric, pain, patellar reflex) ✓ assessed * DAR abnormal																

- Download a copy of the post partum admission and Q shift checklist for assessment tips and reminders.

Obstetrical Section

OBSTETRICAL CARE (refer to postpartum checklist for WDL definitions) * if not WDL (requires DAR note)																
Lochia (✓ if WDL, or * and DAR)																
Fundal Height (✓ if WDL, or * and DAR)																
Perineum (✓ if WDL, or * and DAR)																
Abdominal Incision																
Pre Eclampsia/Eclampsia Assess (headache, vision, epigastric, pain, patellar reflex) ✓ assessed * DAR abnormal																

All patients with preeclampsia or eclampsia (or who are receiving **M**g$S0_4$ treatment) must be assessed q 1 h for presence of headache, vision changes, epigastric pain and patellar reflexes.

Headache, visual changes, epigastric pain and/or hyperreflexia are signs of worsening preeclampsia.

Obstetrical Section

Definition Review:

Preeclampsia: new onset of hypertension and either proteinuria or end-organ dysfunction after 20 weeks of gestation in a previously normotensive woman

Eclampsia: Preeclampsia PLUS generalized seizure that is not due to another neurological cause

The treatment for preeclampsia is birth.

$MgSO_4$ Use

$MgSO_4$ is indicated to prevent progression of preeclampsia to eclampsia (defined by onset of seizures). It is the drug of choice for the treatment of seizures due to eclampsia (this is the one indication where benzodiazepines are not the first line anticonvulsants).

$MgSO_4$ is not used for the management of hypertension alone. Drugs such as labetolol or hydralazine are used.

$MgS0_4$ Toxicity

Reflex testing is also important if a patient is receiving $MgS0_4$ as decreased reflexes (hyporeflexia) may indicate $MgS0_4$ toxicity. Toxicity risk increases in renal failure.

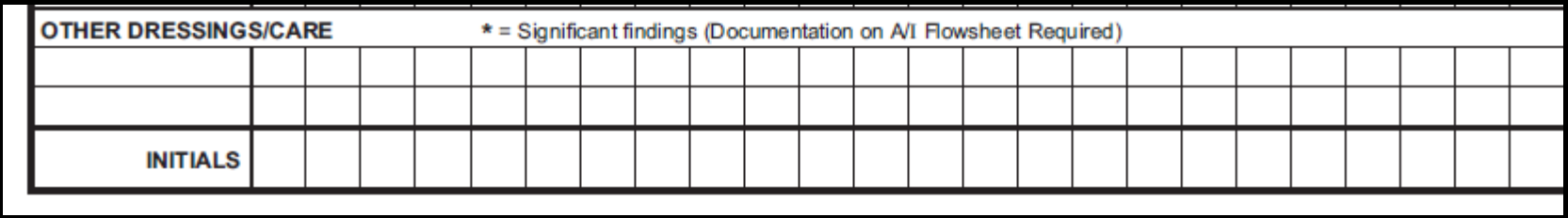
$MgS0_4$ can also cause respiratory depression/arrest or hypotension and cardiac arrest. Sudden hemodynamic instability or cardiac arrest during $MgS0_4$ therapy is treated with calcium chloride.

Postpartum Eclampsia

Preeclampsia or eclampsia is usually a complication of pregnancy, but symptoms of preeclampsia/eclampsia can develop or worsen > 2 days and up to 6 weeks postpartum. Preeclampsia/eclampsia should be considered in the differential diagnoses of any pregnant or post partum patient with hypertension and headache, visual changes, epigastric pain, proteinuria, organ dysfunction or seizures.

The first line treatment for the seizures due to eclampsia is $MgS0_4$ even if seizure onset is postpartum.

Nursing Care Documentation



OTHER DRESSINGS/CARE	* = Significant findings (Documentation on A/I Flowsheet Required)																							
INITIALS																								

- List other dressings that do not have a dedicated spot
- * and DAR significant findings