1st Thing

(EWIIIE)

Enter

Wash Hands

Introduce Yourself & Instructor

Id Patient Using 2 Forms of ID

Inquire How They Prefer to be Addressed

Explain Your Role & Nature of Care

SAFE PATIENT CARE

(CCABSSCW)

Can't Catch A Bad Sister Showing Cat Wax

Clear Clutter

Call Bell Within Reach

Ask If They Need Anything

Bed Low and Locked

Socks On

Siderails Up

Check Fluid Left in Bag

Wash Hands

ABDOMINAL ASSESSMENT

(4PS LLS FR)

4PS Love Listen Speak For Real*

PEE

PRIVACY

PAIN

POSITION (Lay Flat, Knees Slightly Bent)

SUCTION OFF

LOOK

- Appearance
  - (Drains, Incision Site, Dressings, Discolorations)
- Contour
  - (Flat, Round, Distended, Convex, Concave)

LISTEN (Auscultate X4, Absent or Present)

SUCTION ON

FEEL (Tenderness, Pain, Soft, Firm, Rigid)

REPOSITION

ABDOMINAL ASSESSMENT

DOCUMENT:

- ~ Appearance of Abdomen
- ~ Contour of Abdomen
- ~ Bowel Sounds in all Quadrants
- ~ Tenderness or Pain
- ~ Muscle Resistance

0830 NG suction suspended for abdominal assessment. Abdomen round with no discoloration. Well approximated 2 cm incision noted in right lower quadrant with surgical adhesive intact. Bowel sounds hypoactive in all 4 quadrants. Abdomen soft without muscle rigidity. Patient reports tenderness at right lower quadrant upon light palpation. No tenderness in remaining abdominal quadrants. Suction re-established after assessment.....AR ECSN

NEUROLOGICAL ASSESSMENT

(LAPP GFS)

****LAPP Go For Some****

LOC

- ~ Patient is Awake & Responds to **Verbal Stimuli**
- ~ **Tactile Stimuli**, if Unresponsive to Verbal Stimuli
- ~ **Painful Stimuli**, by Applying Pressure to the Nail Bed, if Unresponsive to Tactile Stimuli

AOX3

- ~ Patient is Alert & Orientated to Person, Time, Place
- ~ 1 - 3 Y/O or Non-Communicating
  - Observe Ability to Recognize Faces or Objects

PERRL

- ~ Pupils Equal Round, Reactive to Light Bilaterally

PALPATE ANTERIOR FONTANELL

< 1 Y/O (Flat, Bulging, Sunken)

GRIP (Strong, Weak Grip Bilaterally of Upper Extremities)

FEET (Active Motion Strong or Weak Against Resistance Bilaterally)

- ~ **Dorsiflexion** (Toes to the Nose)
- ~ **Plantar flexion** (Breaks on Car)

SYMMETRY- in child less than 3

- ~ Observe Movement & Symmetry in Upper & Lower Extremities

NEUROLOGICAL ASSESSMENT

DOCUMENT:

- Level of Arousal
- Level of Orientation
- Characteristics of Anterior Fontanel
- Equality of Pupil Size
- Pupil Reaction to Light
- Equality of Muscle Strength

0832 Patient oriented to time, place and person. Patient responds to verbal stimulation. Pupils equal and reactive to light bilaterally. Patient's hand squeeze strong and equal bilaterally. Plantar flexion and dorsiflexion strong and equal bilaterally against resistance.....AR ECSN

0832 Baby turns head toward nursing student when nursing student calls patient's name. When baby's palm is touched, baby wraps hand around nursing student's finger. Baby reached arms out to mother when mother walked into patient's room. Anterior fontanel is flat. Pupils equal and reactive to light bilaterally. Movement of both upper and lower extremities symmetrical.....AR ECSN

VITAL SIGNS

PAIN-use pain scale

TEMPERATURE-Skin

-Tympanic-Child (pinna down and back)
-Adult (pinna up and back)
-Axillary
-Oral
-Rectal

PULSE-Apical -5TH Intercostal space midclavicular/Radial-Rate (#bpm)

-Rhythm (regular, irregular)
-Quality (strong, weak, thread, bounding)
-Equality (equal or unequal in strength bilaterally)

RESPIRATORY-Rate (#bpm)

-Depth (deep, shallow)
-Rhythm (regular, irregular)
-Effort (labored, unlabored)
-Sounds (clear, abnormal, rhonchi, wheeze, adventitious)

SPO2-amount to exact number

COMFORT MANAGEMENT

(CP2R)

Can't Produce 2 Rakes

COMFORT LEVEL (Verbal, Daisies Scale, Observed Behaviors)

PATIENT PREFENCES (How do they address discomfort)

2 INTERVENTIONS

- Adults
  - Relaxation techniques (comfort rub, meditation)
  - Distraction techniques (tv, talking, music)
  - Heat or cold when assigned
  - Reposition
  - Straighten linens (adjust pillow)
  - Hygiene (wash face, comb hair)
- Infant
  - Swaddle
  - Pacifier
  - Comfort object
  - Distractions (TV, coloring)

REASSESS COMFORT LEVEL (Use comfort scale or observed behaviors)

COMFORT MANAGEMENT

NANDA LABEL:

~ IMPAIRED COMFORT

RATIONALE:

An acceptable level of comfort is a basic physiological need. If (patient name) does not meet his/her acceptable level of comfort THEN he/she is at risk for COMPLICATIONS such as failure to participate in the plan of care that can lead to decreased tissue perfusion, skin breakdown, and muscle atrophy

TEACHING:

Have you ever heard of the Comfort Verbal Rating Scale? Total Comfort includes physical, psychological, spiritual, and social aspects of comfort, all combined into one score. Comfort is what you perceive it as. Changing positions often, good hygiene, room temperature, family/friends and religious support, massage, heat, cold, relaxation, distraction, swaddle infant, pacifier, and comfort object can help increase comfort. So, tell me what you learned about managing your comfort level?

DOCUMENT:

~ **EDUCATION** provided
~ **UNDERSTANDING** of education provided
~ Comfort **ASSESSMENT METHOD**
~ **COMFORT ASSESSMENT** prior to intervention
~ **PATIENT PREFERENCES** for comfort needs
~ Comfort **INTERVENTIONS IMPLEMENTED**
~ **REASSESS COMFORT** after interventions

0802 Patient rates her comfort as a 1 out of 10 on the Comfort Verbal Rating Scale. She states she does not know how she can move herself since she had hip surgery. Head placed on a pillow, positioned on her right side with abductor pillow adjusted between knees. Offered an ice pack to her hip and she was agreeable. Patient educated about proper body alignment, the purpose of the abductor pillow, the ice pack, and length of time it is applied. Informed she may request it as needed. Post interventions, patient stated comfort was 8 out of 10 on the Comfort Verbal Rating Scale. Patient able to state keeping her body in proper alignment makes her feel better, the abductor pillow will support the muscles in her hip and the ice pack remains in place for 20 minutes at a time. She also states she can use her arms to move herself in bed

OXYGEN MANAGEMENT

(PASS CCC SAFE)

POSITION TO FACILITATE BREATHING
(upright, slow breaths)

AMOUNT OF O_2-LPM, METHOD OF O_2

SATs (before/after interventions)

SAFETY (ignition sources, tubing, water based lubricants)

COLOR

- **Skin** (pink, pale. cyanotic)
- **Mucus Membranes** (moist, dry)

CLUBBING

CAPILLARY REFILL (nail beds)

SKIN INTEGRITY

- **Lips** (dry, cracked, moist)
- **Mucous Membranes** (moist, dry, sticky)
- **Skin** (color changes, chafing)

ACTIVITY INTOLERANCE-resp. changes w/ activity

FLOW OF HUMIDITY-check it

EFFORT OF BREATHING

NANDA LABEL:

~ IMPAIRED GAS EXCHANGE
~ ACTIVITY INTOLERANCE
~ INEFFECTIVE BREATHING PATTERN

TEACHING:

Tell me what you know about oxygen saturation? It is important to maintain adequate oxygenation in the blood so that the blood can carry oxygen to body cells like the brain. Without oxygen our cells and tissues will die affecting every organ in the body. If we are unable to maintain adequate oxygenation by breathing normal room air then supplemental oxygen is needed like what's coming from your nasal cannula. Inadequate oxygenation long term can lead to brain damage, stroke, heart attack and death. It is also important to keep an eye on your skin where your oxygen device touches and mucous membranes. So what did you learn about oxygenation?

OXYGEN MANAGEMENT

DOCUMENT:

~ **EDUCATION** provided
~ **LEARNER UNDERSTANDING**
~ **CONDITION OF SURFACE**s
~ **O_2 DELIVERY METHOD & RATE**
~ **O_2 SAT LEVEL BEFORE & AFTER**
~ **RESPIRATORY CHANGES** dt activity
~ **NURSING INTERVENTIONS IMPLEMENTED**
  - **Improve Oxygenation**
  - **Maintain Integrity** of **Surfaces**
~ **PATIENT RESPONSE**

0932 Patient on 4 L O_2 via nasal cannula, lips moist and pink, no cracking. O_2 saturation 93%. States area behind right ear is "sore"; skin is intact, reddened. Gauze placed as a barrier. No skin alterations to nose or cheeks. Skin on left ear intact, no redness noted. Patient states she takes 02 off some times because "right ear is sore" Reinforced need to wear O_2 at all times, use gauze pad to prevent skin breakdown that may be caused by friction. Patient repositioned self in bed, reported shortness of breath with activity. Head of the bed raised, taught slow deep breathing in through nose and out mouth. Patient demonstrated deep breathing, O_2 saturation 95% following interventions. Patient states ear "feels better" and feels less short of breath after interventions. Patient was asked what is known about O_2 therapy. Verbalized need to wear O_2 at all times, will request gauze behind ear if soreness persists. The environment was safe for the patient, O_2 tubing unobstructed and permitted movement in bed.

MUSCULOSKELETAL MANAGEMENT

(FARS AID BRAD)

FALL RISK (Morse fall scale)

ASSESS ASSIGNED EXTREMIETES

- **Appearance** (atrophy, swelling, contractures, nodules, symmetry, condition of skin)
- **Mobility** (full, limited range of motion)
- **Strength** (strong, weak, flaccid)
- **Symptoms** (pain, stiffness)

ROM-2 JOINT MOVEMENTS X 2 PER JOINT

- Flexion/Extension
- Adduction/Abduction
- Pronation/Supination

SAFETY BEFORE ACTVITY

(socks, call bell, demonstrate call bell, dangle legs, use safety devices (walker, cane, glasses)

ACTIVITES (reposition, transfer, ambulate)

ICE/HEAT (barrier, 15 mins)

DEVICES (cpm, traction, splint, brace, slings)

BODY ALIGNMENT

RESPONSE TO INTERVENTIONS

ANY PAIN (with or without movement)

DOCUMENT

NANDA LABEL:

~ IMPAIRED PHYSICAL MOBILITY
~ IMPAIRED BED MOBILITY
~ ACTIVITY INTOLERANCE

MUSCULOSKELETAL MANAGEMENT

DOCUMENT:

~ **EDUCATION** provided
~ **LEARNER UNDERSTANDING**
~ **MORSE FALL SCALE SCORE**
~ **MORSE FALL SCALE RISK LEVEL**
~ **ASSESSMENT DATA**
  - **APPEARANCE**
  - **MUSCLE STRENGTH**
  - **JOINT MOBILITY**
  - **SYMPTOMS**
~ **NURSING INTERVENTIONS IMPLEMENTED**
  - **Fall prevention**
  - **Range of motion**
  - **Therapeutic devices**
  - **Application of heat/cold**
  - **Body alignment**
  - **Positioning/activity**
~ **PATIENT RESPONSE**

TEACHING:

Can you tell me what you know about mobility, walking, safety, or your orthopedic precautions? It is important to follow your weight bearing and orthopedic precautions and wear your braces to allow for proper bone healing and to prevent further injury. Following safety precautions outlined are important in preventing falls which can lead to further injury. Keeping your body in proper alignment is important to promote proper musculoskeletal healing and proper skeletal alignment, as well as preventing joint contractures and pain. CPM is a device that puts your knee joints through passive ROM in order to increase or maintain proper joint mobility and flexibility as well as preventing ligaments from tightening up.So, tell me what you learned about _____?

0932 Morse fall score of 55 indicating high risk for falls. Standard fall prevention interventions implemented - "Call, Don't Fall" signage in room. Reminded patient of ordered bedrest. Patient educated to use call light whenever a need to go to the bathroom. Patient agreed to use call light when a need to use bathroom "I will push that button" pointing to the call light. Dime sized bruise noted on left inner mid forearm. Right handgrip strong, left handgrip weak. Patient unable to move left upper extremity which was noted to be symmetrical, flaccid, however, patient denies pain. Passive range of motion exercises performed with two repetitions of flexion/extension and abduction/adduction to the left shoulder along with flexion/extension and supination/pronation to left elbow and wrist. Patient repositioned to right side with one assist. Patient denied any discomfort or pain with repositioning or range of motion exercises. Proper body alignment maintained throughout the PCS.

PERIPHERAL NEUROVASCULAR MANAGEMENT

(SPEID)

SKIN CCTC-bilateral comparison most distal area of assigned extremities

- ~ **Color** (pink, appropriate for ethnicity)
- ~ **Capillary refill** (brisk, less than 2 seconds)
- ~ **Temperature** (warm, cool)
- ~ **Condition** (dry, smooth)

PMS-Pulse (quality-weak strong, pulse location)

- ~ **Sensory** (multiple fingers, toes)
- ~ **Motor** have patient wiggle fingers, toes

-under 3 watch movement
(symmetry, movement)

EDEMA

INTERVENTIONS X 2

(position, keep warm, exercise, compression device, anitembolism stocking)

DOCUMENT

NANDA LABEL:

~ INEFFECTIVE PERIPHERAL TISSUE PERFUSION

PERIPHERAL NEUROVASCULAR MANAGEMENT

TEACHING:

Tell me what you know about your SCD's, ted hose, why we elevate your legs, importance of mobility, and circulation. Circulation is blood flow and blood return. It is most difficult for blood to return back to the heart from your hands/fingers, and feet/toes. Certain s/s can indicate how well your blood is circulating like color, temperature, cap refill, sensation and edema. When blood isn't circulating like it should your distal extremities can become pale, cold, have slow cap refill, numbness, tingling, and even swelling. Without proper circulation you are at risk for tissue damage, nerve damage, impaired wound healing, and skin breakdown. Things you can do to help improve circulation while in the hospital are using warm blankets/warm packs, using your SCD's, Ted hose, getting OOB and walking, and elevating your legs in bed. So, what did you learn about circulation?

DOCUMENT:

~ **EDUCATION** provided
~ **UNDERSTANDING** of education provided
~ **ASSESSMENT DATA**
  - **Color**
  - **Capillary Refill**
  - **Motor Function**
  - **Sensation**
  - **Temperature**
  - **Pulse Location & Quality**
  - **Edema**
~ **INTERVENTIONS IMPLEMENTED**
~ **PATIENT RESPONSE**

0802 Peripheral neurovascular assessment performed. Ten digits of feet pink and warm; capillary refill less than 3 seconds bilaterally; able to freely move all digits on both feet. Able to correctly identify light touch to left digits, unable to correctly distinguish between 3rd and 4th digits of right foot; pedal pulses equal, strong, and palpable bilaterally; no edema noted in either ankle. Patient educated on benefits of anti-embolism stockings, how to apply anti-embolism stockings, ankle flexion, and importance of not crossing ankles. Interventions performed included: positioning of legs with no crossing of ankles, and application of below the knee anti-embolism stocking bilaterally. Able to verbalize benefits of anti-embolism stockings, importance of not crossing ankles. Patient demonstrated ankle flexion to promote circulation. Patient verbalized intention to continue these interventions.

RESPIRATORY MANAGEMENT

(PABOI SORD)

POSTION

AUSCULTATE bare skin, posterior upper and lower lung fields

- ~ Clear breath sounds?
- ~ Adventitious breath sounds present?
- ~ Diminished (decreased) breath sounds?

BREATHING

Note signs of respiratory distress (e.g. labored, shallow, rapid respirations, use of ancillary muscles, nasal flaring, presence of intercostal retractions)

- ~ **Rate** (number of breaths in 1 min)
- ~ **Rhythm** (regular or irregular)
- ~ **Effort** (labored or unlabored)
- ~ **Depth** (deep, shallow, normal)

OXYGEN

- ~ **Saturation**
- ~ **Delivery method, Amount**

INTERVENTIONS x 2-Adult

- ~ **Exercises** - Deep Breathing, Coughing (Splint)
- ~ **Devices** - Incentive Spirometer, Pin Wheels, Blowing Bubbles
- ~ **Suction** - Trach, Oral, Bulb Syringe

SECRETIONS- Absent/ Present, COCA

ORAL HYGEINE REASSESS DOCUMENT

NANDA LABEL:

- **INEFFECTIVE AIRWAY CLEARANCE**
- **IMPAIRED GAS EXCHANGE**
- **INEFFECTIVE BREATHING PATTERN**

RESPIRATORY MANAGEMENT

TEACHING:

Tell me what you know about your lungs and how to keep them clear. During hospitalization your not as mobile and active as your normally are. This causes your lungs to become lazy or not worked as much. When your lungs aren't worked out they can begin to accumulate secretions and muscle atrophy affecting your ability to exchange oxygen and breathe adequately and comfortably. In order to prevent complications like fluid on the lungs or pneumonia we must do lung exercises like I.S. cough, deep breathing or exercise. By doing this you're able to expel secretions and expand the lung volume and strengthen intercostal or lung muscles improving oxygenation, proper gas exchange and clear lungs. So, tell me what you learned about managing your respiratory system?

DOCUMENT:

EDUCATION provided
UNDERSTANDING of education provided
ASSESSMENT before interventions

- **RESPIRATORY STATUS, RATE, DEPTH, EFFORT**
- **BREATH SOUNDS**
- **O_2 SATURATION LEVEL**
- **O_2 DELIVERY METHOD & RATE**
- **SECRETIONS,** presence or absence, COCA

RESPIRATORY HYGIENE INTERVENTION(s)
REASSESSMENT after interventions
ORAL CARE provided
PATIENT RESPONSE

0802 Patient states, "I'm not sure how to use this incentive spirometer." Initial respiratory assessment: rate 13 breaths /minute, respirations deep, regular and unlabored. Breath sounds bronchi in bilateral lower posterior lobes, clear in bilateral upper posterior lobes. Oxygen 2 liters nasal cannula on at all times, 02 saturation 96%. Non productive cough. Described rationale for using incentive spirometer while patient attempted. Patient demonstrated incentive spirometry correctly, repeated 5 times. Deep breath followed by forceful cough repeated 2 times. After interventions: respiratory rate 12 breaths/minute, respirations deep, regular and unlabored. Rhonchi persist in bilateral lower posterior lobes, clear in upper bilateral posterior lobes. 02 saturation 97% on 2 liters nasal cannula. Expectorated moderate amount thick dark tan sputum into tissue. Mouth care provided. Patient states, "I know how to use this device now, I should use it 5 times every hour. I think these breathing exercises are helping me feel less short of breath"

TRACH SUCTION

(SOPHID)

STERILE TECHNIQUE

O_2 SATURATION - Monitor

PATENCY - Verify

HYPEROXYGENATE

INSERT CATHETER

- ~ Close control valve after insertion
- ~ Rotate catheter continuously during suctioning
- ~ Suction for no more than 15 seconds at a time

DEEP BREATHS after suctioning

ORAL SUCTION

(OSPID)

O_2 SATURATION – Monitor

SET SUCTION PRESSURE

PATENCY – Verify

INSERT SUCTION DEVICE

- ~ Close control valve after insertion
- ~ Rotate catheter continuously during suctioning
- ~ Suction for no more than 15 seconds at a time

DEEP BREATHS after suctioning

BULB SYRINGE SUCTION

(DIAR)

DEFLATE

INSERT INTO MOUTH or NOSE

ASPIRATE

REPEAT

SKIN MANAGEMENT

(BLT-CEMTIT-IRAKPA)

BRADEN SCALE

LOCATE (Impaired Skin Surface & Bilateral Comparison)

TOUCH

- Color Changes (Blanchable, Ethnic Variation)
- Edema
- Moisture (Moist, Dry)
- Turgor (Clavicle)
- Integrity (Skin Intact or Wound Noted)
- Temperature (Warm, Hot, Cold)

INTERVENTIONS X 2

- Reposition
- Apply Redistribution Device
- Keep Skin Clean
- Provide Incontinence Care
- Apply Protective Products

NANDA LABEL:

- **IMPAIRED SKIN INTEGRITY**
- **IMPAIRED TISSUE INTEGRITY**

TEACHING:

Can you tell me what you know about your skin and how to prevent breakdown? Your skin has blood flow to it and covers every part of our body. It is important to keep it clean, dry, and intact. When we lay or sit in one position for too long blood flow to the skin around boney areas of our body is slowed or cut off. This can lead to pressure ulcers and skin break down. In order to prevent this we must reposition frequently, perform skin checks, and maintain good hygiene. While you're in the hospital you are lying in bed more than normal so it can be easy to forget to reposition, especially if parts of your body have impaired sensation. Placing pillows under your heels and arms and turning side to side is a good way that you can prevent skin breakdown. So, can you tell me what you learned about your skin?

SKIN MANAGEMENT

DOCUMENT:

EDUCATION provided
UNDERSTANDING of education provided
BRADEN SCALE
ASSESSMENT Data

- **Location**
- **Color changes**
- **Edema**
- **Integrity** (altered, not altered)
- **Moisture level status** (moist, dry)
- **Temperature** (warm, hot, cool)
- **Turgor**

INTERVENTIONS
PATIENT RESPONSE to interventions

0832 Explained to patient that a skin assessment would be performed. Skin at clavicle assessed for turgor; non-tenting. Patient was asked what she understands about the importance of moving around and not staying in one position. Patient stated that she knows that she must move around so she doesn't "keep pressure in the same area" and wondered if there was anything else that could be done to keep skin healthy. Braden Scale score is 18. Bilateral heels assessed: right heel red, area blanches with pressure, no edema, skin is intact, no drainage noted. Left heel no redness, no edema, intact and dry. Patient educated about the role that nutrition plays in skin care and healing, benefit of keeping heels elevated off bed, remembering not to cross her feet, use of barrier cream, and to use the call bell to ask for assistance with moving in bed. Feet elevated off the bed using a pillow under her ankles. Patient stated comfortable with heels elevated. Prescribed barrier cream was applied. When asked what she had learned about skin care, patient stated "I need to keep my heels up with the pillow, use the call bell if help is needed for repositioning, drink more water for hydration and eat more of my meals for the protein." Reinforced use of barrier cream as ordered.

WOUND MANAGEMENT

(PPOWL)

PAIN SCALE

(Based on Age, Developmental Stage, Cognitive & Verbal Ability)

PAIN MEDS

(Prior to Wound Change)

OBSERVE:

- **Location** (Note Body Part)
- **Appearance** (Redness, Edema, Dry, Moist, Approximated, Sutures, Staples)
- **Surrounding skin**
- **Type** (Surgical Incision, Tissue Trauma, Pressure Ulcer)
- **Drainage** (COCA)

WOUND CHANGE (Cleanse, Irrigate, Pack, Topical)

LABEL (Date, Time, Initials)

NANDA LABEL:

IMPAIRED SKIN INTEGRITY
IMPAIRED TISSUE INTEGRITY

WOUND MANAGEMENT

TEACHING:

Tell me what you know about your wound and how to help it heal and prevent infection? There are several factors that affect wound healing. Eating an adequate amount of calories and protein are important to facilitate wound healing. Prevent your wound/dressing from getting wet during showers by covering it with aqua-guard and avoid taking baths. Keep wound clean by frequent and proper dressing changes. It is important to change your dressing using aseptic technique regularly so that any drainage doesn't sit in the wound too long which can lead to infection. Since your skin is open you are at risk for bacteria getting into the wound. If not managed properly the wound may get infected which can lead to a systemic infection in the blood or sepsis. Another important factor r/t wound healing is managing your diabetes properly if you have it. So, can you tell me what you learned about your wound?

DOCUMENT:

- **EDUCATION** provided
- **UNDERSTANDING** of education provided
- **ASSESSMENT DATA**
  - **Location**
  - **Type**
  - **Appearance**
  - **Presence or absence of drainage**
  - **Method used to assess pain**
  - **Pain measurement**
- **INTERVENTIONS**
- **PATIENT RESPONSE**

0926 The patient stated that her pain was 2/10 on the numeric rating scale. Patient states, "I can't do anything except wait for this to get better. "Educated about role of nutrition (hydration and increased protein) in wound healing, need to protect wound, signs and symptoms of infection (increased redness, swelling, drainage). Dressing to left forearm removed, incision is red, sutures intact, wound edges well approximated, no drainage. Incision cleansed with normal saline. Dry sterile dressing applied. Patient stated that the dressing change did not hurt, pain remains 2/10 on Numeric Rating Scale. Patient verbalized plan to increase fluid and protein intake, strategies to protect wound, signs and symptoms of infection.

FLUID MANAGEMENT

(HOMP IS TOR)

HYDRATION STATUS x 2

- Mucus membranes (moist, dry, sticky)
- Skin Turgor (Skin returns immediately to original position, Tenting)
- Anterior fontanel
  - < 1 y/o (Bulging, Flat, Sunken)
  - > 1 y/o Skin Turgor on Abdomen

ORAL FLUIDS (Encourage, Restrict, Thicken, Feed Infant, Measure Intake)

MAKE SURE TO CHECK IV FLUIDS

POSITION to promote nutritional safety (eating, drinking)

INTEGRITY OF SYSTEM (secured & functioning properly)

SKIN SURROUNDING INSERTION SITE-

TIME OF MEASUREMENT

OUTPUT - COCA (Measure all types)

RESPONSE to Feeding, Drains, IV, Intake

NANDA LABEL:

DEFICIENT FLUID VOLUME

FLUID MANAGEMENT

TEACHING:

*Water regulates your body temperature and lubricates your joints. It also helps transport nutrients to give you energy and keep you **healthy**. If you're not properly **hydrated**, your body can't perform at its highest level. You may experience fatigue, muscle cramps, dizziness, or more serious symptoms. So, tell me what you learned about the importance of fluids?*

DOCUMENT:

ON FUID MANAGEMENT CLINICAL NOTES

- **EDUCATION** provided
- **UNDERSTANDING** of education provided
- **HYDRATION STATUS**

0926 The patient stated that her pain was 2/10 on the numeric rating scale. Patient states, "I can't do anything except wait for this to get better. "Educated about role of nutrition (hydration and increased protein) in wound healing, need to protect wound, signs and symptoms of infection (increased redness, swelling, drainage). Dressing to left forearm removed, incision is red, sutures intact, wound edges well approximated, no drainage. Incision cleansed with normal saline. Dry sterile dressing applied. Patient stated that the dressing change did not hurt, pain remains 2/10 on Numeric Rating Scale. Patient verbalized plan to increase fluid and protein intake, strategies to protect wound, signs and symptoms of infection.

20 MINUTE CHECK

(CHIPPICOOOOWS)

COMMUNICATE (What you are doing.Teach)

HYDRATION STATUS X 2 (Turgor, Mucus Membranes)

IV (Rate, Amount, Type)

PALPATE SITE (Wear Gloves, Redness & Edema)

PUMPS (Settings/Drops)

INSPECT TUBING (Kinks, Bubbles)

CHECK ENTERAL FEED

ORAL EXPLAIN

OTHER DRAINS CHECK

OXYGEN

WRITE IT DOWN

SOCKS ON

ENTERAL FEEDING

(VIMR)

VERIFY FEEDING FORMULA & FLOW RATE

INSPECT TUBING & SURROUNDING SKIN

MEASURE GASTRIC RESIDUAL, when assigned

REINSTILL GASTRIC RESIDUAL, when assigned

ENTERAL FEEDING

DOCUMENT on FLUID MANAGEMENT FLOW SHEET WITHIN 20 MINUTES

- FEEDING FORMULA & FLOW RATE
- INTEGRITY of System
- APPEARANCE of SKIN Surrounding Entry Site
- VOLUME (ml) of ENTERAL FEEDING DURING PCS
- TIME of MEASUREMENT
- INITIALS in Appropriate Box on FLUID MANAGEMENT FLOW SHEET
- AMOUNT of GASTRIC RESIDUAL
- AMOUNT of GASTRIC RESIDUAL RE-INSTILLED
- PATIENT RESPONSE to Feeding

ORAL ENTERAL FEEDING

ENCOURAGE FLUIDS, when assigned

RESTRICT FLUIDS, when assigned

THICKEN LIQUIDS, when assigned

FEED INFANT, when assigned

~ ENCOURAGE MOTHER to BREASTFEED

~ PREPARE BOTTLE with FORMULA as noted on PCS Assignment

- PROVIDE BOTTLE to INFANT
- BURP INFANT periodically during feeding & as necessary

MEASURE INTAKE of enteral fluids

PATIENT RESPONSE

ORAL ENTERAL FEEDING

DOCUMENT on **FLUID MANAGEMENT FLOW SHEET** WITHIN 20 MINUTES

- **TYPE** of **ENTERAL FLUID INTAKE** (e.g. water, breastfed, Enfamil)
- **AMOUNT** of each enteral fluid, in ml (e.g. 120 ml) or **TIME** (e.g. 10 minutes on each breast) within 10% of actual intake during implementation
- **PATIENT RESPONSE** to feeding

PARENTERAL FLUIDS

(VIA DMC)

VERIFY IV SOLUTION & FLOW RATE

INSPECT

- INSERTION SITE (Redness, Edema)
- INTEGRITY (Dressing Intact & Tubing Secure w/o Kinks or Air)

ADMIN./MAINTAIN ASSIGNED IV SOLUTION

DISCONTINUE IV FLUID when assigned

MEASURE AMOUNT OF FLUID INFUSED (inform CE)

CONVERT CONTINUOUS IV TO IVAD when assigned

PARENTERAL FLUIDS

DOCUMENT on FLUID MANAGEMENT FLOW SHEET WITHIN 20 MINUTES

- IV SOLUTION & FLOW RATE
- CONDITION of IV INSERTION SITE
- If IV SOLUTION CHANGED:
  - NEW IV SOLUTION & FLOW RATE
  - CONDITION of IV INSERTION SITE PRIOR TO START of NEW IV SOLUTION
- VOLUME (ml) of PARENTERAL INTAKE DURING PCS
- TIME of MEASUREMENT
- INITIALS in Appropriate Box on FLUID MANAGEMENT FLOW SHEET
- PATIENT RESPONSE to parenteral intake

DRAINAGE DEVICES

(VIMER)

VERIFY TYPE & AMOUNT OF SUCTION

INSPECT

- INSERTION SITE (Redness, Edema)
- INTEGRITY (Dressing Intact & Tubing Secure w/o Kinks or Air)
- DRAINAGE (COCA)

MEASURE AMOUNT

EMPTY DRAINAGE DEVICE, when needed

REMOVE DRAINAGE DEVICE, when assigned

DRAINAGE DEVICES

DOCUMENT on FLUID MANAGEMENT FLOW SHEET WITHIN 20 MINUTES

- TYPE & SITE of DRAINAGE DEVICE
- TYPE & AMOUNT of SUCTION
- INTEGRITY of System
- CONDITION of SKIN Surrounding Insertion Site
- DRAINAGE TYPE
- DRAINAGE (COCA)
- PATIENT RESPONSE of DRAINAGE DEVICE
- PATIENT RESPONSE of REMOVAL of DRAINAGE DEVICE, when assigned

INTERMITTENT INTRAVENOUS ACCESS DEVICE (AAF PA)

ASSESS INSERTION SITE (redness & edema)

ASPIRATE for blood return, unless contraindicated

FLUSH with prescribed solution

PATIENT RESPONSE to flush

ASSESS INSERTION SITE AFTER FLUSH

INTERMITTENT INTRAVENOUS ACCESS DEVICE

DOCUMENT on FLUID MANAGEMENT FLOW SHEET WITHIN 20 MINUTES

~ CONDITION of INSERTION SITE

~ TYPE & AMOUNT of FLUSH (mL)

~ PATIENT RESPONSE to flush

OUTPUT

(TACCMD)

When assigned alone or when assigned with drainage device

TYPE OF OUTPUT (urine, emesis, stool, drainage)

AMOUNT OF OUTPUT @ **BEGINNING**

COLOR OF OUTPUT (COCA)

COLLECT OUTPUT

MEASURE OUTPUT @ **END**

DOCUMENT on Fluid Management Flow Sheet

OUTPUT

DOCUMENT on FLUID MANAGEMENT FLOW SHEET WITHIN 20 MINUTES

~ TYPE of OUTPUT

~ AMOUNT of OUTPUT (ML) during PCS

~ TIME of MEASUREMENT

~ INITIALS in Appropriate Box on FLUID MANAGEMENT FLOW SHEET

~ COLOR of OUTPUT

OXYGEN

AMOUNT

CHECK TUBING

HUMIDITY

MEDICATIONS

(SCAP R DIIGS)

SPECIAL ASSESSMENTS (HR, BP,LAB VALUES)

CHECK MAR

ALLERGIES

PREPARE MEDS (check expiration dates, label drugs)

RECHECK MAR

DO 5 RIGHTS

ID PATIENT X 2

IV SITE BEFORE/AFTER

GIVE MEDS (one drug at a time)

SIGN IMMEDIATELY AFTER MEDS (name, initials, ecsn)

MEDICATIONS

DOCUMENT THE FOLLOWING (ON THE MAR, UNLESS OTHERWISE SPECIFIED):

- EDUCATION PROVIDED
- LEARNER UNDERSTANDING OF EDUCATION
- PRIOR TO PREPARING MEDICATION
  - CORRECT INDICATION FOR USE OF MEDICATIONS
  - ACCURATE FLOW RATE FOR GRAVITY FLOW (dpm) OR ICD SETTING (ML PER HOUR) ON THE MAR
  - PERTINENT PATIENT DATA
    - TEMPERATURE TO EXACT DEGREE & SITE
    - PULSE & SITE
    - BLOOD PRESSURE & SITE
    - PAIN LEVEL TO EXACT NUMBER OR DESCRIPTION OF OBSERVED BEHAVIORS
    - METHOD USED FOR PAIN ASSESSMENT
- IMMEDIATELY AFTER ADMINISTERING MEDICATION
  - STUDENT NAME, INITIALS, & DESIGNATION ON THE SIGNATURE SECTION OF MAR
  - INDICATE WHETHER EACH MEDICATION IS GIVEN OR NOT GIVEN BY PLACING INITIALS IN APPROPRIATE BOX
  - DOCUMENT ASSESSMENT DATA TO SUPPORT REASON FOR NOT GIVING A MEDICATION
  - CONDITION OF THE INTRAVENOUS INSERTION SITE (PERIPHERAL, CENTRAL) BEFORE & AFTER MEDICATION ADMINISTRATION, INCLUDING MEDICATIONS STILL INFUSING
  - SITE OF INJECTABLE MEDICATION
  - CONDITION OF SITE OF INJECTABLE MEDICATION
  - TYPE & VOLUME OF FLUSH ON FLUID MANAGEMENT FLOW SHEET
  - TYPE & VOLUME OF INTRAVENOUS MINI BAG ON FLUID MANAGEMENT FLOW SHEET
- PATIENT RESPONSE TO MEDICATION