Enter: EWIGG

When entering the room for 1st time

Enter

Wash hands with soap & water

ID patient with 2 identifiers

Introduce self, CE, & explain

Glove up

Exit: SCABS

Side rails up

Call light within reach

Ask if ok/need anything

Bed low & locked

Say Thank You!

VITAL SIGNS

LAST SET		MY SET
T	|	T
P	|	P
R	|	R
02	|	02
BP	|	BP
PX	|	PX

20 Minute Checks

HIPPICODR – per assigned tasks

Hydration status (skin turgor, mucous membrane, fontanel

IV rate/type/meds (check against Kardex)

Palpate site with gloves

Pump settings/check gtts (check against Kardex)

Inspect IV tubing (kinks, leaks, occlusions)

Check tube feeding/NG (if assigned)

Oral fluids/encourage Vs restrict

Double check/Declare 20 minute checks

Record

Comfort Management:

A 3RD CHANCER

Assess comfort level
3 comfort measures
Reposition
Dental hygiene
Cold/heat
Hygiene (face/hands)
Arrange linens
Nsaids, other symptomatic meds
Comfort rub
Environmental adjustments
Record (evaluations, measures, reevaluations)

Comfort Management:

Documentation:

1 *Comfort needs or discomfort* (**patient statement**)
2 *Comfort interventions implemented* (**three from list or other**)
3 *Patient response to the interventions implemented* **(patient statement**)

Abdominal Assessment

4Ps LLF RR

		Order
Privacy	**L**ook	1 RUQ
Pee	**L**isten	2 LUQ
Pain	**F**eel	3 LLQ
Position		4 RLQ
Suction off	**R**eposition/Suction on	
	Record	

Pain or incision? Do that quadrant last!!

Abdominal Assessment

Documentation:

1. ***Distention*** (flat/non-distended/distended/rounded).
2. ***Presence or absence of bowel sounds*** (bowel sounds present/hypoactive/hyperactive/absent in XYZ quadrant(s))
3. ***Tenderness or rigidity*** (no tenderness/slight tenderness/non-tender to XYZ quadrant(s) upon light palpation, soft

Fluid Management

SODPICHOW

Safety
Oxygen flow rate
Drainage
Palate I've site (color/edema)
Iv (tart)
Check enteral feed
Hydration (2 methods)
Oral (explain I+O, diet restrictions)
Write it down and declare (20min)

Medications - MAR DOSAGES

MAR check meds
Appropriate dose
Recheck MAR to ID
Do 5 rights (patient, drug, dose, route, time
Observe allergies
Special assessment (BP, pulse before admin)
Ask how patient takes pills (1 at a time, all at once)
Gather equipment
Evaluate & administer
SIGN MAR

Musculoskeletal Management

MAPHATR or MAD PART

Mobility	**M**obility Status
Abnormalities	**A**bnormalities
Pain with movement	**D**evices & balance
Hot or cold apply	**P**ain
Apply / adjust devices	**A**pply heat/cold
Traction	**R**ange of motion
ROM	**T**raction (socks)

Musculoskeletal Management

Documentation:

1 *Presence or absence of abnormalities of the assigned extremity* (**no abnormality noted/atrophy**)

2 *Level of mobility of the assigned extremity* (**contracture/flaccid/able or unable to move freely**)

3 *Pain with movement of the assigned extremity* (**pain, no pain noted**)

4 *Assigned musculoskeletal interventions implemented* (**passive or active ROM -abduction and adduction or flexion and extension x # of reps to assigned extremity(ies/Apply supportive or therapeutic device/heat or cold pack/prescribed traction**)

5 *Patient response to intervention* (**shortness of breath/diaphoresis/fatigue/discomfort**)

Neurological Assessment

LOGICSS

LOC (person, place, time)
Observe pupils - PERRLA
Grasp hands
Inspect fontanel (anterior & upright in 1 yo)
Check dorsi/plantar flexion
Stimuli (noxious for unconscious patient)
Symmetry of movement

Neurological Assessment

1 *Level of consciousness* (**alert to person, place, and time, alert to person with confusion, ect. Recognizes xyz familiar person/object, xyz stimuli provided to child 1-3 or non-communicative adult with response**)
2 *Assessment of fontanel* (**flat, sunken/depressed, bulging**)
3 *Pupillary response* (**equal, reactive to light**)
4 *Equality of motor response* or observation of musculoskeletal response (**bilateral hand grasps and bilateral plantar/dorsiflexion strong and equal bilaterally against resistance, moves all four extremities equally and spontaneously**)
5 *Response to noxious stimuli* (**responsive/non-responsive to nail bed pressure**)

Oxygen Management

SHORT AIR

Sats (if assigned)
Humidity (if ordered)
Observe (ears/nares)
Reposition up
Tolerance to activity
Amount of 02
Ignition sources
Report (color/clubbing)

Oxygen Management

Documentation:
1 *Response to activity level* (**able to transfer without dyspnea/able to ambulate without shortness of breath**)
2 *Oxygenation status* (**O2 sat % or capillary refill, nailbed color, or clubbing**)
3 *Condition of skin surfaces in contact with oxygen delivery system* (**skin is intact around face mask and elastic strap, Skin of the ears/nares intact or reddened**)
4 *Oxygenation management interventions implemented* (**start/maintain O2 amount - Xl of oxygen via delivery method, position upright, maintain humidity, measure O2 sat when assigned**)
5 *Patient response to interventions implemented*

Peripheral NV Management

BLOOD FLOW / PERIPH

Bilaterally
Look at color
Or capillary refill
Observe sensation bilaterilly
Doppler if no pulse
Feel for most distal pulses
Look for movement
Observe temp
Write it down - Document

Pulses (bilaterally)
Extremity (designated ↑ or↓)
Refill (capillary)
Is there sensation w eyes closed/movement
Pale/Pink
Hot/cold (temp of skin)

Peripheral Neurovascular

Documentation:

1 *Presence or absence of the most distal pulses* (**present/absent**)
2 *Comparison of most distal palpable corresponding palpable pulses* (**palpable and equal, audible pedal pulse via Doppler**)
3 *Capillary refill or color* (**capillary refill greater/less than 3 seconds, fingertip/toe-tip color pink/pale**)
4 *Temperature of extremities* (**fingers/toes warm/cool**)
5 *Response to tactile stimuli* (**With her eyes closed, patient correctly states that she can/cannot feel touch in multiple areas of the toes/fingers on both feet/hands**)
6 *Motor function* (**able to wiggle fingers/toes bilaterally without difficulty on command**)

Respiratory Management

BREATHE EASIER

Breathing pattern
Rhythm & rate & effort
Explain & equipment (stethoscope/pillow)
Assess deep breathing (use of acc. muscles)
Timing →tell to breath through nose & out mouth → slow & deep
Hear in 4 spots **LISTEN LU, RU, RL, LL (Z PATTERN)**
Evaluate 02

Emesis basin
Assess breating
Suction
Incentive or DB & C
Evaluate again
Record

Respiratory Management

Assessment:

1 *Comparison of breath sounds bilaterally* (**clear/abnormal bilaterally in upper and lower lobes posteriorly**)
2 *Abnormal breathing patterns* (**shallow/rapid/regular/irregular**)
3 *Oxygen saturation when assigned* (**X% on room air/oxygen liters/delivery method**)

Management:

1 Bilateral breath sounds heard after treatment in comparison with those heard initially, related to each of the assessment findings (**clear/abnormal to upper/lower lobes posteriorly**)
2 Abnormal breathing patterns (**labored/unlabored, regular**)
3 Respiratory hygiene interventions implemented (**list**)
4 Patient response to hygiene interventions implemented (**tolerated activity without shortness of breath or dyspnea**)

Pain Management

PAIN	MGMTT
Pain scale	Massage
Assess location	Guide/distract
Intensity / duration	Meds
Need reassess	Turn/reposition
	Temp(heat/cold)

Pain Management

DOCUMENTATION:

1 *Level of pain* (**0-10 verbal pain scale, FLACC, Faces**)
2 *Pain location* (**place on body or area**)
3 *Pain characteristics* (**stabbing, throbbing, radiating, ect**)
4 *Duration of pain* (**it's been going on for X days and the last episode of pain started X minutes ago**)
5 *Pain relief interventions implemented* (**list**)
6 *Patient response to interventions implemented (***after 20-30 minutes, pain level now X**)

Skin Management

SKINNED OR	TWICED RED
Skin color	Temp
Keep warm & dry	Wet/dry (moisture
Intact/integrity	Intact/integrity
Note edema	Color
Needs repositioning	Edema
Evaluate pain	Reposition
Do 2 areas	Do 2 areas (elbow/sacrum)

Skin Management

Documentation: Record 2 Areas

1 *Color changes* (**reddened/non-reddened**)
2 *Integrity* (**intact/lesions/rash/skin tears/ect**)
3 *Temperature* (**warm/cool**)
4 *Edema* (**no edema/edema**)
5 *Moisture* (**perspiration/incontinence/diarrhea /non-intact ostomy or drainage system**)

Wound Management

WOUNDED

Wound location
Observe drainage, type, amount
Unique irrigation & supplies
Need clean or sterile field?
Dressing change
Evaluate pain/tolerance
Document (what was done, findings, tolerance.

Specimen Collection

COLD TACT

Collect
Observe (color/odor/etc)
Label (date/time/initial)
Document
Type
Amount
Color
Tolerance

SPECIAL

Specimen collected
Place tube
Examine (color/odor/etc)
Clean surrounding area
I & O record
Assess site
Label & send to Lab

Irrigation

STOP FLOW

Solution
Temperature (room temp)
Other equipment (chicks, trash, gloves)
Position to facilitate drainage
Flow rate (slow & gentle)
Look at return solution (amount & color)
Observe patients tolerance
Write it down – Document

Patient Teaching

LEARN

Learning readiness
Evaluate knowledge
Act of learning
Reassess understanding
Need to record - DOCUMENT

Enteral Feedings

FLOW STOMACH R & R

Feeding type
Low Fowlers
Orient patient
Warmth of solution
Select device
Total amount
On time
Monitor feeding during PCS
Assess skin around NG/G-tube
Check residual if assigned
Have baby burp
Reassess & Record

DROP ATT

Device
Room temp
Orient Patient
Position
Amount
Type
Time