



London Health Sciences Centre

A close-up photograph of a healthcare professional wearing a blue surgical cap, clear safety glasses, and a white surgical mask. The professional is focused on a task, with a bright light source visible near their eyes.

Standards of Care & Documentation: The A & I Flowsheet

CCTC SITE SPECIFIC
NURSING ORIENTATION

SEPT 2019

CCTC Standards

GENERAL NURSING CARE

Critical Care Trauma Centre Website

Critical Care Trauma Centre											
<ul style="list-style-type: none"> ▶ About Us ▶ Patients, Families & Visitors ▼ Health Professionals <ul style="list-style-type: none"> ▪ What's New ▪ Monographs ▪ Standards of Nursing Care ▪ Procedures ▪ Protocols ▪ Educational Links ▪ EduBriefs ▪ Educational Quizzes ▪ Courses & Events ▪ E-Learning ▪ Medical Education ▪ Employees Only ▶ Research & Training ▶ Ways to Give 	<div style="background-color: #FFD700; text-align: center; padding: 10px; margin-bottom: 10px;"> GENERAL CARE ROUTINES FOR ALL PATIENTS STANDARDS OF NURSING CARE IN CCTC (SONC) </div> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 50%;"> <ol style="list-style-type: none"> 1. Maintain Patient Safety 2. Demonstrate Accountability 3. Assess Patient 4. Participate in Care Planning 5. Communicate Findings 6. Monitor Vital Signs 7. Monitor Temperature </td> <td style="vertical-align: top; width: 50%;"> <ol style="list-style-type: none"> 8. Promote Integumentary Integrity 9. Promote Buccal Integrity 10. Promote Oral Hygiene 11. Promote Hygiene 12. Change IV Tubing 13. Change Dressings 14. Review Orders </td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #FFD700; color: white;">STANDARD OF NURSING CARE</th> <th style="background-color: #FFD700; color: white;">RATIONALE FOR STANDARD</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <p>Ensure 4 moments of hand hygiene are met when performing assessments and/or managing monitoring equipment.</p> <p>Perform risk assessment and select appropriate PPE based on patient diagnosis and procedure being performed.</p> </td> <td style="padding: 5px;"> <table border="0" style="width: 100%;"> <tr> <td style="background-color: #333; color: white; padding: 5px; width: 20px;">1.</td> <td style="background-color: #333; color: white; padding: 5px;">Maintain Patient Safety</td> </tr> <tr> <td style="padding: 5px;">No bay/room will be left without a RN in attendance.</td> <td style="padding: 5px;">Critically ill patients require continuous monitoring, and are at risk for developing</td> </tr> </table> </td> </tr> </tbody> </table>	<ol style="list-style-type: none"> 1. Maintain Patient Safety 2. Demonstrate Accountability 3. Assess Patient 4. Participate in Care Planning 5. Communicate Findings 6. Monitor Vital Signs 7. Monitor Temperature 	<ol style="list-style-type: none"> 8. Promote Integumentary Integrity 9. Promote Buccal Integrity 10. Promote Oral Hygiene 11. Promote Hygiene 12. Change IV Tubing 13. Change Dressings 14. Review Orders 	STANDARD OF NURSING CARE	RATIONALE FOR STANDARD	<p>Ensure 4 moments of hand hygiene are met when performing assessments and/or managing monitoring equipment.</p> <p>Perform risk assessment and select appropriate PPE based on patient diagnosis and procedure being performed.</p>	<table border="0" style="width: 100%;"> <tr> <td style="background-color: #333; color: white; padding: 5px; width: 20px;">1.</td> <td style="background-color: #333; color: white; padding: 5px;">Maintain Patient Safety</td> </tr> <tr> <td style="padding: 5px;">No bay/room will be left without a RN in attendance.</td> <td style="padding: 5px;">Critically ill patients require continuous monitoring, and are at risk for developing</td> </tr> </table>	1.	Maintain Patient Safety	No bay/room will be left without a RN in attendance.	Critically ill patients require continuous monitoring, and are at risk for developing
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Assessment of Patient

Critically ill patients:

- Require continuous monitoring
- Are at risk for developing sudden condition changes or complications due to invasive monitoring devices

Assessment of Patient

Two primary documentation forms:

- CCTC 12 Hour Assessment/Intervention Flowsheet
- CCTC 24 hour Flowsheet



Assessment of Patient

Capture:

- Assessments & Plans
- Significant Changes
- Interventions
- Responses to Interventions



Maintain Patient Safety

- No bay or room will be without a clinical nurse in attendance.

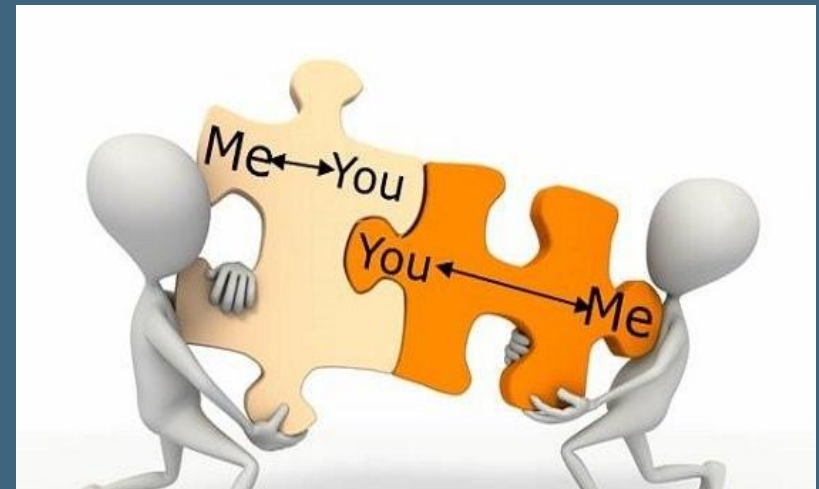
Participate in Care Planning

- Participate in Rounds
- Document & communicate the plan



Accountability

- Monitoring and coordinating care for assigned patients
- Communicating relevant information



General Nursing Care Standards: Oral Hygiene

- Mouth care every 4hr & PRN
- Teeth brushed every 12hr
- Chlorohexidine mouth rinse every 12hr for intubated patients or those with a tracheostomy



General Nursing Care Standards: Skin Integrity and Hygiene

- Full bath early in night shift with
- Peri-care/catheter care is provided every 6-12hr and PRN
- Hair wash weekly and PRN



Skin Integrity



- At start of shift:
 - Thorough skin assessment
 - Braden Risk Assessment Daily
- All immobile patients are repositioned and have their skin inspected q2h- 4h and PRN
- Consider if patient is on optimal bed surface

Braden Risk Assessment Screening Tool

The screenshot displays a software interface with a dropdown menu open under the heading "Screening Tools (1)". The menu lists the following items:

- Braden Risk Assessment (highlighted)
- Braden Q Risk Assessment
- CAM - Confusion Assessment Method for Delirium
- CSSRS - Suicide Severity Risk Screening Tool
- Fall Risk Assessment - Humpty Dumpty
- Fall Risk Assessment - Humpty Dumpty ED
- Fall Risk Assessment - Morse
- ARI Screening Tool
- CSSRS - Suicide Severity Risk Screen Paediatrics


The background interface includes a "Selected visit" section with a "Braden Risk Level" field and a date/time stamp "07/10/18 13:17". Below this is a "Documents (0)" section with the text "Last 7 days for all visits" and "No results found".

Braden Risk Assessment

Initial risk assessment and subsequent re-assessment within 12 hours of admission. Re-assess weekly, with change in patient condition, and with transfer of care.

Sensory Perception Ability to respond meaningfully to pressure related discomfort	<input checked="" type="radio"/> Completely limited <input type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No impairment	Completely Limited (1)	Unresponsive (does not moan; flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. -OR- Limited ability to feel pain over most of body surface.
		Very Limited (2)	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. -OR- Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.
		Slightly Limited (3)	Responds to verbal commands, but cannot always communicate discomfort or need to be turned. -OR- Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
		No Impairment (4)	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture	<input type="radio"/> Constantly moist <input checked="" type="radio"/> Often moist <input type="radio"/> Occasionally moist <input type="radio"/> Rarely moist	Constantly Moist (1)	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is turned.
		Often Moist (2)	Skin is often, but not always moist. Linen must be changed at least once a shift.
		Occasionally Moist (3)	Skin is occasionally moist requiring an extra linen change approximately once a day.
		Rarely Moist (4)	Skin is usually dry, linen requires changing only at routine intervals.
Activity Ability to change and control body position	<input checked="" type="radio"/> Walks frequently <input type="radio"/> Walks occasionally <input type="radio"/> Chairfast <input type="radio"/> Bedfast	Bedfast (1)	Confined to bed.
		Chairfast (2)	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
		Walks Occasionally (3)	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
		Walks Frequently (4)	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	<input type="radio"/> Completely immobile <input checked="" type="radio"/> Very limited <input type="radio"/> Slightly limited <input type="radio"/> No limitations	Completely Immobile (1)	Does not make even slight changes in body or extremity position without assistance.
		Very Limited (2)	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
		Slightly Limited (3)	Makes frequent though slight changes in body or extremity position independently.
		No Limitations (4)	Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern	<input checked="" type="radio"/> Very poor <input type="radio"/> Probably inadequate <input type="radio"/> Adequate <input type="radio"/> Excellent	Very Poor (1)	Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take liquid dietary supplement. -OR- Is NPO and/or maintained on clear liquids or IV for more than 5 days.
		Probably Inadequate (2)	Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. -OR- receives less than optimum amount of liquid diet or tube feeding.
		Adequate (3)	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. -OR- Is on a tube feeding or TPN regimen which probably meets most of nutritional needs.
		Excellent (4)	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	<input checked="" type="radio"/> Problem <input type="radio"/> Potential problem <input type="radio"/> No apparent problem	Problem (1)	Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent positioning with maximum assistance. Spascity, contractures or agitation leads to almost constant friction.
		Potential Problem (2)	Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains good position in chair or bed most of the time but occasionally slides down.
		No Apparent Problem (3)	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely

Braden Risk Score

Risk Level 
 Low
 Medium
 High
 Very High

Score	Level of Risk
15-18	= Low
13-14	= Medium
10-12	= High
< /=9	= Very High

Additional Risks Factors

<input checked="" type="checkbox"/> Existing skin breakdown	<input checked="" type="checkbox"/> Fever
<input checked="" type="checkbox"/> Age greater than/equal to 75 yrs	<input type="checkbox"/> PVD/Diabetes
<input checked="" type="checkbox"/> Diastolic pressure less than 60 mmHg	<input checked="" type="checkbox"/> Obesity
<input checked="" type="checkbox"/> Hemodynamically unstable	

Adjusted Risk Level Low Medium High Very High

If one or more of the the "Additional Risk Factors" are present then risk level is automatically adjusted to the next level.

Interventions

Interventions	
Reduce Pressure <small>(for decreased sensation, activity or mobility)</small>	Turn <ul style="list-style-type: none"> <input type="checkbox"/> Turn every hour <input type="checkbox"/> Turn every 2 hours <input type="checkbox"/> Supplement turning with small repositioning shifts
	Position & Pressure Reducing Aids <ul style="list-style-type: none"> <input type="checkbox"/> Cradle <input type="checkbox"/> Elevate heels off the mattress <input type="checkbox"/> Foam wedge <input type="checkbox"/> Footboard <input type="checkbox"/> Gel filled <input type="checkbox"/> Pillow <input type="checkbox"/> Position 15-30 degrees lateral <input type="checkbox"/> Therapeutic mattress/bed <input type="checkbox"/> Cushion <input type="checkbox"/> Other:
	Ambulate <ul style="list-style-type: none"> <input type="checkbox"/> Ambulate every 2 hours <input type="checkbox"/> Ambulate every 3 hours <input type="checkbox"/> Ambulate every 4 hours <input type="checkbox"/> Ambulate every 8 hours <input type="checkbox"/> Ambulate every 12 hours <input type="checkbox"/> Ambulate daily <input type="checkbox"/> Other:
Control Moisture	<ul style="list-style-type: none"> <input type="checkbox"/> Offer toileting/diaper change every 1-2 hours <input type="checkbox"/> Provide skin/incontinence care <input type="checkbox"/> Use moisture barrier cream <input type="checkbox"/> Perform daily skin assessment <input type="checkbox"/> Other:
Reduce Friction and Shear	<ul style="list-style-type: none"> <input type="checkbox"/> Moisturize skin <input type="checkbox"/> Use mechanical devices for safe patient handling <input type="checkbox"/> Use elbow protectors <input type="checkbox"/> Use heel protectors <input type="checkbox"/> Keep head of bed less than/equal to 30 degrees <input type="checkbox"/> Other:
Encourage Good Nutrition	<ul style="list-style-type: none"> <input type="checkbox"/> Offer fluids every hour <input type="checkbox"/> Offer fluids every 2 hours <input type="checkbox"/> Offer fluids every 3 hours <input type="checkbox"/> Offer fluids every 4 hours <input type="checkbox"/> Offer oral nutritional supplements if prescribed <input type="checkbox"/> Assist with meals as appropriate <input type="checkbox"/> Other:

Braden Scale Plan of Care Guidelines

If Patient is Low to Moderate Risk for Developing Pressure Ulcer (Braden Scale = 13-18)

1. Toileting as necessary to maintain continence or check for incontinence every 2-4 hours
2. Use absorbent pads to wick and hold moisture
3. Provide routine skin care
4. Manage moisture, friction and shear, and nutrition
5. Assess need for friction redistribution surface
6. Inspect skin when repositioning, toileting and assisting with ADLs
7. Elevate heels off the bed at all times, even with therapeutic support surfaces
8. Use elbow and heel protectors
9. Consult dietitian to maximize nutritional status
10. Maximize mobility
11. Develop and document individualized plan of care

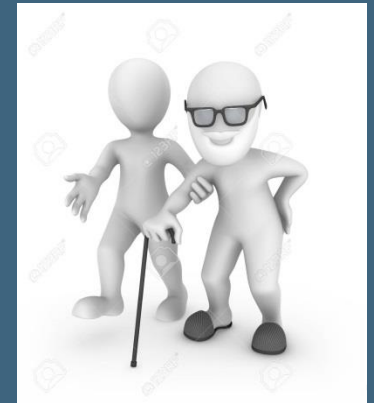
If Patient is High to Very High Risk for Developing Pressure Ulcers (Braden Scale is 12 or less)

In addition to interventions in the Low to Moderate Risk Category:

1. Consultation with PT/OT to maximal mobilization
2. Identify and initiate appropriate redistribution surface
3. Reposition every 1-2 hours regardless of support surface. Incorporate small shifts in positions between turns.
4. Use devices to support lateral 15-30 degree turns/positions
5. Reposition chair bound immobile patients every hour. Use appropriate chair devices for pressure relief and limit sitting to 2 hour intervals.
6. Maintain head of bed at 30 degrees or less
7. Protect sacral/perianal wounds from incontinence
8. Remove slings and transfer devices from under patient

Critical Care Falls Risk & Treatment Interference

All patients in adult critical care will be deemed “high risk for falls and treatment interference”, therefore, Falls risk screening will not be required until transfer.



Critical Care Falls Risk & Interference Prevention

- All patients in critical care will have all of the LHSC Standard AND Enhanced falls risk reduction strategies implemented (as deemed appropriate at the time), ***along with the additional safety measures that are already standards of care in CCTC.***

Falls Risk Assessment

- PRIOR TO TRANSFER, all patients in critical care will be screened in Power Chart with the MORSE Falls Risk Screening Tool. A yellow arm bracelet will be applied if indicated before transfer.



Falls Risk Assessment (Morse) Screening Tool

The screenshot displays a software interface with a dropdown menu open under the heading "Screening Tools (2)". The menu lists the following options:

- Braden Risk Assessment
- Braden Q Risk Assessment
- CAM - Confusion Assessment Method for Delirium
- CSSRS - Suicide Severity Risk Screening Tool
- Fall Risk Assessment - Humpty Dumpty
- Fall Risk Assessment - Humpty Dumpty ED
- Fall Risk Assessment - Morse** (highlighted)
- ARI Screening Tool
- CSSRS - Suicide Severity Risk Screen Paediatrics

The background interface includes a table with the following structure:

Selected visit	
Braden Risk Level	07/13/18 12:35
Braden Adjusted Risk Level	07/13/18 12:35

Below the table is a "Documents (0)" section with a filter for "Last 7 days for all visits" and a "No results found" message.

Morse Fall Risk Assessment and Fall Precautions

Patient Unconscious? Yes No

History of Falling
(immediate or within 3
months)

Yes No

Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)

Secondary Diagnosis

Yes No

Yes = Greater than one medical diagnosis listed on the chart. (15)
No = Only one medical diagnosis listed on the chart. (0)

Ambulatory Aids

Furniture
 Crutches/Cane/Walker/Wheelchair/Needs Assistance
 None/Bedrest

Ambulates by clutching onto furniture for support (30)
Patient uses crutches, cane or walker (15)
Patient ambulates with nurse assistance consistently (0)
Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)

Morse Fall Risk Assessment and Fall Precautions

Patient Unconscious?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	
Morse Fall Scale Risk Factor	History of Falling (immediate or within 3 months)	<input type="radio"/> Yes <input type="radio"/> No		Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)
	Secondary Diagnosis	<input type="radio"/> Yes <input type="radio"/> No		Yes = Greater than one medical diagnosis listed on the chart. (15) No = Only one medical diagnosis listed on the chart. (0)
	Ambulatory Aids	<input type="radio"/> Furniture <input type="radio"/> Crutches/Cane/Walker/Wheelchair/Needs Assistance <input type="radio"/> None/Bedrest		Ambulates by clutching onto furniture for support (30) Patient uses crutches, cane or walker (15) Patient ambulates with nurse assistance consistently (0) Patient walks without walking aid, uses wheelchair, or in on bedrest and doesn't get out of bed (0)
	IV/Saline Lock	<input type="radio"/> Yes <input type="radio"/> No		IV apparatus or saline lock (20)
	Gait/Transferring	<input type="radio"/> Impaired <input type="radio"/> Weak <input type="radio"/> Normal/Bedrest/Immobile		Impaired = Difficulty rising from chair, may use several attempts or "bounces". Patient keeps head down focuses on ground, loses balance easily, clutches tightly to objects, air or nurse. Cannot walk without assistance of aids/nurse. (20) Weak = Patient stooped, may shuffle, but keeps heads up, does not lose balance, may featherweight touch objects or aids for support. (10) Normal/Bedrest/Immobile = Head erect, strides without hesitation, arms swing freely at side; OR is immobile, on bedrest and doesn't get out of bed; uses lift aid, or transfers safely to wheelchair. (0)
	Mental Status	<input type="radio"/> Forgets limitations <input type="radio"/> Oriented to own ability		Ask patient, "Are you able to go to the bathroom alone, or do you need assistance?" Compare patient's answer with your clinical judgement. Overestimates abilities, or forgetful of limitations. (15)
	Total Fall Risk Score	<input type="text"/>		
Fall Risk Level	<input type="radio"/> Low <input type="radio"/> Moderate - High		"Low"= score of 0 - 24 "Moderate-High"= score of 24 or higher	

Low Risk - Universal Fall Precautions		Yes	No	Comment
	Call bell in reach & operational			
	Adequate lighting			
	Oriented to unit, room, bathroom			
	Bed at lowest level, brakes on			
	Ensure secure, non-slip footwear			
	Walking aids, commode, urinal accessible			
	Assess need for frequent toileting			
	Pathway clear of obstacles			
	Ensure bed exiting/equipment/items on pt's strong side			
	Education & Fall prevention brochure given to pt/family			
	Evaluation of current medication			
	Other Precaution #1			
Other Precaution #2				

Considerations

- * Consider placement in room near nursing station or in an area of high visibility
- * Consider assistance from family members
- * Consider observation care with leadership approval
- * Consider referrals as specific risk factors are identified to reduce risk of fall or repeat falls
- * Consider need for medication review by team

- * Communicate risk for fall status at shift report and upon patient transfer to other unit (RNAO, 2007,p9)
- * The use of bedrails to prevent falls is not recommended (RNAO, 2011)
- * Never underestimate the power of clinical judgement



Moderate - High Fall Risk Precautions

(includes Low Risk - Universal Fall Precautions)

	Yes	No	Comment
Call bell in reach & operational			
Adequate lighting			
Oriented to unit, room, bathroom			
Bed at lowest level, brakes on			
Ensure secure, non-slip footwear			
Walking aids, commode, urinal accessible			
Assess need for frequent toileting			
Pathway clear of obstacles			
Ensure bed exiting/equipment/items on pt's strong side			
Education & Fall prevention brochure given to pt/family			
Evaluation of current medication			
Assess for contributing factors (vision, UTI, delirium)			
Inform pt/family/team of fall risk status			
Fall Risk sign posted			
"Call Don't Fall" armband applied			
Activate bed/chair exit alarm			
Assist with mobilization			

Behavioural Safety Assessment (BSA)

- The policy has been implemented in order to communicate risk and to ensure a safe environment for staff, patients and everyone in the care environment.
- Screening tool is tasked to each nurse for each shift 0700 and 1900

Behaviour Safety

Behaviour Safety Alert Inpatient Reassessment and Plan

History of Violence? Past occurrence of any of the following

- No known incident
- Exercised physical force, in any setting, towards any person including a caregiver that caused or could have caused injury
- Attempted to exercise physical force, in any setting, towards any person including a caregiver that could cause injury
- Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury

New Occurrence of Violence? Yes

Observed Behaviours

- No observed concerning behaviours
- Confused
- Irritable
- Boisterous
- Verbal threat of violence
- Physical threats
- Attacking objects
- Agitated/Impulsive
- Paranoid/Suspicious
- Substance intoxication/withdrawal
- Socially inappropriate/disruptive behaviour
- Body language

Observed Behaviours Descriptors	
Confused	Disoriented - e.g. unaware of time, place, or person
Irritable	Easily annoyed or angered; Unable to tolerate the presence of others; Unwilling to follow instructions
Boisterous	Overtly loud or noisy - e.g. slamming doors, shouting, etc
Verbal threats	Raises voice in an intimidating or threatening way; shouts angrily, insulting others or swearing; Making aggressive sounds
Physical threats	Raises arm/legs in an aggressive or agitated way.; Makes a fist; Takes an aggressive stance; Moves/lunges forcefully towards others
Attacking objects	Throws objects; Bangs or breaks windows; Kicks objects; Smashes furniture
Agitated/Impulsive	Unable to remain composed; Quick to overreact to real or imagined disappointments; Troubled, nervous, restless or upset; Spontaneous, hasty or emotional
Paranoid/Suspicious	Unreasonably or obsessively anxious; Overtly suspicious or distrustful - e.g. belief of being spied on or someone conspiring to hurt them
Substance intoxication/withdrawal	Intoxicated or in withdrawal from alcohol or drugs
Socially inappropriate/disruptive behaviour	Makes disruptive noises; Screams; Engages in self-abusive acts, sexual behaviour or inappropriate behaviour - e.g. hoarding, smearing faeces/food, etc.
Body Language	Torso shield - arms/objects acting as a barrier. Puffed up chest - territorial dominance; Deep breathing/panting; Arm dominance - arms spread, behind head, on hips; Eyes - pupil dilation/constriction, rapid blinking, gazing; Lips - compression, sneering, blushing/blanching.

Total Score

Behaviour Safety Alert

- Low
- Moderate
- High
- Very High

Behaviour Safety ranking of "Moderate", "High" or "Very High" will automatically set the "Behaviour Safety Alert" flag on the demographic banner after the form is signed.

Continue to monitor and remain alert for any potential increase in risk. Communicate any changes in behaviour that may put others at risk to leader/delegate and during transfer of accountability. Be prepared to apply behaviour management and self protection teachings according to organization policy/procedures that are appropriate to the situation, e.g. Workplace Violence Prevention, Gentle Persuasive Approach.

Risk Reduction and Safety Plan

Visual indicators applied as per organization protocol and as applicable (signage, armband, Kardex sticker, chart spine label)	<input type="radio"/> Completed	Comment	<input type="text"/>
Leader or delegate notified	<input type="radio"/> Completed	Comment	<input type="text"/>
Scan environment for potential risks and remove if possible	<input type="radio"/> Completed	Comment	<input type="text"/>
Use effective therapeutic communication	<input type="radio"/> Completed	Comment	<input type="text"/>
Communication devices are in place according to unit or organizational protocol (e.g. panic alarm)	<input type="radio"/> Completed	Comment	<input type="text"/>
Communicate behaviour changes that may put others at risk to leader or delegate if applicable	<input type="radio"/> Completed	Comment	<input type="text"/>

BSA Scoring

- **Score of 0** indicates low risk for violent behaviour
- **Score of 1-3** indicates moderate risk for violent behaviour
- **Score of 4-8** indicates high risk for violent behaviour
- **Score of great than 8** indicates very high risk for violent behaviour

If a Violent Episode Occurs

- If you are unable to manage a situation without risk of harm to staff, patients, or visitors, call 55555 and initiate a Code White
- Engage Security to provide support as appropriate
- Ensure the safety of staff and other patients
- Complete a report in the AEMS system

Communication Strategies

Applying a Purple Armband Conversation

- “Your loved one has an individualized plan of care in place to communicate the measures we need to put in place to support them and to make their stay pleasant. We use this armband to tell others that care for your loved one that there has been an individualized care plan created.”
- “I am applying this armband to your wrist to indicate that we have documented extra strategies to support your care.”



Removal of BSA from EHR

Removal of a Behaviour Safety Alert may occur for two reasons:

- Patient may appeal identification of risk for violent behaviour by submitting a formal appeal to Patient Relations
- Leader may remove BSA if it was placed on wrong chart

Remove Behaviour Saf... Order 2018/01/08 11:48 Flag Removed

Details for **Remove Behaviour Safety Alert Flag**

Details Order Comments

Requested Start Date/Time: 2018/01/08 11:48 *Reason:
Flag added in error
Successful patient/family/SDM appeal
Removed after consultation with MRP/RHPs

When I eat too
much dessert, I
don't post about
it on Facebook

Because if it
isn't charted,
it didn't happen.



Robb Hillman Coaching - Life Coaching for Nurses

Critical Care Trauma Centre (CCTC)
**12 HOUR NURSING ASSESSMENT/
 INTERVENTION FLOWSHEET**

DATE: _____ CCTC DAY NO: _____
 (YYYY/MM/DD)

KEY: * = Significant Findings TIME OF ASSESSMENT: _____

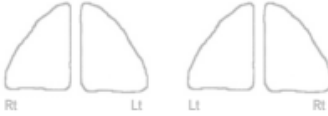
NEUROLOGICAL / COMFORT

NMB Hypothermia Protocol **GCS:** _____ **GAG:** YES NO **COUGH:** YES NO
 C-SPINE COLLAR C-SPINE PRECAUTION T & L PRECAUTION
 RESTRAINTS TYPE: _____ CONSENT: YES NO DATE OF CONSENT: _____
ICP: TYPE: EVD PARENCHYMAL REFERENCE CODE: _____ INSERTION DATE: _____
 EVD DRAINAGE LEVEL: _____ (cm) ICP WAVEFORM POSTED TO CHART _____
CSF: CLEAR BLOOD TINGED CLOUDY OTHER: _____
 PAIN SCORE - NRS (0-10): _____ OR CPOT (0-8/8): _____ VAMAAS TARGET: _____ ACTUAL VAMAAS: _____
 NARCOTIC SEDATION INFUSION? YES NO WAP PA F W * DAR for other
 ANTIPSYCHOTICS: YES NO YES, EPSE/IM P A * and DAR

12 Hour Nursing Assessment/Intervention Flowsheet

RESPIRATORY

CRACKLES WHEEZE DECREASED AIR ENTRY ABSENT AIR ENTRY CLEAR



CHEST TUBE SITE	2 cm LWS CONFIRMED		LWS FLUCTUATES		AIR LEAK (0-7/7)	SUCTION (cmH ₂ O)	TYPE OF DRAINAGE
	Yes	No	Yes	No			

NON INVASIVE: NP L/MIN _____ FIO₂ _____ FM VENTI MASK HIGH HUMIDITY REBREATHER
 CPAP _____ NIV: IPAP _____ OTHER: _____
 INVASIVE: ORAL ETT NASAL ETT _____ SIZE _____ CAPPED
 SPEAK VALVE LARYNGOTOMY TUBE VENTILATOR PB 840 OTHER _____ FIO₂ _____ PEEP _____
 PaO₂/FIO₂ _____ AC/SIMV/PS/PAV _____ TV/PC _____ BILEVEL/PAV/TC _____ LRM/BREATH STACKING Q _____ /DAY
TARGETS: SpO₂ > _____ PCO₂ (NEURO) _____ PH _____ CHG ORAL CARE _____
VENTILATION PLAN: FULL SUPPORT Protective Lung Ventilation Prone until _____ h Reprone at _____ h
 WEAN BY: SBT PS/PAV TMT

VASCULAR-HEMODYNAMIC

ECG LEAD: _____ ANALYSIS: _____ QTC _____ or QT < 50% OF R-R YES NO
PACEMAKER: TC PERM TV TEMP TV INSERTION SITE: _____
PACEMAKER CODE: VVI OTHER _____
 V RATE: _____ A RATE: _____ OUTPUT (MA): _____ SENSITIVITY (MV): _____ AVI: _____
 BP: NIBP ARTERIAL LINE SITE: _____ WAVEFORM: WDL POSITIONAL _____
 TARGET MAP _____ REQUIRES VASOACTIVE INFUSIONS FLOTAC: PA CATHETER POSITION: _____ (cm)
 WAVEFORMS POSTED: ECG ARTERIAL CVP PA
VTE PROPHYLAXIS: TEDS IPC Prophylactic AC Therapeutic AC _____

ARTERIAL PULSE	RAD	BRACH	AX	FEM	POP	DP	PT	Other
0 - Absent 3 - Bounding 1 - Weak D - Doppler								

SKIN TEMP: HOT WARM COOL CLAMMY DIAPHORETIC
 SKIN COLOUR: _____

Patient Identifier/Date



London Health
Sciences Centre

Critical Care Trauma Centre (CCTC)
**12 HOUR NURSING ASSESSMENT/
INTERVENTION FLOWSHEET**

DATE: _____ CCTC DAY NO: _____
(YYYY/MM/DD)

KEY: * = Significant Findings TIME OF ASSESSMENT: _____
< = Greater than > = Less than ↑ = Increased ↓ = Decreased Δ = Increment

2 Patient Identifiers

1. Prior to placing the armband, the first staff member will spell the client's last name and state their first name and DOB from a reliable source document (e.g. government-issued ID or reliable photo ID),
2. The second staff member will spell the client's last name and state their first name and DOB out loud from the armband,
3. Place the armband on the client

Neurological/Comfort

NEUROLOGICAL / COMFORT

NMB Hypothermia Protocol **GCS:** _____ **GAG:** YES NO **COUGH:** YES NO

C-SPINE COLLAR C-SPINE PRECAUTION T & L PRECAUTION

RESTRAINTS TYPE: _____ **CONSENT:** YES NO **DATE OF CONSENT:** _____

ICP: TYPE: EVD PARENCHYMAL **REFERENCE CODE:** _____ **INSERTION DATE:** _____

EVD DRAINAGE LEVEL: _____ (cm) ICP WAVEFORM POSTED TO CHART _____

CSF: CLEAR BLOOD TINGED CLOUDY OTHER: _____ **CEEG:** YES NO

PAIN SCORE: NRS (0-10/10): _____ **OR** CPOT (0-8/8): _____ **VAMAAS TARGET:** _____ **ACTUAL VAMAAS:** _____

NARCOTIC OR SEDATIVE INFUSION? YES NO **If YES, SWAP:** Pass Fail **If SWAP passed:** Wean or * DAR for other

ANTIPSYCHOTICS: Yes No **If YES, EPSE/NMS:** Present Absent **If PRESENT * and DAR**

Cough is weak

Gag is normal if stimulation of BOTH sides of the oral pharynx elicits response

- Normal cough should be able to bring secretions forward
- If cough is weak, note this here on lines

Neurological/Comfort

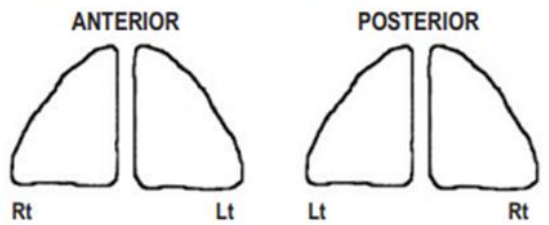
COMFORT	<input type="checkbox"/> NMB <input type="checkbox"/> Hypothermia Protocol GCS: _____ GAG: <input type="checkbox"/> YES <input type="checkbox"/> NO COUGH: <input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> C-SPINE COLLAR <input type="checkbox"/> C-SPINE PRECAUTION <input type="checkbox"/> T & L PRECAUTION
COMFORT	<input type="checkbox"/> RESTRAINTS TYPE: _____ CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF CONSENT: _____
	ICP: TYPE: <input type="checkbox"/> EVD <input type="checkbox"/> PARENCHYMAL REFERENCE CODE: _____ INSERTION DATE: _____
	<input type="checkbox"/> EVD DRAINAGE LEVEL: _____ (cm) <input type="checkbox"/> ICP WAVEFORM POSTED TO CHART _____
COMFORT	CSF: <input type="checkbox"/> CLEAR <input type="checkbox"/> BLOOD TINGED <input type="checkbox"/> CLOUDY <input type="checkbox"/> OTHER: _____ CEEG: <input type="checkbox"/> YES <input type="checkbox"/> NO
	PAIN SCORE: NRS (0-10/10): _____ OR CPOT (0-8/8): _____ VAMAAS TARGET: _____ ACTUAL VAMAAS: _____
	NARCOTIC OR SEDATIVE INFUSION? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, SWAP: <input type="checkbox"/> Pass <input type="checkbox"/> Fail If SWAP passed: <input type="checkbox"/> Wean or <input type="checkbox"/> * DAR for other
NEUROLOGICAL	ANTIPSYCHOTICS: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, EPSE/NMS: <input type="checkbox"/> Present <input type="checkbox"/> Absent If PRESENT * and DAR

Respiratory

RESPIRATIONS: WDL OTHER: _____ CHEST EXPANSION: WDL OTHER: _____

TARGET HOB: 30° REV TRENDLENBURG OTHER: _____ SECRECTIONS: QUALITY/QUANTITY ISSUES YES * DAR NO

- CRACKLES
- WHEEZE
- DECREASED AIR ENTRY
- ABSENT AIR ENTRY
- CLEAR



CHEST TUBE SITE	2 cm UWS CONFIRMED		UWS FLUCTUATES		AIR LEAK (0 - 7/7)	SUCTION (cmH ₂ O)	TYPE OF DRAINAGE
	Yes	No	Yes	No			

Invasive Support: ETT oral / nasal R / L SSdT Distance at teeth _____ (cm) Tracheostomy Laryngotomy

Tube size: _____ Cuff up/down _____ Speaking valve / capped CHG oral care

Targets: FiO₂ 92-96% 88-92% Other: _____ pH 7.30-7.40 PCO₂ (Neuro) _____ Other: _____

Mechanical Ventilation: PB840 HG5 Other: _____ FiO₂: _____ PaO₂/FiO₂: _____ CPAP/PEEP: _____

Mode: _____ Ventilator Rate: _____ Total Rate: _____

Ventilation Plan: Full Support Protective Lung Ventilation Prone Ventilation Until: _____ h Wean as tolerated

Weaning Plan: _____

LRM / Breath Stacking _____ /day Other: _____

Non-Invasive Support: NP FM / TM Ventimask Rebreather High Flow CPAP / NIV via Nasal / Facial mask

Oxygen: _____ L/min or _____ % High Flow: _____ % CPAP: _____ NIV IPAP: _____ EPAP: _____

Cardiovascular/Hemodynamic

MIC	ARTERIAL PULSE	RAD	BRACH	AX	FEM	POP	DP	PT	Other	SKIN TEMP: <input type="checkbox"/> HOT <input type="checkbox"/> WARM <input type="checkbox"/> COOL <input type="checkbox"/> CLAMMY <input type="checkbox"/> DIAPHORETIC SKIN COLOUR: _____ CAPILLARY REFILL: <input type="checkbox"/> BRISK <input type="checkbox"/> PROLONGED
	0 - Absent 3 - Bounding									
	1 - Weak D - Doppler									
	2 - Normal									
ODYN	CONTINUOUS ECG: <input type="checkbox"/> 5 LEAD <input type="checkbox"/> 12 LEAD PRIMARY LEAD: _____ ANALYSIS: _____ QTc _____ ΔQTc _____									
	CARDIOVASCULAR-HEM	PACEMAKER: <input type="checkbox"/> TC <input type="checkbox"/> Temp TV <input type="checkbox"/> Perm Site: _____					Target MAP: _____ <input type="checkbox"/> In target <input type="checkbox"/> Requires vasoactive agents			
Type: <input type="checkbox"/> VVI or <input type="checkbox"/> _____ V Rate: _____ A Rate: _____					Art Line Site: _____ <input type="checkbox"/> Normal Waveform <input type="checkbox"/> Positional					
Output (MA) V: _____ A: _____ Sense (MV) V: _____ A: _____					Waveforms Posted: <input type="checkbox"/> ECG <input type="checkbox"/> Art <input type="checkbox"/> CVP					
Other: <input type="checkbox"/> PPV <input type="checkbox"/> FloTrac <input type="checkbox"/> VV ECMO <input type="checkbox"/> VA ECMO					<input type="checkbox"/> PAP PA catheter position: _____(cm)					
CARDIOVASCULAR-HEM	VTE PROPHYLAXIS: <input type="checkbox"/> TEDS <input type="checkbox"/> IPC <input type="checkbox"/> Prophylactic / Therapeutic AC <input type="checkbox"/> IVC Filter									
										Nurse's Initials: _____

When to Print an ECG Tracing

- Admission
- Every 12 hours & PRN
- After any rhythm change
- When the rhythm returns to normal
- When IV cardiac meds are being given
- Before discontinuing the cardiac monitor

Cardiovascular/Hemodynamic

CARDIOVASCULAR-HEMODYNAMIC	ARTERIAL PULSE	RAD	BRACH	AX	FEM	POP	DP	PT	Other	SKIN TEMP: <input type="checkbox"/> HOT <input type="checkbox"/> WARM <input type="checkbox"/> COOL <input type="checkbox"/> CLAMMY <input type="checkbox"/> DIAPHORETIC SKIN COLOUR: _____ CAPILLARY REFILL: <input type="checkbox"/> BRISK <input type="checkbox"/> PROLONGED
	0 - Absent 3 - Bounding 1 - Weak D - Doppler	Rt								
	2 - Normal	Lt								
CONTINUOUS ECG: <input type="checkbox"/> 5 LEAD <input type="checkbox"/> 12 LEAD PRIMARY LEAD: _____ ANALYSIS: _____ QTc _____ ΔQTc _____										
CARDIOVASCULAR-HEMODYNAMIC	PACEMAKER: <input type="checkbox"/> TC <input type="checkbox"/> Temp TV <input type="checkbox"/> Perm Site: _____ Type: <input type="checkbox"/> VVI or <input type="checkbox"/> _____ V Rate: _____ A Rate: _____ Output (MA) V: _____ A: _____ Sense (MV) V: _____ A: _____ Other: <input type="checkbox"/> PPV <input type="checkbox"/> FloTrac <input type="checkbox"/> VV ECMO <input type="checkbox"/> VA ECMO					Target MAP: _____ <input type="checkbox"/> In target <input type="checkbox"/> Requires vasoactive agents Art Line Site: _____ <input type="checkbox"/> Normal Waveform <input type="checkbox"/> Positional Waveforms Posted: <input type="checkbox"/> ECG <input type="checkbox"/> Art <input type="checkbox"/> CVP <input type="checkbox"/> PAP PA catheter position: _____ (cm)				
	VTE PROPHYLAXIS: <input type="checkbox"/> TEDS <input type="checkbox"/> IPC <input type="checkbox"/> Prophylactic / Therapeutic AC <input type="checkbox"/> IVC Filter									
										Nurse's Initials: _____

Capillary Refill

- Testing Capillary Refill

1. Hold hand above the heart
2. Apply light pressure to blanch the fingernail bed
3. Release and measure the time until the circulation returns to normal

- Normal < 2

- Sluggish > 3

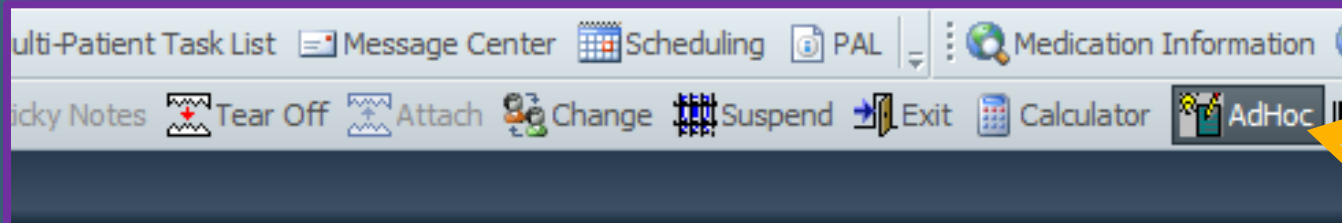
- Abnormal > 5

IV Infusions

INTRAVENOUS	CENTRAL AND PERIPHERAL VENOUS LINES/LUMENS	SOLUTIONS (record solution or medication only, record rate and concentration in Flowsheet)
	Rt IJ Introducer	Norepi and Vasopressin
	Rt IJ TL : Brown	CVP/RL infusion
	White	Dilaudid and Propofol infusions
	Blue	Insulin Infusion
	Lt forehead #18 PIV	Heparin Infusion

Sepsis Screen

SEPSIS ASSESSMENT	INFECTION CONTROL <input checked="" type="checkbox"/> if yes):
	ARI Screen (on admission or new respiratory symptoms): <input type="checkbox"/> Pass <input type="checkbox"/> Fail
	<input type="checkbox"/> Travel History Documented (in Power Chart at admission)
	Precautions: <input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Droplet <input type="checkbox"/> Negative Pressure
	<input type="checkbox"/> Enhanced PPE <input type="checkbox"/> Precautions Documented (into Power Chart)
	SEPSIS SCREENING <input checked="" type="checkbox"/> if yes):
	<input type="checkbox"/> WBC > 10 or < 4.0 <input type="checkbox"/> Temp < 36 or > 38 during past 12 hours
	<input type="checkbox"/> ↓ BP or ↑ Vasopressors
	<input type="checkbox"/> Lactate > 2.0 <input type="checkbox"/> ↑ Secretions <input type="checkbox"/> ↑ Oxygen/Vent support <input type="checkbox"/> At risk lines
	Other Concerns: _____
If any options above selected date last cultured: _____	
<input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Urine Other (specify): _____	



Ad Hoc Charting - Critical Care UH, Jane

- Assessment and Monitoring
- Blood Transfusion Labs
- Breast Assessment Program
- Clinical Nutrition
- CH Oncology
- Colposcopy Forms
- Diabetes Education Program (DEP)
- LRCF Health Records
- Nephrology Forms
- NIV Forms
- Oncology Scales
- Order Detail Forms
- Patient Summaries
- Perinatal
- Perioperative Care TVHPP
- Pharmacy Forms
- PreAdmit Clinics London
- MENT HEALTH Forms
- Screening Tools**
- Spiritual Care Forms
- Oncology
- All Items

Acute Respiratory Illness and Travel History Screen

Travel History

Has patient travelled to any of the following geographic areas within the past 21 days?

- Denies travel to any of the listed locations
- China
- Guinea
- Jordan
- Liberia
- Oman
- Qatar
- Republic of Korea - health care setting
- Saudi Arabia
- Sierra Leone
- United Arab Emirates (UAE)
- Yemen

Had contact in past 21 days with a sick person who travelled to any of these geographic areas?

- Denies contact with sick person who travelled to any of the listed locations
- China
- Guinea
- Jordan
- Liberia
- Oman
- Qatar
- Republic of Korea - health care setting
- Saudi Arabia
- Sierra Leone
- United Arab Emirates (UAE)
- Yemen

Travel Alert

Pass Fail

To see the the most up to date travel reference material RIGHT CLICK inside the yellow box and select "Reference Text"

Acute Respiratory Illness (ARI) & Travel

Assess Symptoms

- Denies symptoms as listed below
- New/worse cough (onset within 7 days)
- New/worse shortness of breath (worse than usual)?

Assess Temperature for Past 24 Hours

- Denies symptoms as listed below
- Patient feeling feverish
- Patient had chills and shakes

General Symptoms

Does the patient have any of the following symptoms?

- Denies symptoms as listed below
- Severe headache
- Diarrhea
- Sore throat
- Rash
- Vomiting

Acute Respiratory Illness (ARI) Screen

Pass Fail

Travel & Symptom Screen

Pass Fail

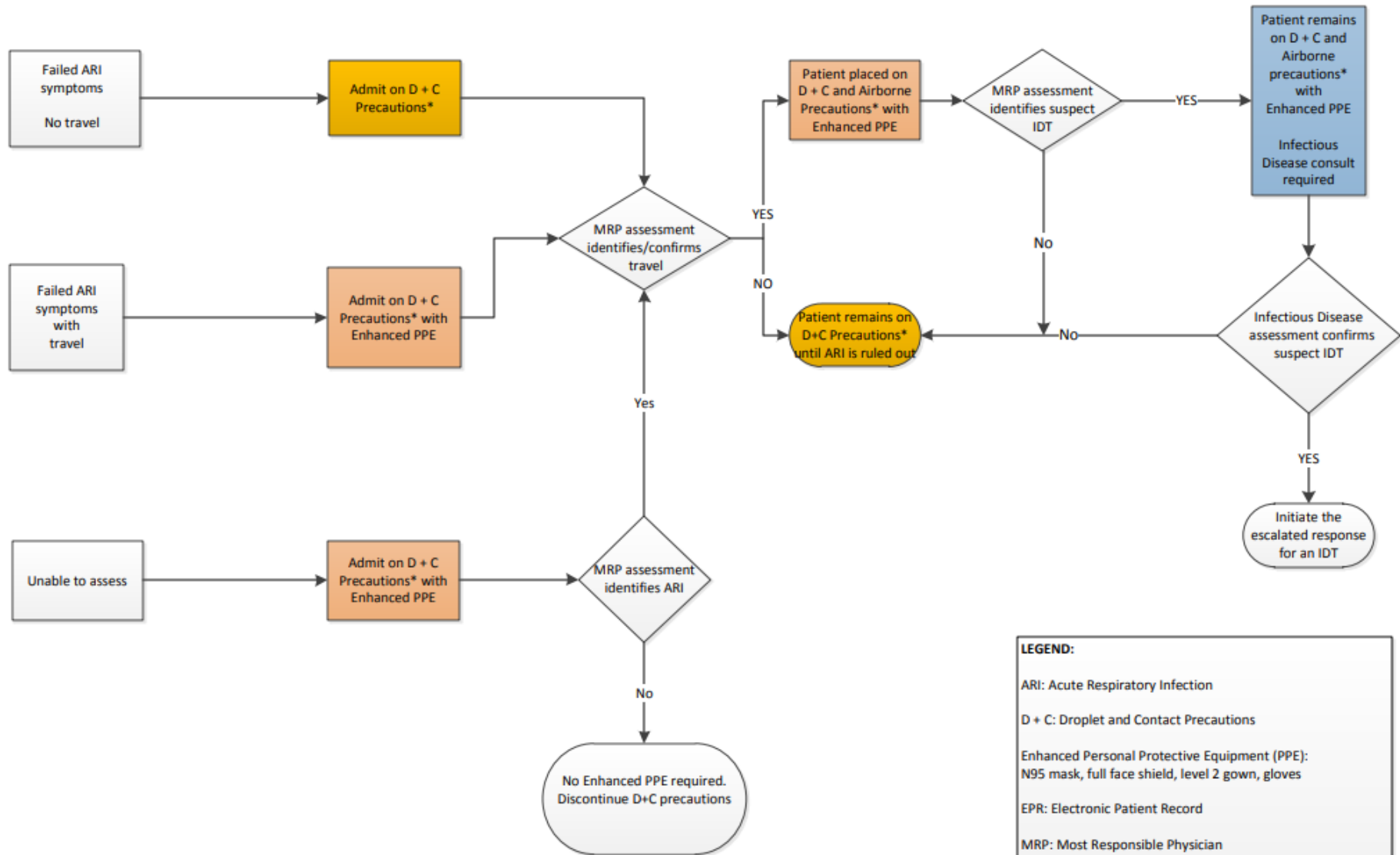
Note: Implement appropriate PPE and protocols as per your facility's guidelines.

Adult Critical Care Department Flow Map for Travel/Symptom Screening

Initial Assessment

MRP Assessment

Infectious Diseases Assessment



LEGEND:

- ARI: Acute Respiratory Infection
- D + C: Droplet and Contact Precautions
- Enhanced Personal Protective Equipment (PPE):
N95 mask, full face shield, level 2 gown, gloves
- EPR: Electronic Patient Record
- MRP: Most Responsible Physician
- IDT: Infectious Disease Threat

*Ensure signage posted and precaution order in PowerChart

Critical Care Protocol-Initial Assessment

Screening: Acute Respiratory Illness/Travel Screen

- **Failed ARI, no travel-** admit on Droplet + Contact precautions
- **Failed ARI with travel-** admit on Droplet + Contact precautions with Enhanced PPE
- **Unable to assess-** admit on Droplet + Contact precautions with Enhanced PPE

Enhanced Precautions

ACUTE CARE



STOP

No Visitors: Speak to a charge nurse

Staff: Enhanced PPE Required
DROPLET + CONTACT PRECAUTIONS



N95 mask and full face shield



Gloves required for all patient /patient environment contact. Level 2 gown required



Patient room door closed



Consult IPC if patient transport required



Use dedicated equipment

ACUTE



STOP

Visitors: Speak to a nurse before entering this room.

DROPLET + CONTACT PRECAUTION



Procedure/surgical mask and protective eyewear required within 2 metres of patient



Gloves required for all patient/ patient environment contact



Long-sleeved gown required if skin or clothing will contact patient/patient environment



Patient to wear a procedure/surgical mask for transport



Use dedicated equipment or disinfect before use with another patient



Droplet + Contact with Enhanced PPE

- Order as Droplet/Contact with Enhanced PPE

The screenshot displays a patient's medical record interface. At the top, patient information is shown: Name (partially visible as 'Dummy, Dumm...'), PIN: 1157 88 87, VISIT #: 424989433, Age: 18 months, DOB: 2018/08/01, Weight: 76 kg, Ht/Length: 134 cm, Sex: Male, and Allergies: acetaminophe. A search bar contains the text 'Droplet' and the Type is set to 'Inpatient'. Below the search bar, a folder list is shown with 'Droplet and Contact with Enhanced PPE' highlighted by a red box. At the bottom, a table lists orders with columns for Order Name, Status, Start, and Details.

Order Name	Status	Start	Details
U-5; A5-305; A VISIT #:424989433 Admit: 2013/10/26 08:01			
Alerts			
Droplet and Contact with Enhanced PPE	Order	2020/02/04 08:40	Started on: 2020/02/04 08:40 EST, Indications: Infectious Disease Threat

Droplet + Contact Precautions

- Acute respiratory infection (undiagnosed)
- Pneumonia
- Influenza

ACUTE CARE



STOP

Visitors: Speak to a nurse before entering this room.

DROPLET + CONTACT PRECAUTIONS

-  Procedure/surgical mask and protective eyewear required within 2 metres of patient
-  Gloves required for all patient/patient environment contact
-  Long-sleeved gown required if skin or clothing will contact patient/patient environment
-  Patient to wear a procedure/surgical mask for transport
-  Use dedicated equipment or disinfect before use with another patient

OVER

Droplet + Contact Precautions

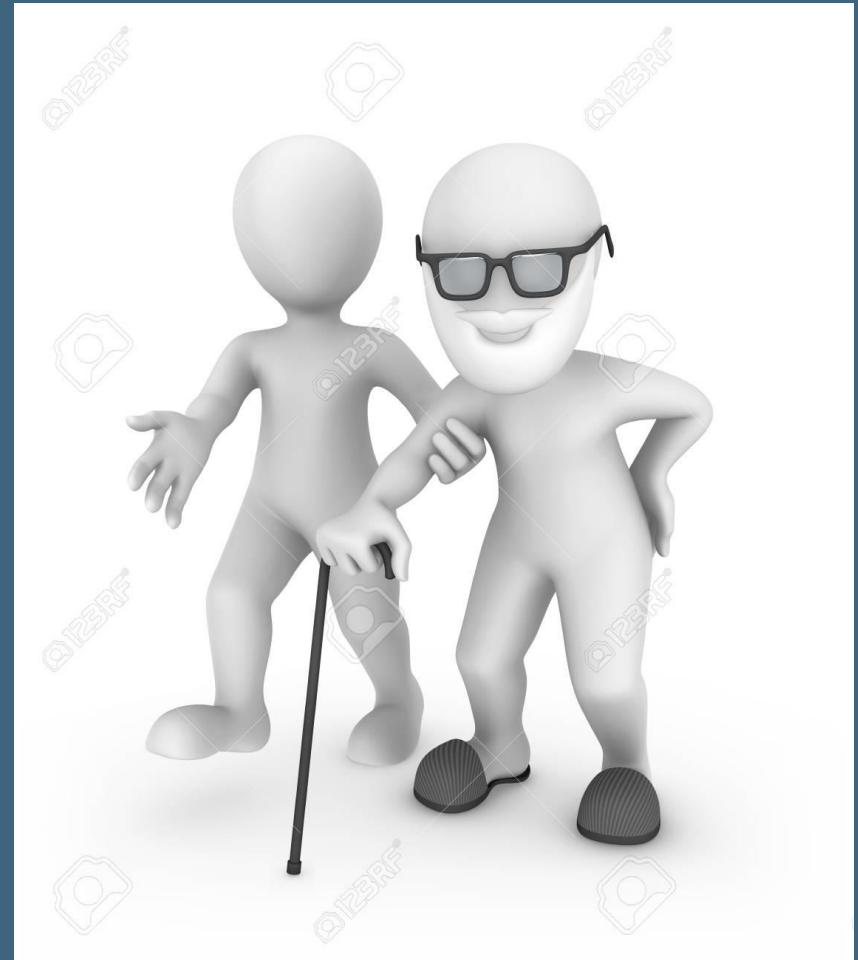
- Gloves required for all patient and environment contact
- Long sleeve gown required if skin or clothing will contact patient/patient environment



Droplet + Contact Precautions

Visitors

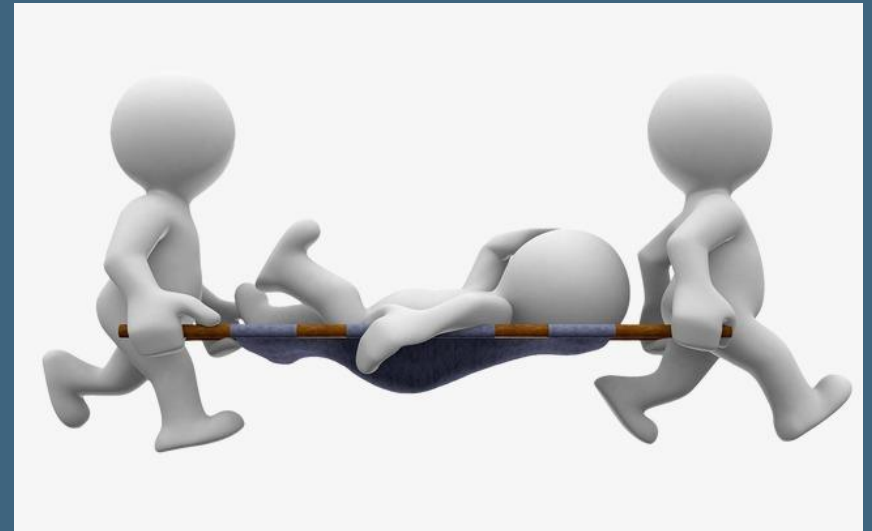
- Wear gloves and gown if providing DIRECT care
- Wear procedure/surgical mask and eye protection within 2 metres of patient
- Visitors are to perform hand hygiene prior to entering and exiting the room and removal of PPE



Droplet + Contact Precautions

Transporting

- Staff to wear gloves and gown if assisting in the “hands on” transfer/care
- Staff to wear fluid resistant mask, eye protection or face shield
- Patient to perform hand hygiene and wear procedural mask



Specialized Precautions



Specialized PPE:

- One piece suit
- Full gown
- Two pair of gloves
- Positive Air Pressure Respirator (PAPR)

**Donning and doffing of PPE requires an observer*



ACUTE CARE

STOP

Visitors: Speak to a nurse before entering this room.

DROPLET + CONTACT PRECAUTIONS

- Procedure/surgical mask and protective eyewear required within 2 metres of patient
- Gloves required for all patient/patient environment contact
- Long-sleeved gown required if skin or clothing will contact patient/patient environment
- Patient to wear a procedure/surgical mask for transport
- Use dedicated equipment or disinfect before use with another patient

8728

ACUTE, NON-ACUTE, AMBULATORY CARE

STOP

Visitors: Speak to a nurse before entering this room.

AIRBORNE PRECAUTIONS

- Negative pressure room with door and windows closed
- N95, fit-tested and seal-checked respirator required for room entry* and transport
- Patient to wear a procedure/surgical mask for transport

*For chickenpox, disseminated zoster or measles, known non-immune staff should enter only if absolutely necessary

8728

You admit a patient from the emergency department at 2200. You identify the patient requires droplet/contact precautions to be ordered and wear the appropriate PPE. Later at 2400, when the dust settles, you order the precautions in Power Chart. What time will you enter when the precautions had started?

- a. 2000
- b. 2200
- c. 2400
- d. Does it really matter?

Your patient has a history of MRSA and is currently being admitted for suspected pneumonia (failed ARI). What precaution sign(s) will you post outside the room and enter into PowerChart?

- a. Droplet/Contact
- b. Enhanced Precautions
- c. Contact
- d. **A and C**

LHSC Infection Prevention & Control

Infection Prevention and Control (IPAC)

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Infection Prevention and Control (IPAC)

IPAC NEWS AND HIGHLIGHTS

Please share this one pager intended as a quick reminder of the foundational practices that build the organizations Infection Safety processes.

Full descriptions of each process are also available in the [IPAC website](#).



HOT OFF THE PRESS!

ARI Nothing to Sneeze at....

Contact

CLINICAL CONSULTATIONS

Monday to Friday 0800-1600

University Hospital pager 15836

Victoria Hospital Pager 15591

Off site after hours for urgent matters

pager: 14335

(Weekdays: 1600-2100)

(Weekends: 0800-2100)

GENERAL INQUIRIES

Phone ext. 56031

Email infectioncontrolhsc@lhsc.on.ca

[ONLINE CONSULT REQUEST FORM](#)

Safe Handling of Illicit Drug or Unknown Substances

Carfentanil a New Worry for First-Responders

Carfentanil and other fentanyl-related compounds are a serious danger to public safety, first responder, medical, treatment, and laboratory personnel.

BY SHERYL KRIEG, THE NEWS-SENTINEL (FORT WAYNE, IND.) / MAY 11, 2017



Police warn of new drug thousands of times more dangerous than morphine

POSTED 9:49 PM, FEBRUARY 15, 2019, BY MICHELLE MADARAS, UPDATED AT 08:58PM, FEBRUARY 15, 2019



Safe Handling of Illicit Drug or Unknown Substances

- Inadvertent skin exposure to illicit drugs like fentanyl or carfentanil are unlikely to cause toxicity however absorption can occur through mucous membranes if the drug remains on the skin and there is subsequent oral contact (e.g. hand goes in mouth).
- There is a new policy (Safe Handling of Illicit Drugs or Unknown Substances) that establishes the requirements for staff/affiliates to minimize exposure when removing illicit drugs/other substances in order to provide patient care.

What is your role if you see and unknown substance or something you think is an illicit drug?



Risk Assessment

Risk Level	Consider:
Low Risk	<ul style="list-style-type: none">• The quantity/form of the illicit drug or unknown substance• The type of packaging• The chance of exposure for the health care worker
High Risk	<ul style="list-style-type: none">• Intact dosage forms, i.e. pill, capsules• Unknown substance is contained in a sealed container/baggie• Low chance of exposure
	<ul style="list-style-type: none">• Minimal to large quantities of unknown substance are present on an overdosed patient• Unknown substance is loose powder on the patient's clothing or belongings• Unknown substance in an open baggie• Medium to high risk of exposure or prolonged contact



double





double



Double bag the substance using a biohazard bag:



Doffing PPE



Call Security:



Sepsis Screen

SEPSIS ASSESSMENT

INFECTION CONTROL (if yes):

ARI Screen (on admission or new respiratory symptoms): Pass Fail

Travel History Documented (in Power Chart at admission)

Precautions: Contact Airborne Droplet Negative Pressure

Enhanced PPE Precautions Documented (into Power Chart)

SEPSIS SCREENING (if yes):

WBC > 10 or < 4.0 Temp < 36 or > 38 during past 12 hours

↓ BP or ↑ Vasopressors

Lactate > 2.0 ↑ Secretions ↑ Oxygen/Vent support At risk lines

Other Concerns: _____

If any options above selected date last cultured: _____

Blood Sputum Urine Other (specify): _____

Gentio-urinary

PREGNANT POSTPARTUM ACTIVATE CCTC OBSTETRICAL FLOW SHEET

CATHETER: URETHRAL SUBRAPUBIC SIZE: _____ TYPE: _____ ILEAL CONDUIT URETERAL STENT R / L

VOIDING: CONTINENT INCONTINENT URINE VOLUME: WDL < 0.5 mL/kg/hr _____

COLOUR: PALE YELLOW AMBER DK AMBER ABNORMAL _____

DIALYSIS: INTERMITTENT CONTINUOUS PERITONEAL DIALYSIS CATHETER SITE: _____

PERINEUM: WDL _____ ELECTROLYTE PROTOCOL: Standard High K/Mg

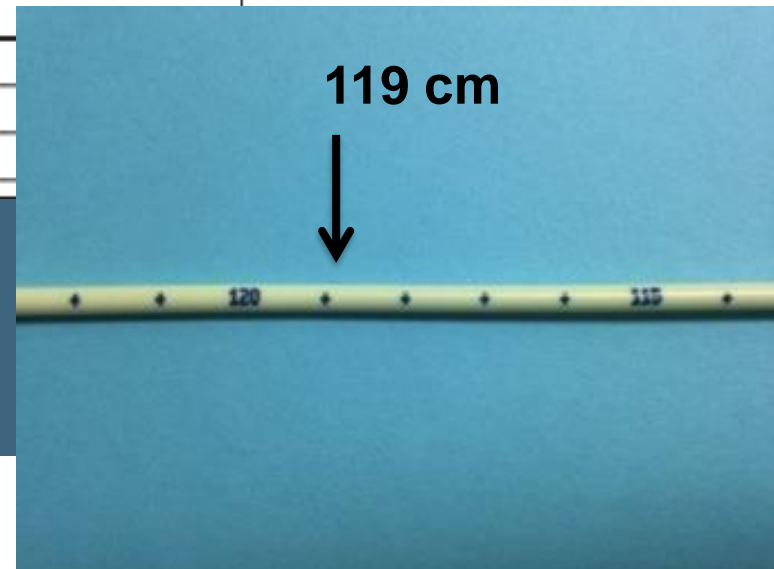
GENITO-URINARY

Gastrointestinal

ABDOMEN: SOFT FIRM DISTENDED **BOWEL SOUNDS:** WDL OTHER: _____
DATE OF LAST BM: _____ **COLOUR/CONSISTENCY:** _____ Standard Bowel Routine ASCI Bowel Routine
FECAL MANAGEMENT SYSTEM TYPE: _____ BLADDER PRESSURE _____
DIET: NPO Parenteral (C/P) Enteral Protein Boluses: _____
FEEDING TUBE: Oral Nasal L / R Distance (cm) **119** Percutaneous **Tip Location:** Gastric Duodenum Jejunum
GASTRIC DRAINAGE: NG/OG L / R Low Intermittent Suction Straight Drainage Drainage: Bile Other: _____
 Ileostomy Colostomy Stoma Appearance: _____
 Intensive Insulin DKA GI Prophylaxis: _____ Prokinetic: _____

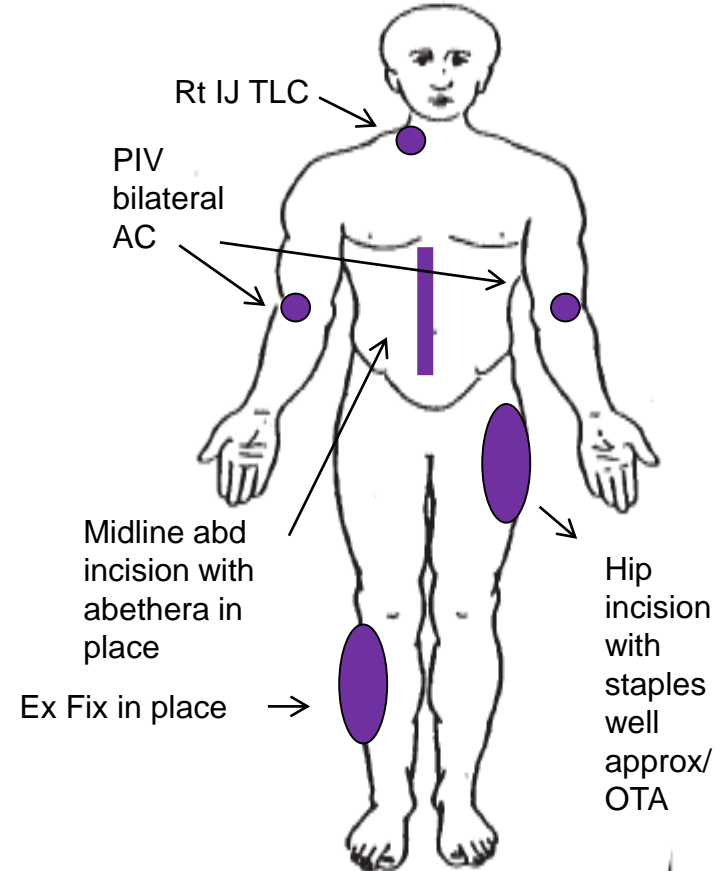
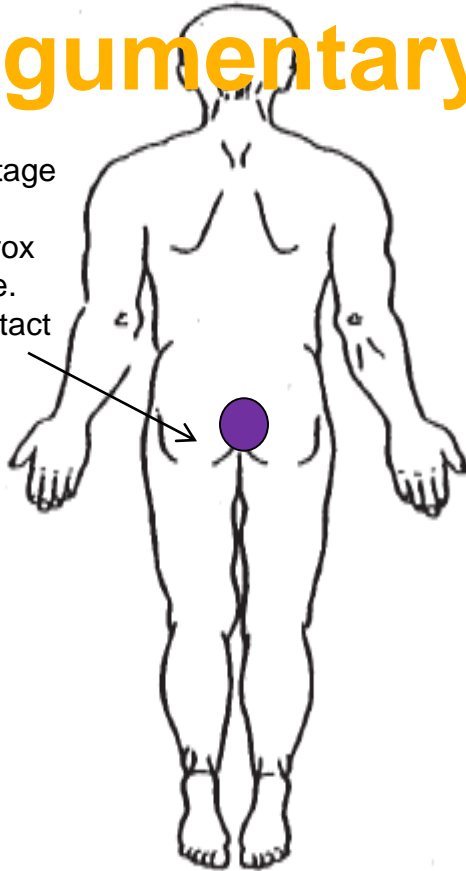
OTHER DRAINS:

TYPE	LOCATION	SYSTEM	DRAINAGE
HMV	RUQ Abd	Suction	Scant, serosanguinous
G-Tube	RLQ Abd	Straight drainage bag	Thick, greenish yellow



Integumentary

Previous Stage
3 PI from
home, approx
3 x 3 in size.
Dressing intact



INTEGUMENTARY

High risk fall / treatment interference High risk pressure ulcer **Bed Surface:** Total Care Versa Care Other: _____

INTEGUMENTARY ASSESSMENT/PLAN: _____

MOBILITY PLAN: _____

Other

OTHER	IF FEMALE < 50 YEARS: <input type="checkbox"/> PREGNANCY RULED OUT BY: <input type="checkbox"/> BLOOD TEST <input type="checkbox"/> HYSTERECTOMY	RESUSCITATION CODE: _____	
	ARMBAND ON PATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO _____	<input type="checkbox"/> CURRENT SAMPLE EXPIRES: _____	<input type="checkbox"/> CURRENT SAMPLE NOT REQUIRED
	BLOOD TRANSFUSION CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____ <small>(YYYYMMDD)</small>	<input type="checkbox"/> CURRENT SAMPLE EXPIRES: _____ <small>(YYYYMMDD)</small>	
	<input type="checkbox"/> EMOTIONAL / INFORMATIONAL SUPPORT PATIENT / FAMILY		
	CAREGIVER FOR ADL: <input type="checkbox"/> 2-3 <input type="checkbox"/> 4 or MORE	SDM Passcode: _____	Nurse's Initials: _____

8460-0580 (Rev. 2018/08/16)

PANEL 4 of 4



Resuscitation Status

This ordered resuscitation status will be viewable in the **Summaries Viewpoint**

The screenshot displays a patient's medical record in a 'Summaries Viewpoint'. The patient is Donna Sadiettest, 51 years old, with a weight of 55 kg and a PIN of 1205 54 47. Her discharge status is 'Red' and her allergies are 'Unable to Obtain/Collect'. The 'Patient Information' section shows her chief complaint as 'chest', primary physician as 'Sridhar, Kumar', and room/bed as 'AS-102-A'. Her code status is highlighted in red as 'DNAR and Restricted Resuscitation'. A tooltip is shown over this status, containing the text: 'Allow natural death if vital signs absent. NO CPR-NO DEFIBRILLATION. NO MECHANICAL VENTILATION (INVASIVE OR NON-INVASIVE). NO VASOACTIVE DRUGS. Otherwise use medical treatments/antibiotics/IV fluids as indicated to manage reversible problems.' The interface also shows sections for 'Assessments', 'Labs', 'Diagnostics (0)', 'Microbiology (0)', 'Measurements and Weights (1)', 'Consolidated Problems', 'Allergies (1)', 'Home Medications (0)', 'Medications', 'Hospital Administered Immunizations (0)', and 'Procedure History (0)'. A sidebar on the left contains a 'Menu' with various options like 'eCardex', 'Results Review', 'Form Browser', 'Orders', 'Medication List', 'MAR', 'MAR Summary', 'Allergies', 'Task List', 'Quick Orders', 'Clinical Documents/Reports', 'Documents', 'Clinical Notes Viewer', 'Blood Product Information', 'Problems and Diagnoses', 'Histories', 'Procedures and Diagnoses', 'OR Surgical Specimens', 'Patient Information', 'Client Info', and 'Infection Control'.

Hover over to view details

12 HOUR NURSING ASSESSMENT AND INTERVENTION FLOWSHEET

KEY: ✓ = Normal findings * = Significant findings

YEAR (YYYY/MM/DD):

Shift: Days Nights

NO.	NURSING ASSESSMENT/INTERVENTION	TIME											
1.	NEUROLOGICAL												
2.	RESPIRATORY												
3.	CARDIOVASCULAR												
4.	GASTROINTESTINAL												
5.	GENITO-URINARY												
6.	INTEGUMENTARY												
7.	PAIN / AGITATION / DELIRIUM / COMFORT treatment and response												
8.													
9.													
10.													
11.	ACTIVITY / MOBILITY												
12.	LAB WORK												
13.	PLAN-OF-CARE												
14.	PATIENT / FAMILY EMOTIONAL / EDUCATION												
		NURSE'S INITIALS											

NO.	TIME	SIGNIFICANT FINDINGS		INITIAL
		D = Data	A = Action R = Response / evaluation	

When to STAR & DAR

- STAR & DAR when:
 - Changes from initial assessment
 - Events happen (e.g., bedside tracheostomy, family meeting, drop in BP, etc.)
- * = Significant Findings
- ➔ = Findings remain unchanged

Reassess findings minimum every 4 hours

What does an → mean?

- The arrow means you have reassessed the findings and there has been **NO CHANGE** from the previous assessment and documentation



If you have last charted on respiratory at 0935:

D: Patient is desaturating.

A: ICU team at bedside intubating

And on reassessment @ 1200 you arrow over...

This means the patient continues to be desaturating, and the ICU team continues to be at the bedside intubating.

12 HOUR NURSING ASSESSMENT AND INTERVENTION FLOWSHEET KEY: ✓ = Normal findings * = Significant findings

YEAR (YYYY/MM/DD):

Shift: Days Nights

NO.	NURSING ASSESSMENT/INTERVENTION	TIME	1200	1300	1430	1600	1830						
1.	NEUROLOGICAL		→	*		→	*						
2.	RESPIRATORY		→			→							
3.	CARDIOVASCULAR		→			→							
4.	GASTROINTESTINAL		→			→							
5.	GENITO-URINARY		→			→							
6.	INTEGUMENTARY/BRADEN Scale		→			→							
7.	PAIN/AGITATION/DELIRIUM/COMFORT treatment and response: summary Q shift												
8.													
9.													
10.													
11.	ACTIVITY / MOBILITY / FALL RISK INTERVENTIONS												
12.	LAB WORK												
13.	PLAN-OF-CARE												
14.	PATIENT / FAMILY EMOTIONAL / EDUCATION				*								
NURSE'S INITIALS													

NO.	TIME	SIGNIFICANT FINDINGS		INITIAL
		D = Data	A = Action R = Response / evaluation	
1	1300	D - Left pupil nonreactive and larger than the right pupil. A- Notified Dr. Dre with Neurosurgery, and Dr. Imonit the CCTC resident. Will reassess hourly and report further neurological changes to teams -----		CBD
14	1430	D - Family meeting, (refer to note in progress section) A - support provided to wife & children -----		CBD
	1830	D - Both pupils now nonreactive. Patient extending without stimulation. A - Drs Dre and Imonit notified, and are assessing patient now. -----		CBD

Bedside Assessment Tools

Pain Assessment: Able to Self-Report

Pain Assessment: Able to Self-Report

Pain Assessment: Unable to Self-Report

Sedation Assessment: VAMASS

Ventilator Adjusted: Motor Assessment Scoring Scale
For unventilated patients, score MASS only. If MASS ≥ 2 , screen for delirium.

Delirium Screening in Critical Care

Critical-Care Observation Tool (CPOT)

Intensive Care Delirium Screening Checklist (ICDSC)

Patient's level of pain
The patient (showing) assess
The patient's perception
When the patient is most

MAS Score

VAP Reduction Bundle Details

- HOB Elevation:** Document HOB elevation in degrees in 24 Hour Floorchart with each change in position.
 - HOB ≥ 30 degrees such as: unclear breakdown, femur
 - If HOB < 30 degrees instability or patient
- Sedation Assessment**
 - Adjust sedative** recording the "t"
 - Q shift for 2
 - Q 4h for patient
 - Chart the V
 - At the end of overall assessment response
 - Attempt daily.** Examples of good management of sedation with small dose reduction

VAP REDUCTION BUNDLE

- HOB ≥ 30 degrees** if intubated or a tracheostomy tube is in place, except during temporary procedures (e.g., bed changes, line insertion) unless contraindicated*
- Maintain appropriate level of sedation:**
 - Adjust sedation to target VAMASS
 - Attempt daily dose reduction of continuous sedatives unless contraindicated*
- Daily SBT**
 - Screen daily for SBT readiness
 - If screen is passed, conduct SBT daily*
- Subglottic Secretion Drainage (SSD)**
 - SSD for all patients with endotracheal tube
 - If intubated without SSD, review during rounds re suitability for possible tube exchange
- Initiate safe enteral feeding within 24-48 hours** unless contraindicated*
 - Attempt small bowel placement for all feeding tubes
 - Avoid nasal placement for gastric drainage tubes; remove and replace orally within 48 hours unless contraindicated (e.g., esophageal/oral surgery or varices)
- Oral decontamination**
 - Oral hygiene with toothbrushing at least q12h per CCTC procedure (unless contraindicated*)
 - Chlorhexidine oral rinse q12h (unless contraindicated*)

- Step 1: Screen for PAIN**
- Screen using Numeric Rating Scale if able to self-report
 - Screen using CPOT if unable
- Step 2: Screen for SEDATION**
- Screen using VAMASS if ventilated
 - Screen using MASS portion if unventilated

Quality Bundles: Blood Stream Infection (BSI) Prevention

BSI Prevention Maintenance Bundle

- Perform Check**
 - Remember**
 - Avoid clutter**
 - Hair re-draping**
 - Scrub chlorhexidine**
 - Allow skin to dry**
 - Cap, m**
 - Cap an**
 - Broad**
 - Flush l**
 - The He**
 - comple**
 - or Arter**
 - these s**
- (Standards apply to BOTH central venous and arterial lines)
- Review insertion date, circumstance and need for continued line use Q shift. Lines inserted without sterile technique should be changed within 24-48 Hrs.
 - Remember the 4 Moments of Hand Hygiene when inserting and maintaining central lines.
 - Palpate and visually inspect site daily.
 - Ensure catheter securement.
 - Change transparent dressings Q7 days and any time dressings become soiled, integrity is disrupted or edges are curled.
 - Change gauze dressings daily (for inspection and skin cleansing); convert to transparent as soon as possible.
 - Use central line dressing tray kit for dressing changes.
 - Allow skin to dry a full 3 minutes after cleansing with chlorhexidine.
 - Apply Cavilon™ to the skin if patient is diaphoretic or adherence is difficult (DO NOT apply to insertion site). Cavilon™ must dry for 2 minutes prior to dressing application.
 - Apply new antiseptic cap (e.g., SwabCap™) to all injection and blood sampling ports after each access and Q 5 days (to prevent drying). If not using an antiseptic cap, scrub hub and allow 30 second dry time before accessing port.
 - Flush lines thoroughly after blood sampling. Flush EACH PICC lumen with 20 ml using turbulent flushing (stop/start technique) after blood sampling or each time a PICC is accessed.
 - Routine tubing changes:
 - TPN Q 24 hours
 - RBC & FFP tubing after 2 bags
 - platelets after every unit
 - high flow rapid infuser Q 3 hours
 - propofol Q 12 hours
 - all other sets Q 96 Hrs.
 - Maintain dedicated line for TPN.
 - Don non-sterile gloves and do not touch insertion site after skin prep for venipuncture and peripheral IV insertion.
 - Blood cultures: Our goal is a minimum of 2 sets for any culture event. If line sepsis is suspected:
 - and line in > 48 Hrs, send venipuncture AND line culture(s) and request "CAB" assessment; draw and order all samples within 15 minute timeframe
 - Identify catheter site and type (e.g., R IJ HD) and date of central and arterial catheter insertion (including PICC/HD lines) when ordering cultures
 - Document assessment findings in "Monitoring of Invasive Line Site(s)" section of the 24 Hour Flow sheet Q shift and PRN.
 - Every member of the team is expected to remind others or stop procedures if any steps are overlooked.**

Central Line

able) if MASS score is 0 or 1
ete rest of the ICDSC
se to noxious stimulus only
and continue ICDSC
ts with environment without

4, 5 or 6 and continue ICDSC
when stimulated by light touch or voice,
s or movement
ponies

ation or instructions
stimuli

in person, place or time
ring:
ns or behaviours probably due to
non-fixed object)
are fixed/unchanging)

tives or restraints
sychomotor slowing or retardation

to clinical events or situation
speech

uring the night
s during the day
do not consider wakefulness
loud extrication)
the above items (1-7) over the

instability for diagnosis of delirium
COMMUNICATED TO THE

/8

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- ▶ About Us
- ▶ Patients, Families & Visitors
- ▼ Health Professionals
 - What's New
 - Monographs
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 - Procedures
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LHSC Health Professionals

- ▶ Programs and Services with Information for Health Professionals

Standards of Nursing Care: CCTC

A-D

E-H

I-L

M-P

Q-T

U-Z

A-D

Arterial Line Monitoring

- **Bedside Assessment Tools:**

- Neuro Assessment
- Neuro Assessment Tools
- Pain, Sedation and Delirium Assessment Tools
- Safety Bundles (CLI, VAP and Procedural Pause)
- Patient Pain Communication Tool

- Cardiovascular System Monitoring
- Central Line Monitoring
- Continuous Lateral Rotation Therapy (CLRT)

Documentation

- 12 Hour Assessment and Intervention Flowsheet in CCTC
 - 12 Hour AI Flowsheet Power Point Instructions: Updated January 12, 2016
 - What's New and a few charting reminders, January 12, 2016
- 24 Hour CCTC Flowsheet
 - 24 Hour Flow Sheet Power Point Instructions: Updated April 2014
 - Changes to CCTC Flowsheet May 2014
 - Changes to 24 Hour CCTC Flowsheet January 2015

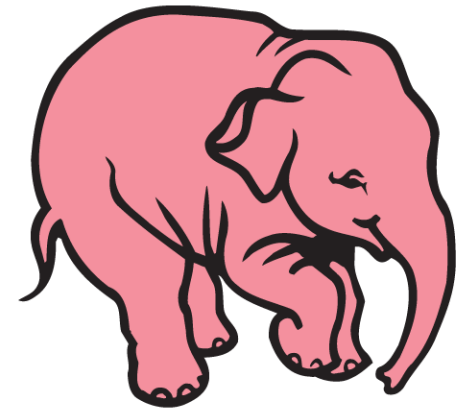
E-H

- ECG Monitoring
- Enteral Feeding and Nasal Gastric Drainage
- Fluid Balance Monitoring
- General Nursing Care
- **Hemodynamic Monitoring**
 - ECG Monitoring
 - Arterial Line Monitoring
 - Central Line Monitoring
 - Pulmonary Artery Catheter Monitoring
- Hypothermia Protocol Standards

Delirium assessment

Standards

- Screen in 2nd half of shift and document time of assessment inside the A&I sheet
- If MAAS is <2 record UTA and document reason in DAR note
- If MAAS is >2 , screen using the ICDSC checklist



DELIRIUM

Delirium Assessment

MID SHIFT ASSESSMENT (complete during hours 6-12 of each shift)

Delirium Screen

Delirium screen completed at _____

Step 1: NRS or CPOT _____

Step 2: VAMAAS _____ (MAAS < 2 | CDSC = U/A)

Step 3: ICDSC Total _____ (circle + items)

- | | |
|-----------------------------|--------------------------------------|
| 1. LOC | 5. Psychomotor agitation/retardation |
| 2. Inattention | 6. Impaired speech/mood |
| 3. Disorientation | 7. Sleep/wake disturbance |
| 4. Hallucinations/Delusions | 8. Symptom fluctuation |

Shift Summary: Pain / Agitation / Delirium

12 HOUR NURSING ASSESSMENT AND INTERVENTION FLOWSHEET KEY: ✓ = Normal findings * = Significant findings
 YEAR (YYYY/MM/DD): Shift: Days Nights

NO.	NURSING ASSESSMENT/INTERVENTION	TIME	0855	1100	1130	1200									
1.	NEUROLOGICAL					→									
2.	RESPIRATORY					→									
3.	CARDIOVASCULAR			*	*	→									
4.	GASTROINTESTINAL					→									
5.	GENITO-URINARY					→									
6.	INTEGUMENTARY/BRADEN Scale					→									
7.	PAIN/AGITATION/DELIRIUM/COMFORT treatment and response: summary Q shift														
8.	CRRT			*											
9.															
10.															
11.	ACTIVITY / MOBILITY / FALL RISK INTERVENTIONS														
12.	LAB WORK														
13.	PLAN-OF-CARE		*												
14.	PATIENT / FAMILY EMOTIONAL / EDUCATION														
NURSE'S INITIALS															

NO.	TIME	SIGNIFICANT FINDINGS D = Data A = Action R = Response / evaluation	INITIAL
13	0855	D: Rounds completed with CCTC team. Dr. Kao made aware of ongoing concerns over 1) kidney function, elevated creat with no urine output and 2) hemodynamic stability, fluctuating MAP less than 65mmg . Plan for day is to have nephrology reassess. If CRRT is warranted, CCTC team would use vasopressors to support BP. A: Nephro notified of need to reassess. -----CB D	
8, 3	1100	D: Nephro in to reassess and Rt fem dialysis catheter inserted by Dr Prize CRRT started per orders. MAP dropped below target of 65. CCTC Jr. Dr. Smith aware A: orders received for norepinephrine infusion and titrated to achieve ordered MAP target -----CBD	
3	1130	R: MAP over 65, continuing to titrate norepinephrine-----CB D	

References

- All Standards of Care, Protocol and Procedures are from the Critical Care Trauma Website. Retrieved on Jan 2 2017:
http://www.lhsc.on.ca/About_Us/CCTC/