London Health Sciences Centre

Standards of Care & Documentation:

The A & I Flowsheet

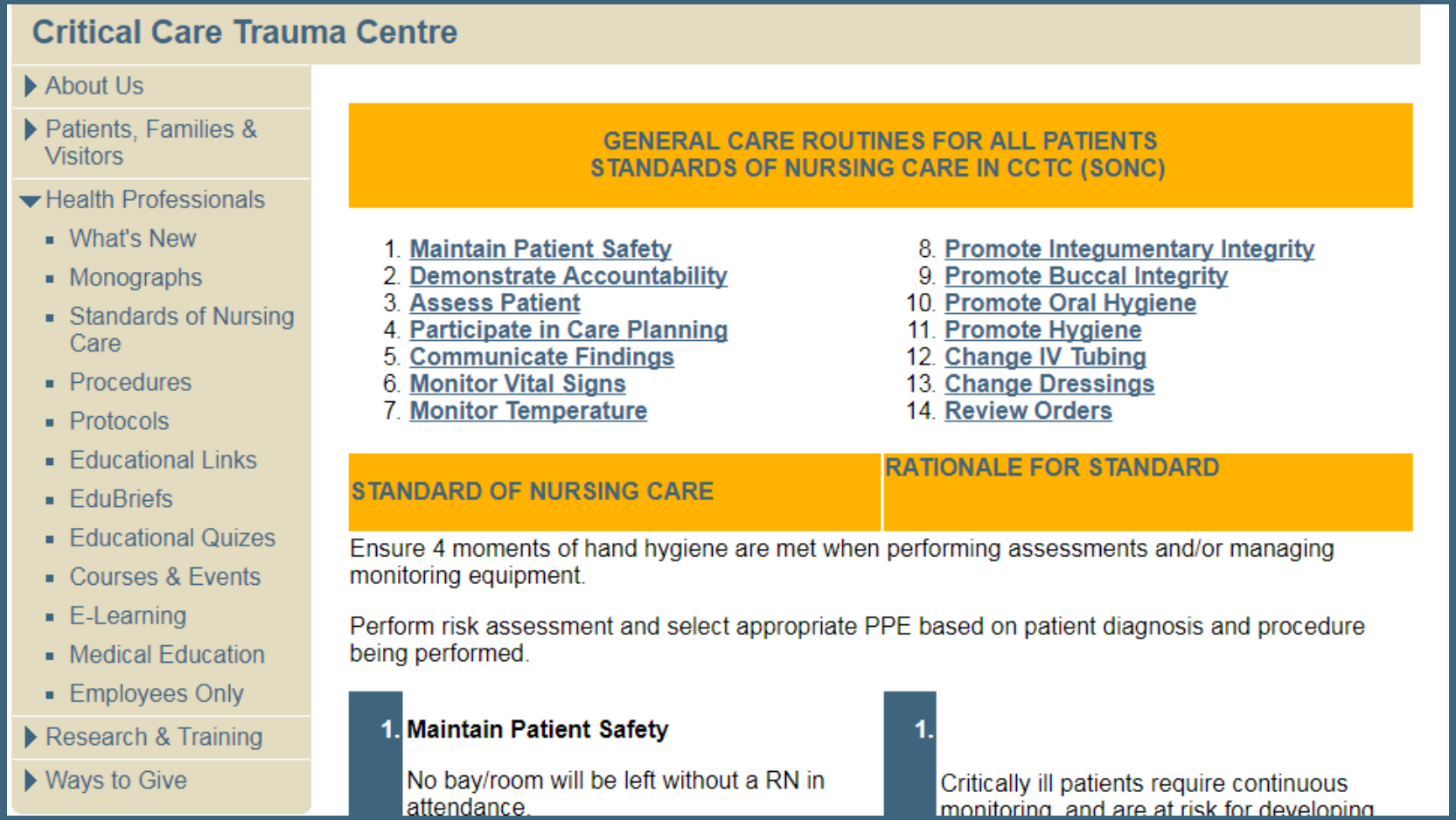
CCTC SITE SPECIFIC NURSING ORIENTATION

SEPT 2019

CCTC Standards

GENERAL NURSING CARE

Critical Care Trauma Centre Website



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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

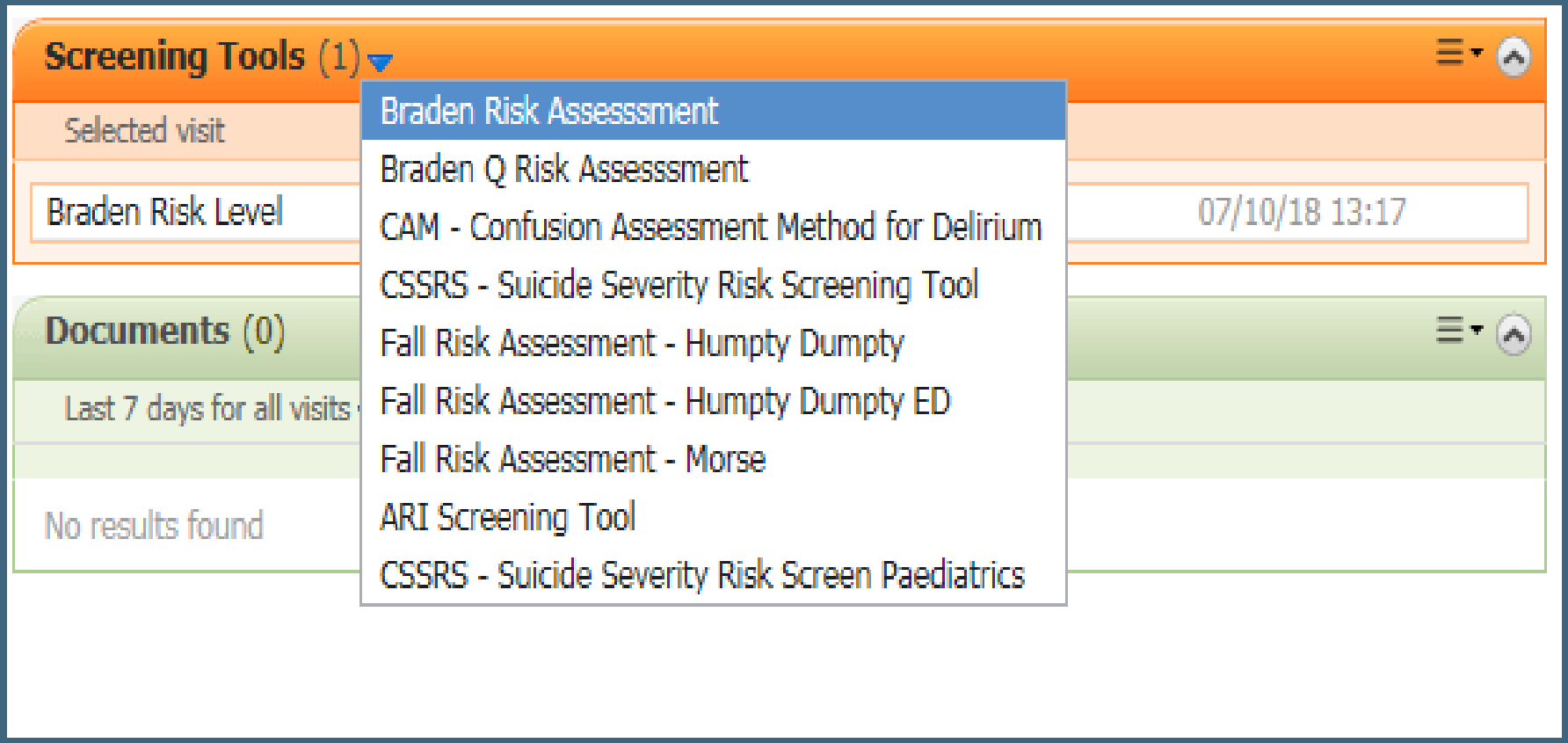
General Nursing Care Standards: Skin Integrity and Hygiene

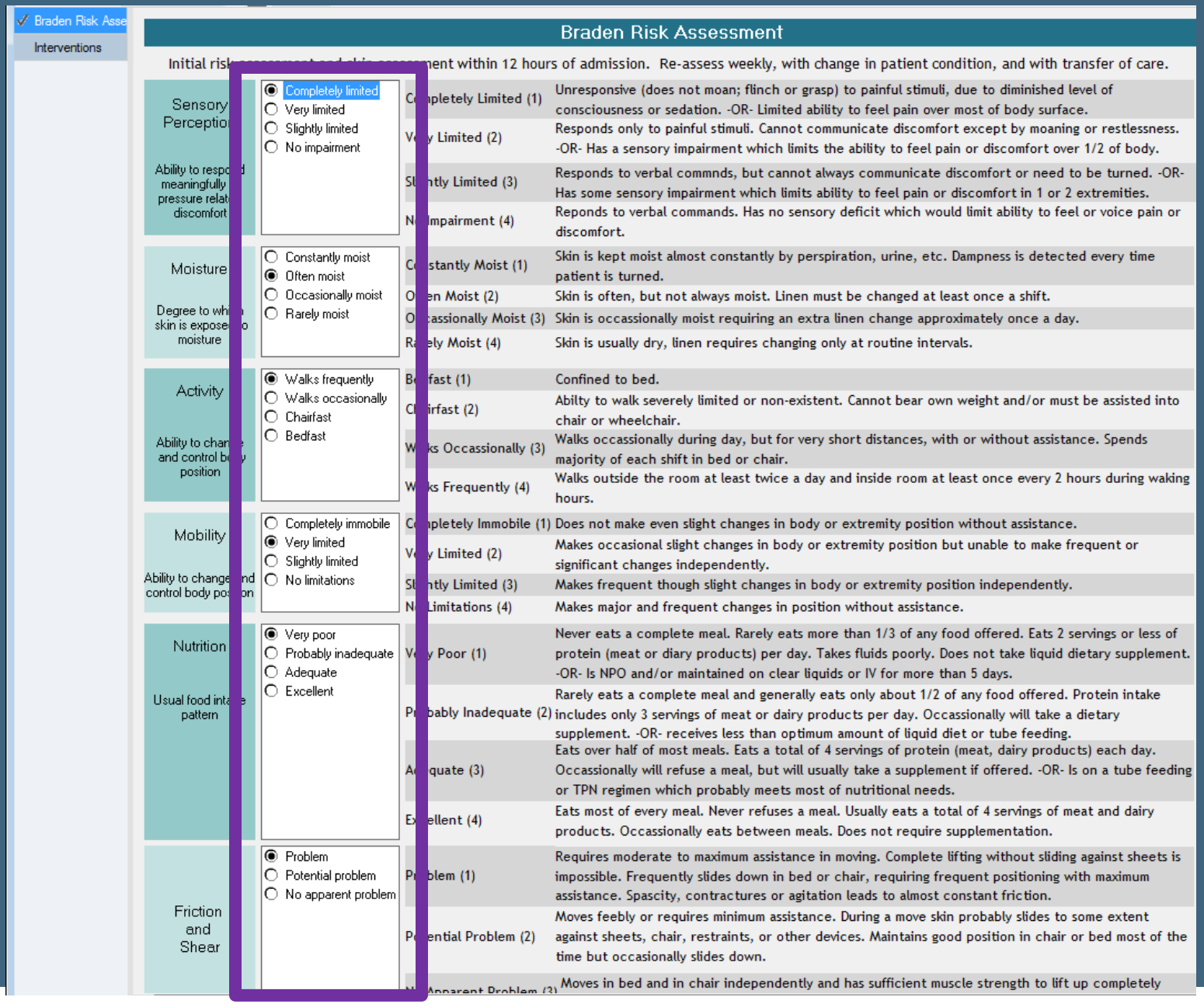
- Full bath early in night shift with
- Peri-care/catheter care is provided every 6-12hr and PRN
- Hair wash weekly and PRN

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





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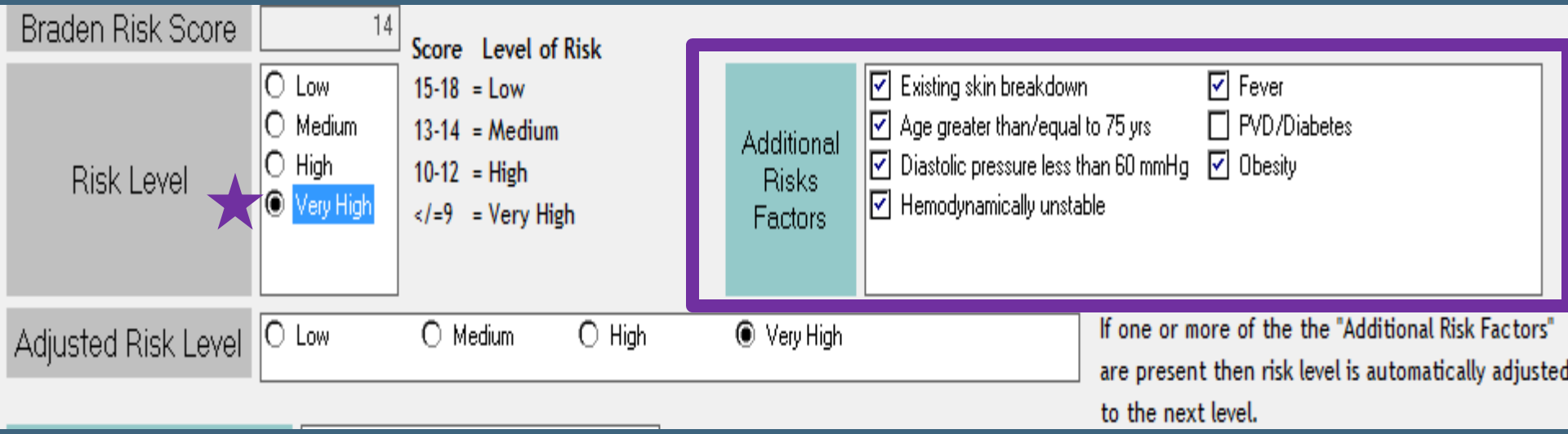
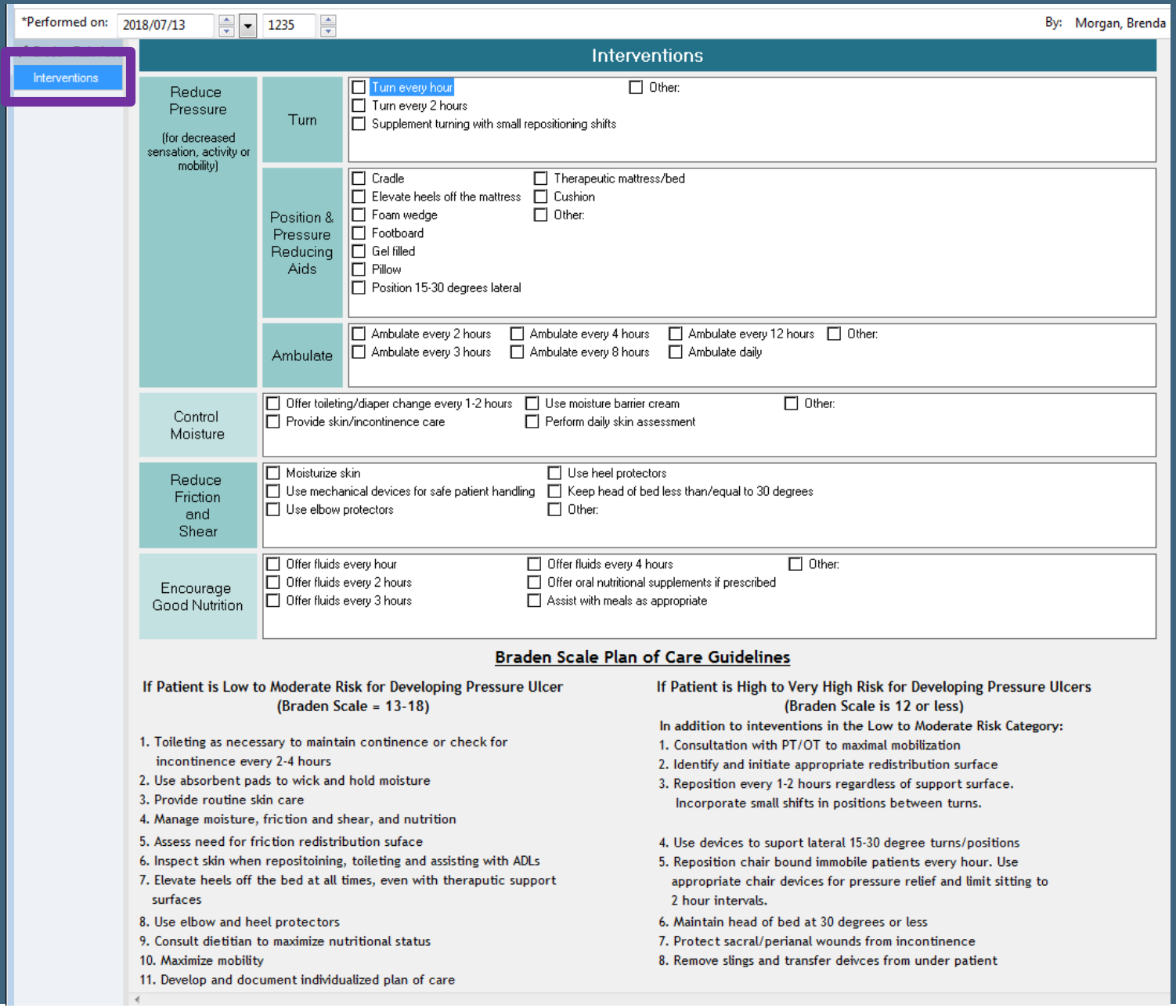

Braden Risk Score
14
Score Level of Risk
15-18 = Low
13-14 = Medium
10-12 = High
</=9 = Very High
Risk Level
Low
Medium
High
Very High
Additional Risks Factors
Existing skin breakdown
Age greater than/equal to 75 yrs
Diastolic pressure less than 60 mmHg
Hemodynamically unstable
Fever
PVD/Diabetes
Obesity
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.



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Critical Care Falls Risk & Treatment Interference

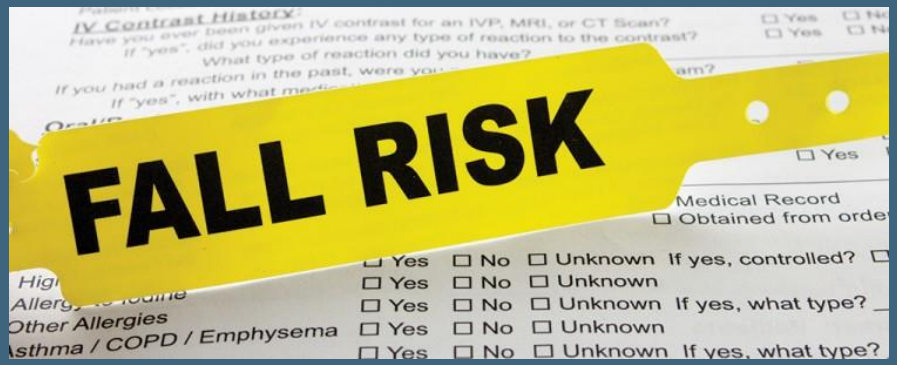
All patients in adult critical care will be deemed "high risk for falls and treatment interference", therefore, Falls risk screening will not be required until transfer.

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.



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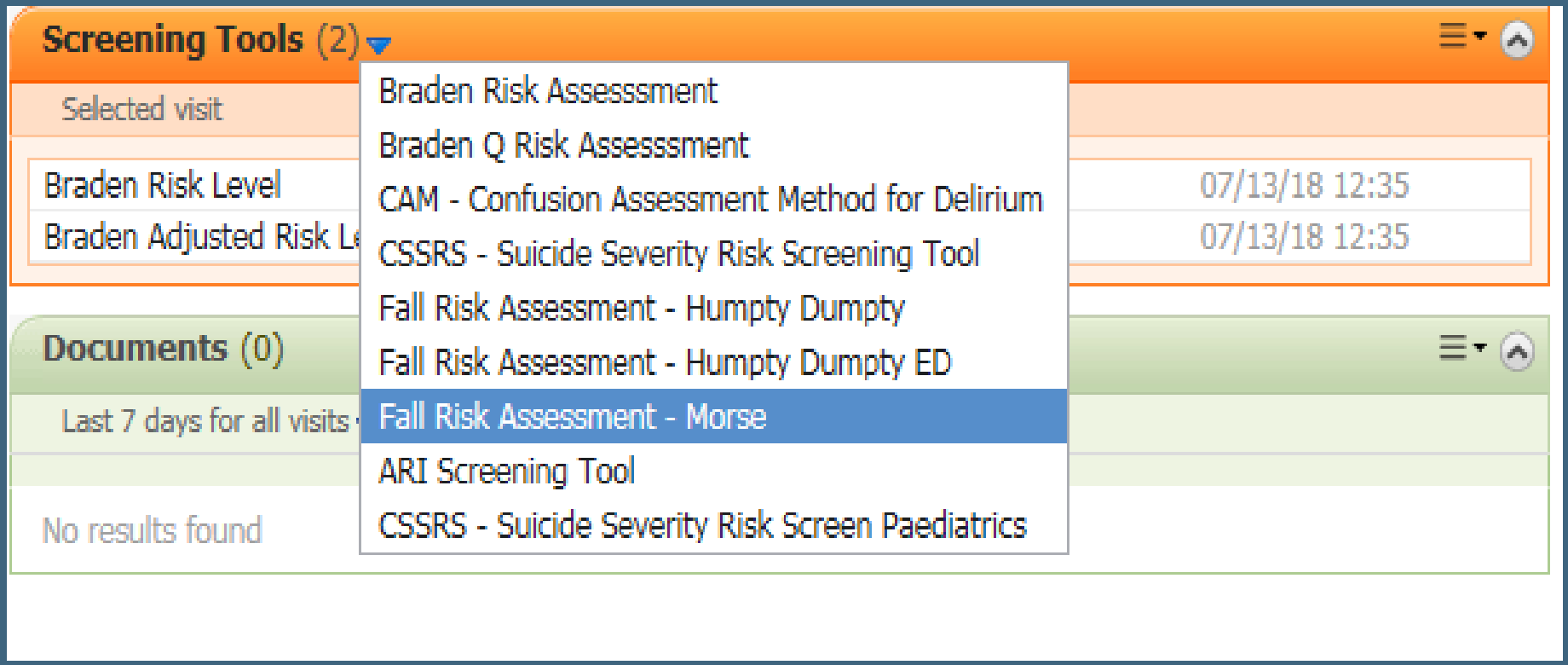
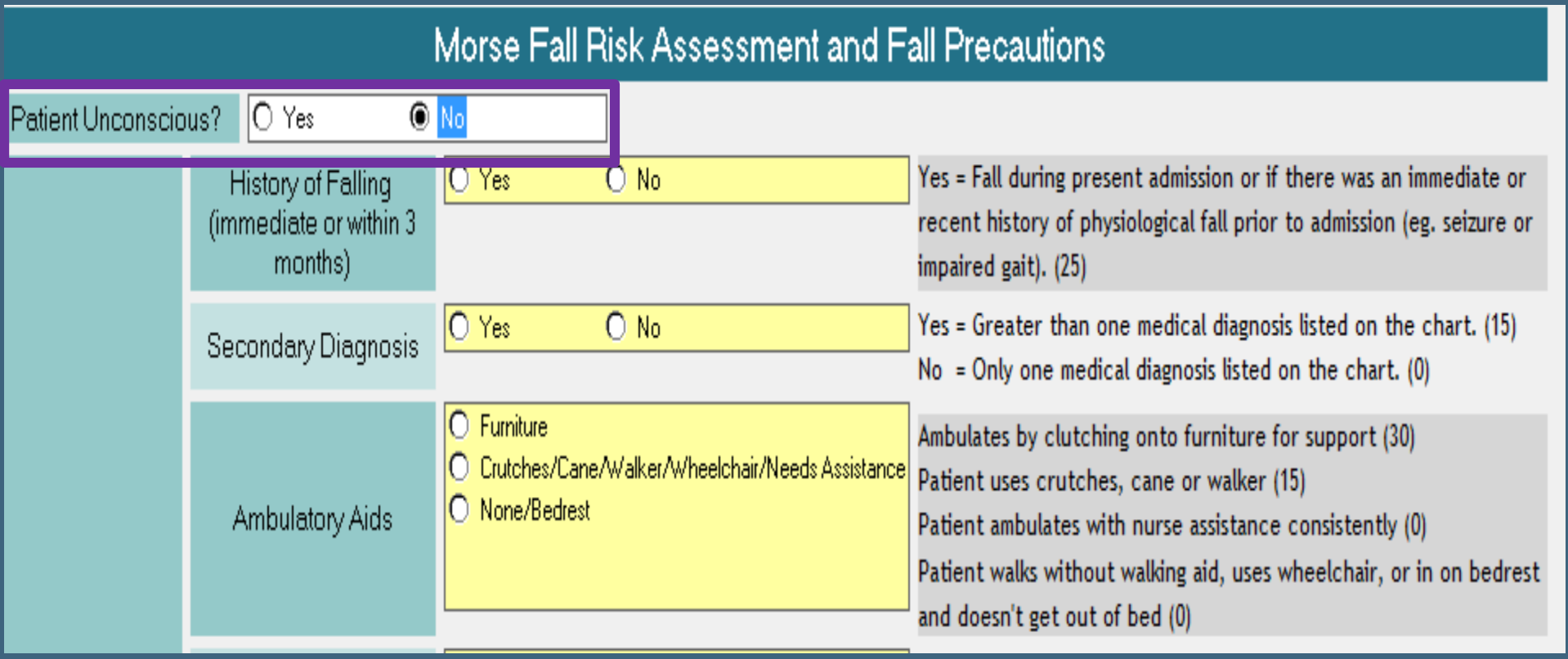
Falls Risk Assessment (Morse) Screening Tool




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? ○ Yes ◉ No

Morse Fall Scale Risk Factor

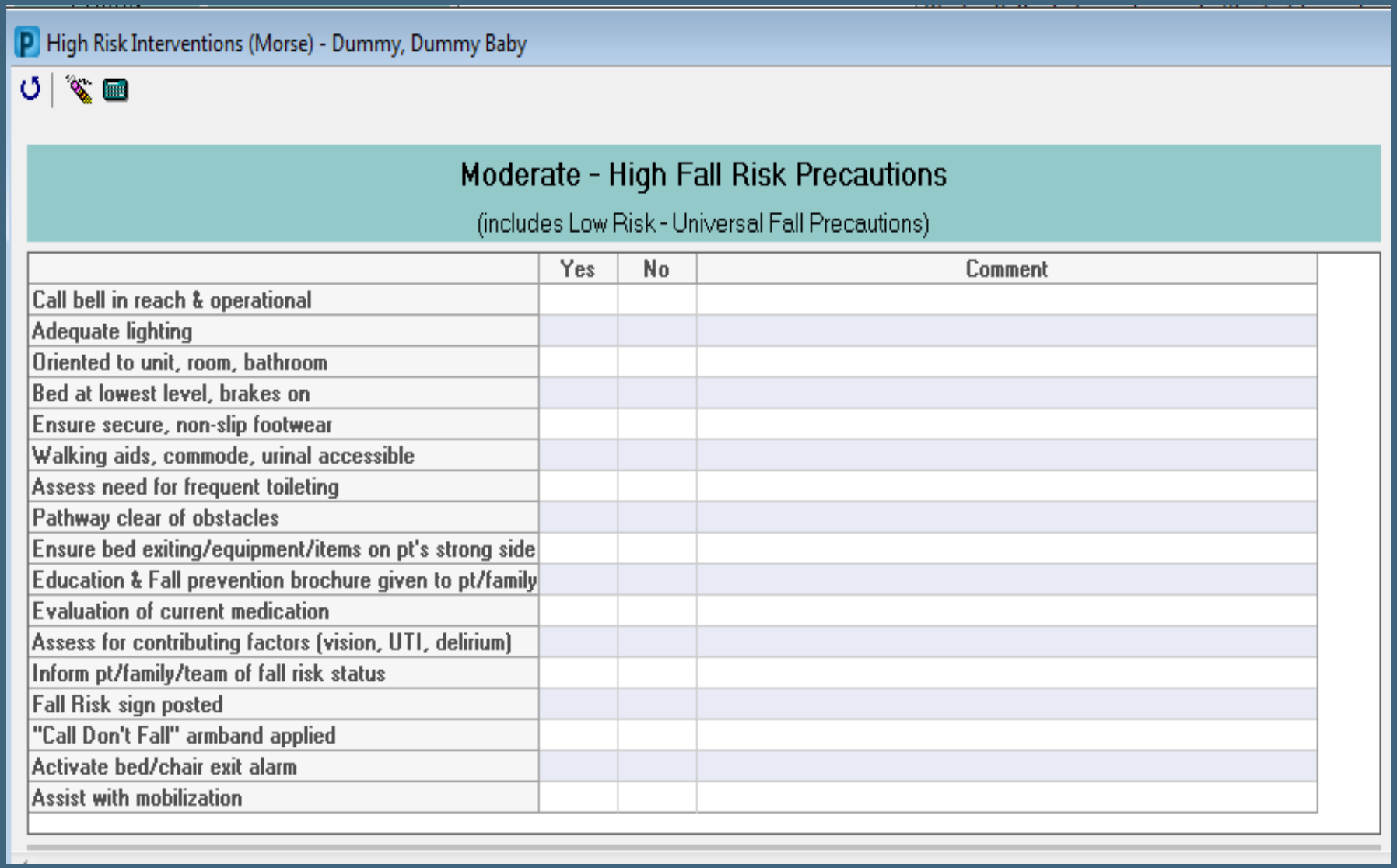
History of Falling (immediate or within 3 months)	○ Yes ○ No	Yes = Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (eg. seizure or impaired gait). (25)
Secondary Diagnosis	○ Yes ○ No	Yes = Greater than one medical diagnosis listed 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)
IV/Saline Lock	○ Yes ○ No	IV apparatus or saline lock (20)
Gait/Transferring	○ Impaired ○ Weak ○ 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	○ Forgets limitations ○ 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		
Fall Risk Level	○ Low ○ 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

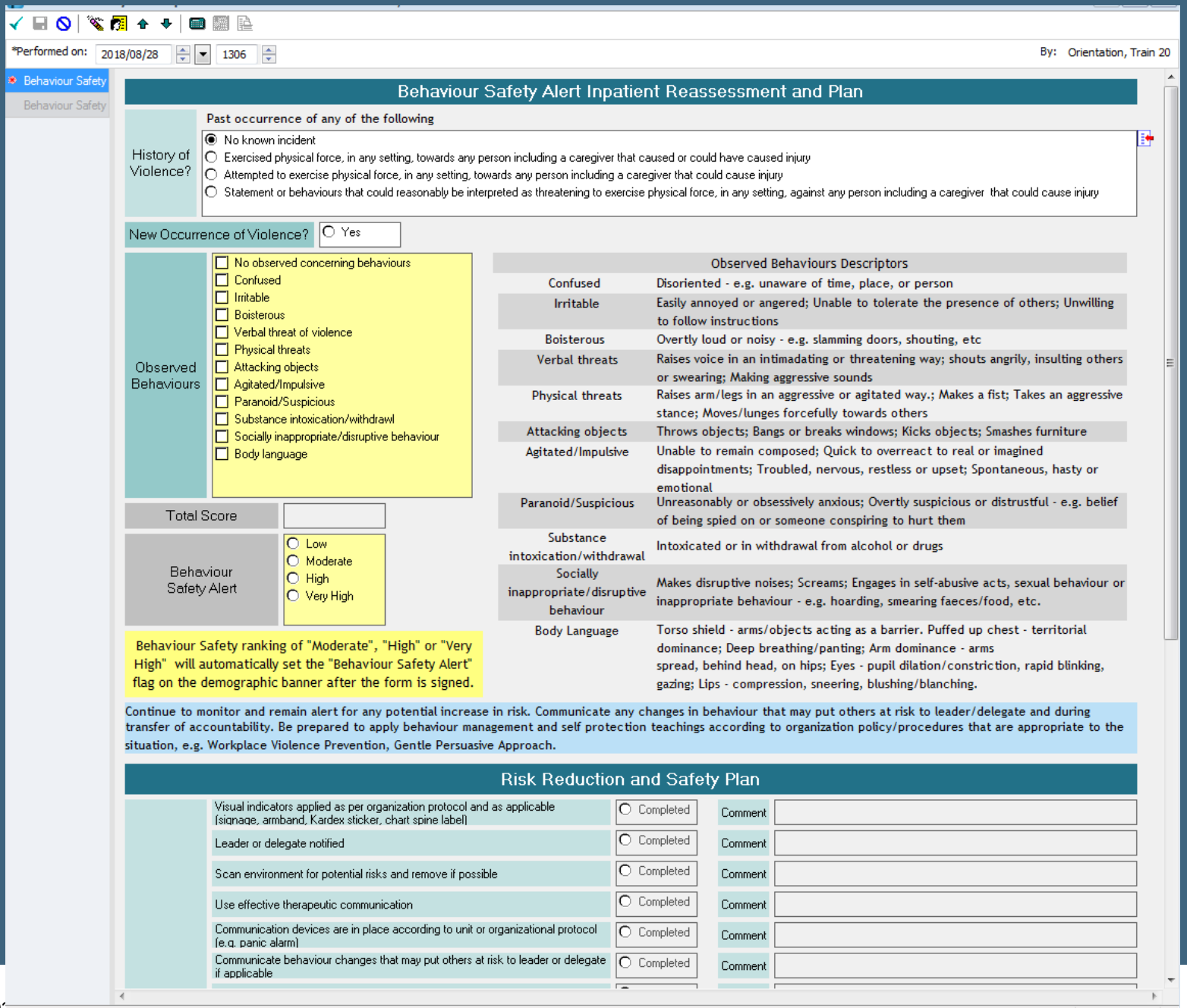
* Consider placement in room near nursing station or in an area of high visiblity
* Consider assistance from family members
* Consider observation care with leadership approval
* Consider referrals as specific risk factors are identified to reduce risk of fall or repeat falls
* Consider need for medication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


High Risk Interventions (Morse) - Dummy, Dummy Baby
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


*Performed on: 2018/08/28 1306
By: Orientation, Train 20
Behaviour Safety
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/withdrawl
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 intimadating 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)
Completed
Comment
Leader or delegate notified
Completed
Comment
Scan environment for potential risks and remove if possible
Completed
Comment
Use effective therapeutic communication
Completed
Comment
Communication devices are in place according to unit or organizational protocol (e.g. panic alarm)
Completed
Comment
Communicate behaviour changes that may put others at risk to leader or delegate if applicable
Completed
Comment

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

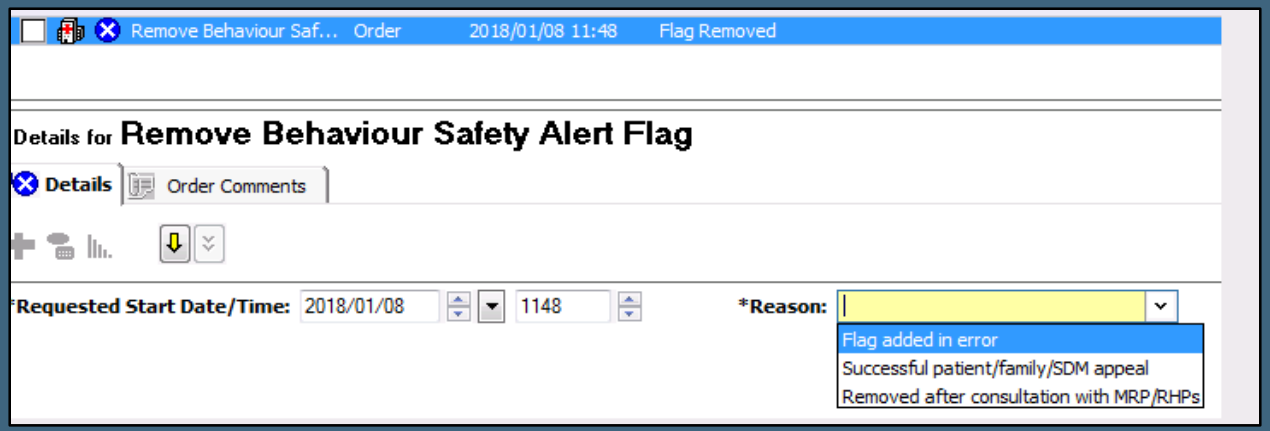
Applying a Purple Armband Conversation

- “Your loved on 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



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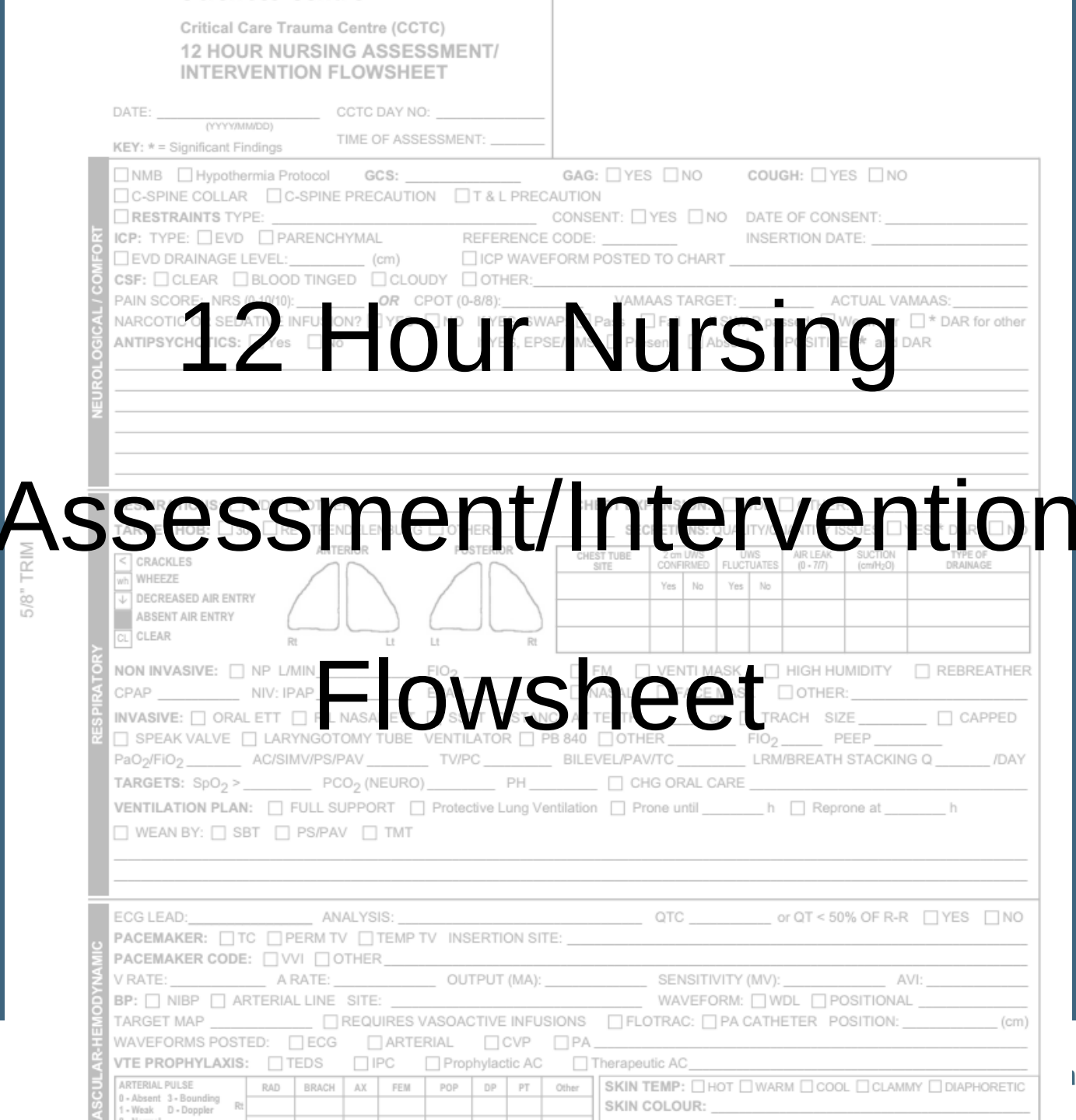
When I eat too much dessert, I don't post about it on Facebook.

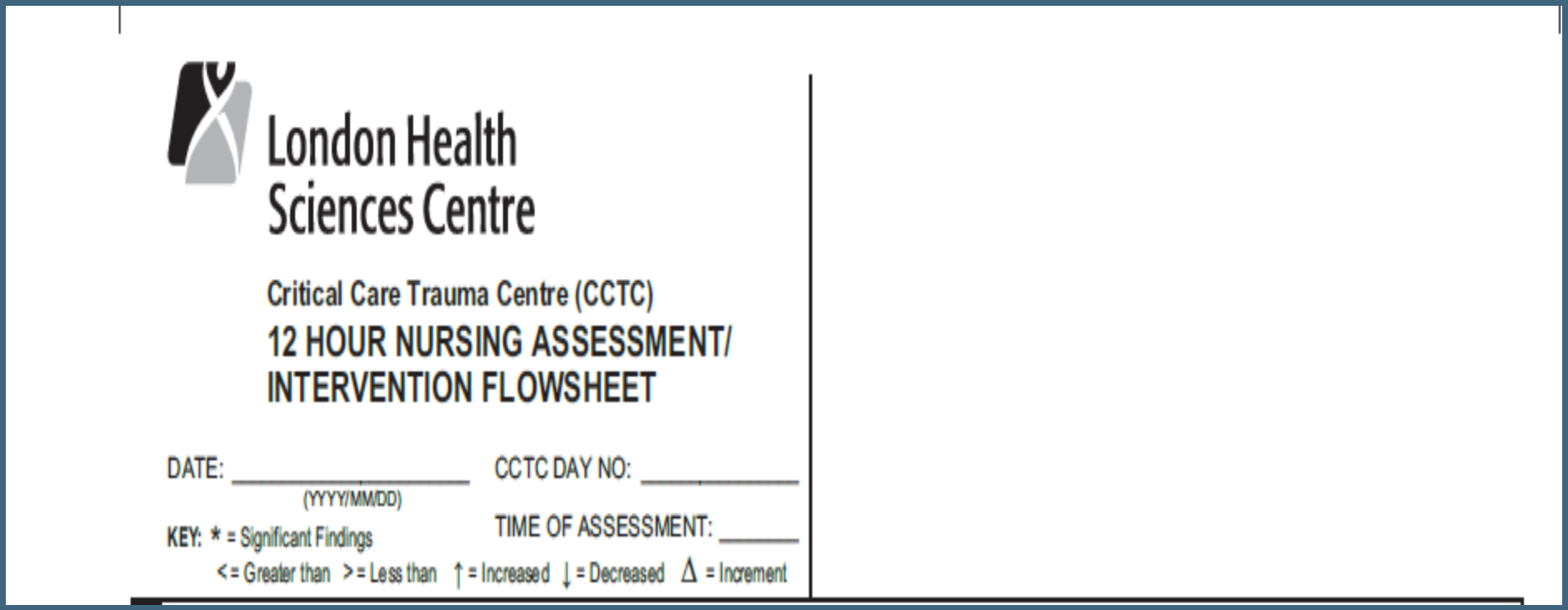
Because if it isn't charted, it didn't happen.

Robb Hillman Coaching - Life Coaching for Nurses

12 Hour Nursing Assessment/Intervention Flowsheet



Patient Identifier/Date



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Critical Care Trauma Centre (CCTC)

12 HOUR NURSING ASSESSMENT/ INTERVENTION FLOWSHEET

DATE: _____ (YYYY/MM/DD)

CCTC DAY NO: _____

TIME OF ASSESSMENT: _____

KEY: * = Significant Findings

<= Greater than >= Less than ↑ = Increased ↓ = Decreased Δ = Increment

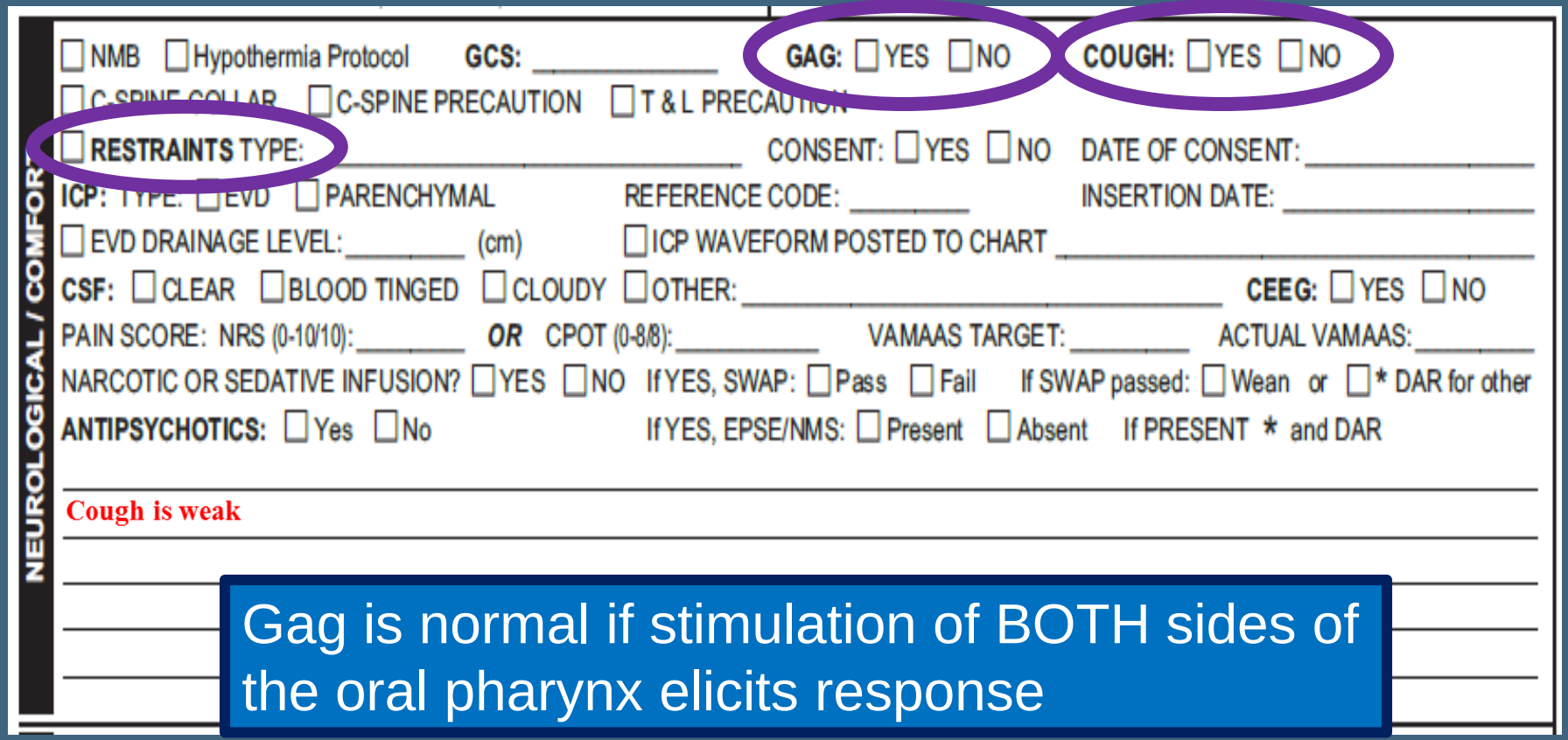
2 Patient Identifiers

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

NEUROLOGICAL / COMFORT

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

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

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☐ 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

_____

_____

_____

_____

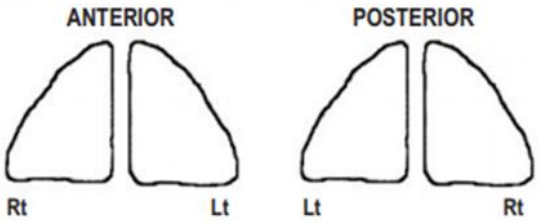
_____

Respiratory

RESPIRATIONS: ☐ WDL ☐ OTHER: _____ **CHEST EXPANSION:** ☐ WDL ☐ OTHER: _____

TARGET HOB: ☐ 30° ☐ REV TRENDELENBURG ☐ OTHER: _____ **SECRETIONS:** QUALITY/QUANTITY ISSUES ☐ YES * DAR ☐ NO

< CRACKLES
wh WHEEZE
↓ DECREASED AIR ENTRY
■ ABSENT AIR ENTRY
CL CLEAR



CHEST TUBE SITE	2 cm UWS CONFIRMED		UWS FLUCTUATES		AIR LEAK (0 - 7/7)	SUCTION (cmH_2O)	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: FiO_2 ☐ 92-96% ☐ 88-92% ☐ Other: _____ pH ☐ 7.30-7.40 ☐ PCO_2 (Neuro) _____ ☐ Other: _____

Mechanical Ventilation: ☐ PB840 ☐ HG5 ☐ Other: _____ FiO_2: _____ PaO_2/FiO_2: _____ 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

CARDIOVASCULAR/HEMODYNAMIC

ARTERIAL PULSE 0-Absent 1-Weak 2-Normal 3-Bounding D-Doppler		RAD	BRACH	AX	FEM	POP	DP	PT	Other
	Rt								
	Lt								

SKIN TEMP: ☐ HOT ☐ WARM ☐ COOL ☐ CLAMMY ☐ DIAPHORETIC

SKIN COLOUR: _____

CAPILLARY REFILL: ☐ BRISK ☐ PROLONGED

CONTINUOUS ECG: ☐ 5 LEAD ☐ 12 LEAD PRIMARY LEAD: _____ ANALYSIS: _____ QTc _____ ΔQTc _____

PACEMAKER: ☐ TC ☐ Temp TV ☐ Perm Site: _____

Type: ☐ VVI or ☐ _____ V Rate: _____ A Rate: _____

Output (MA) V: _____ A: _____ Sense (MV) V: _____ A: _____

Other: ☐ PPV ☐ FloTrac ☐ VV ECMO ☐ VA ECMO

Target MAP: _____ ☐ In target ☐ Requires vasoactive agents

Art Line Site: _____ ☐ Normal Waveform ☐ Positional

Waveforms Posted: ☐ ECG ☐ Art ☐ CVP

☐ PAP PA catheter position: _____(cm)

VTE PROPHYLAXIS: ☐ TEDS ☐ IPC ☐ Prophylactic / Therapeutic AC ☐ IVC Filter

Nurse's Initials: _____

8460-0580 (Rev. 2018/08/24) REFERENCE SONC CRITICAL CARE TRAUMA CENTRE PANEL 1 of 4

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 0 - Absent 3 - Bounding 1 - Weak D - Doppler 2 - Normal		RAD	BRACH	AX	FEM	POP	DP	PT	Other
	Rt								
	Lt								

SKIN TEMP: ☐ HOT ☐ WARM ☐ COOL ☐ CLAMMY ☐ DIAPHORETIC

SKIN COLOUR: _____

CAPILLARY REFILL: ☐ BRISK ☐ PROLONGED

CONTINUOUS ECG: ☐ 5 LEAD ☐ 12 LEAD PRIMARY LEAD: _____ ANALYSIS: _____ QTc _____ ΔQTc _____

PACEMAKER: ☐ TC ☐ Temp TV ☐ Perm Site: _____

Type: ☐ VVI or ☐ _____ V Rate: _____ A Rate: _____

Output (MA) V: _____ A: _____ Sense (MV) V: _____ A: _____

Other: ☐ PPV ☐ FloTrac ☐ VV ECMO ☐ VA ECMO

Target MAP: _____ ☐ In target ☐ Requires vasoactive agents

Art Line Site: _____ ☐ Normal Waveform ☐ Positional

Waveforms Posted: ☐ ECG ☐ Art ☐ CVP

☐ PAP PA catheter position: _____(cm)

VTE PROPHYLAXIS: ☐ TEDS ☐ IPC ☐ Prophylactic / Therapeutic AC ☐ IVC Filter

Nurse's Initials: _____

8460-0580 (Rev. 2018/08/24) REFERENCE SONC CRITICAL CARE TRAUMA CENTRE PANEL 1 of 4

Capillary Refill

- Testing Capillary Refill

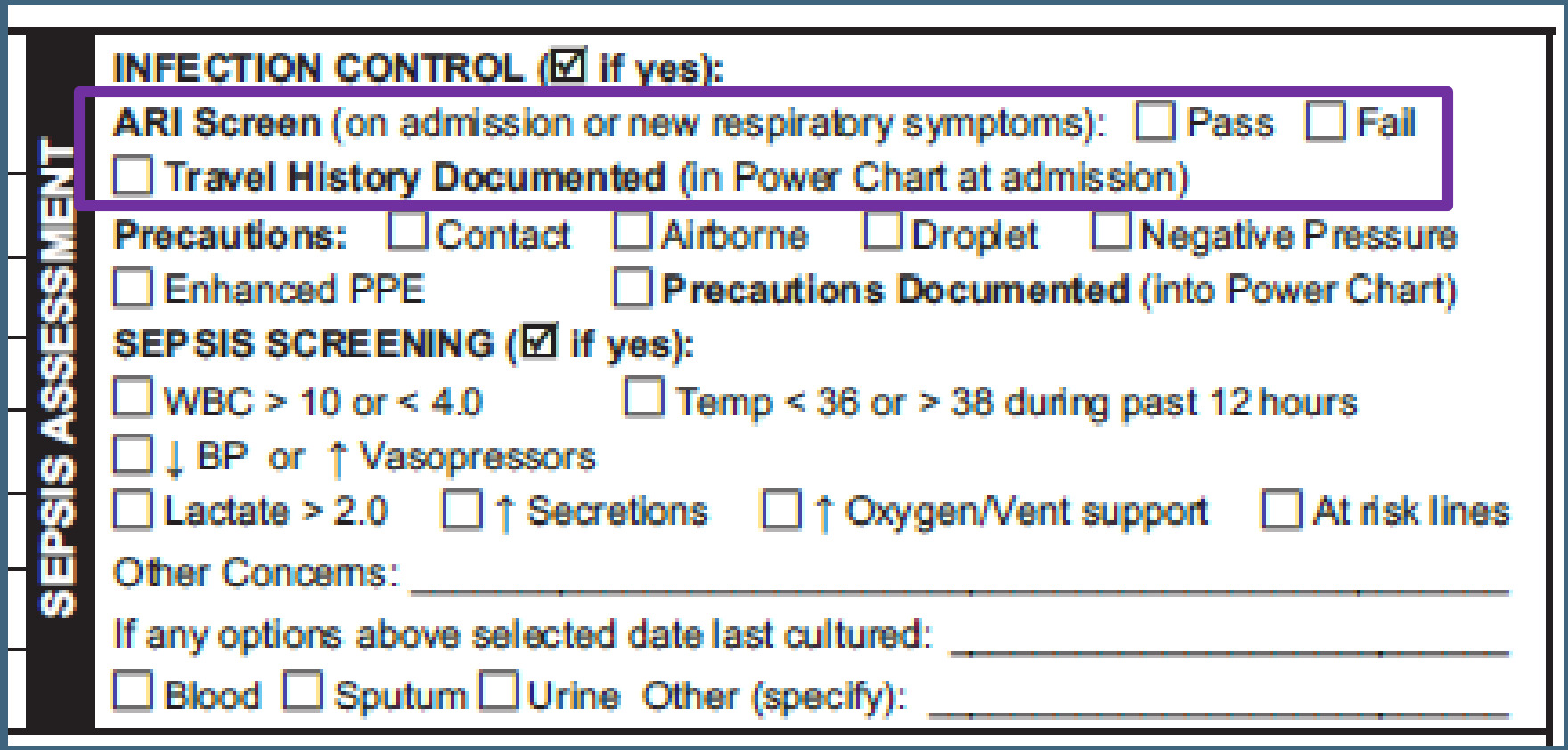
1. Hold hand above the heart
2. Apply light pressure to blanch the fingernail bed
3. Release and measure the time until the circulation returns to normal

- 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 forehand #18 PIV	Heparin Infusion

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

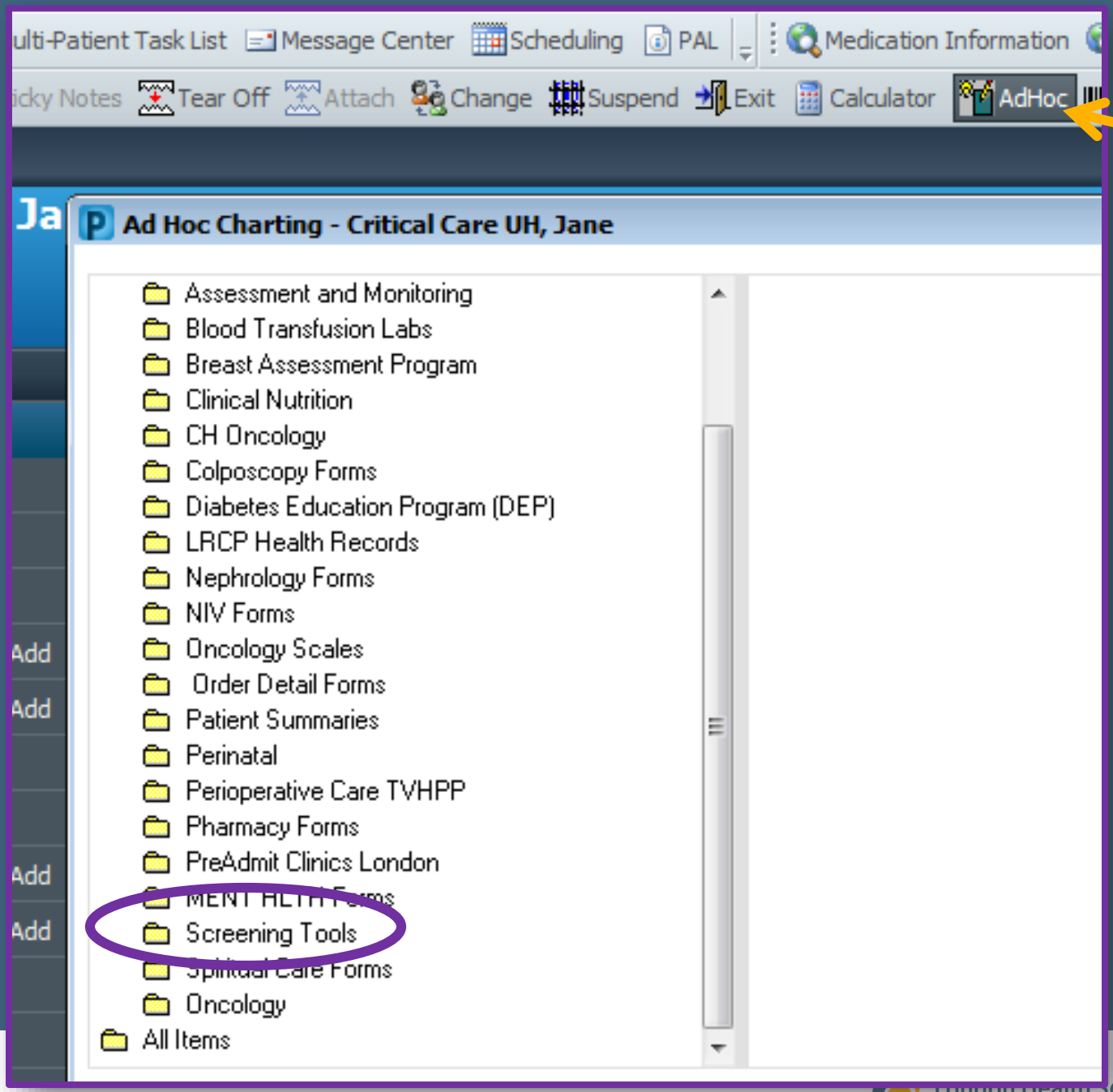
☐ ↓ BP or ↑ Vasopressors

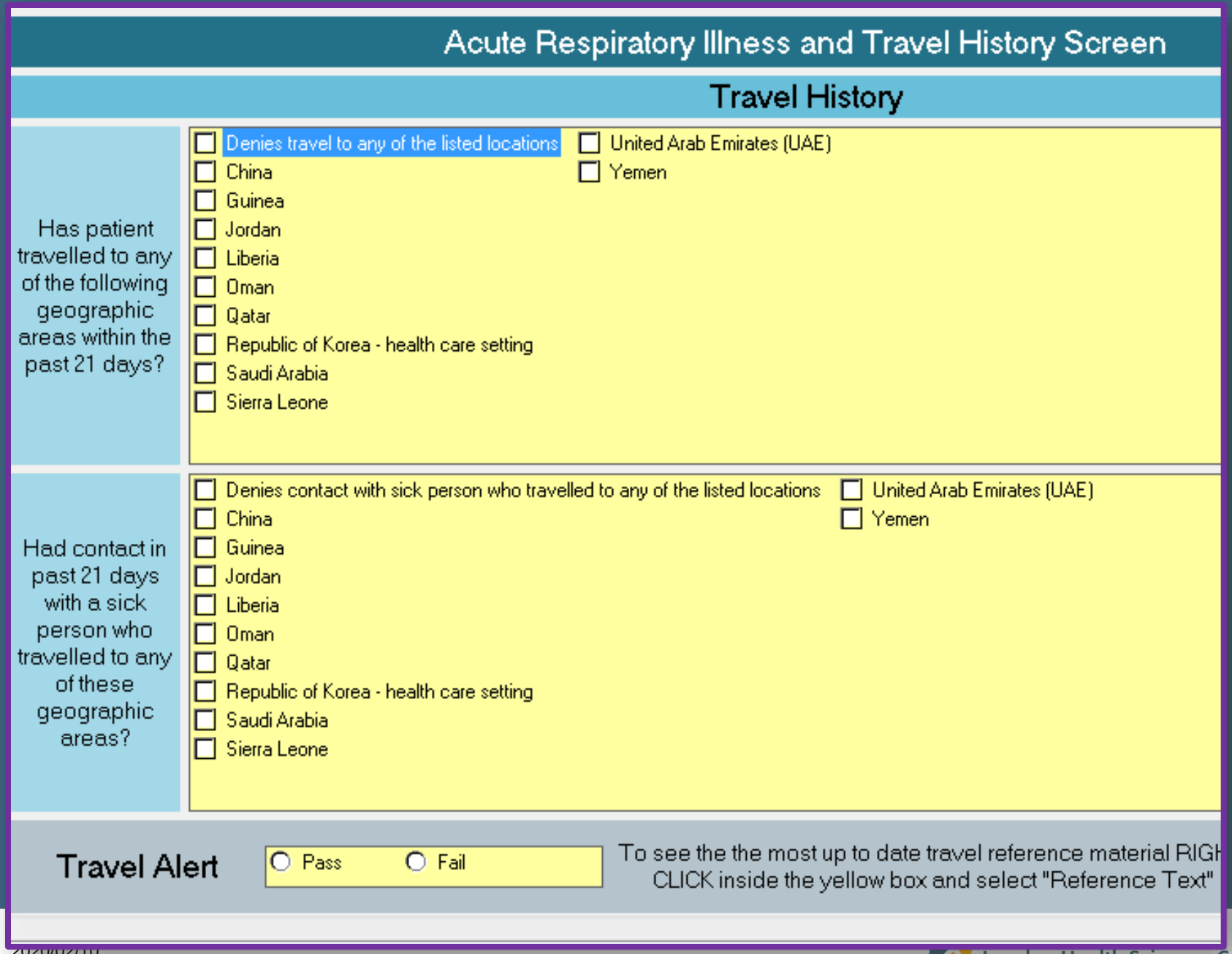
☐ Lactate > 2.0 ☐ ↑ Secretions ☐ ↑ Oxygen/Vent support ☐ At risk lines

Other Concerns: _____

If any options above selected date last cultured: _____

☐ Blood ☐ Sputum ☐ Urine Other (specify): _____


ulti-Patient Task List
Message Center
Scheduling
PAL
Medication Information
icky Notes
Tear Off
Attach
Change
Suspend
Exit
Calculator
AdHoc
Ja
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)
LRCP Health Records
Nephrology Forms
NIV Forms
Oncology Scales
Order Detail Forms
Patient Summaries
Perinatal
Perioperative Care TVHPP
Pharmacy Forms
PreAdmit Clinics London
Screening Tools
Oncology
All Items
Add
Add
Add
Add


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 RIGH
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 ☐ Diarrhea ☐ Rash ☐ Severe headache ☐ Sore throat ☐ Vomiting	

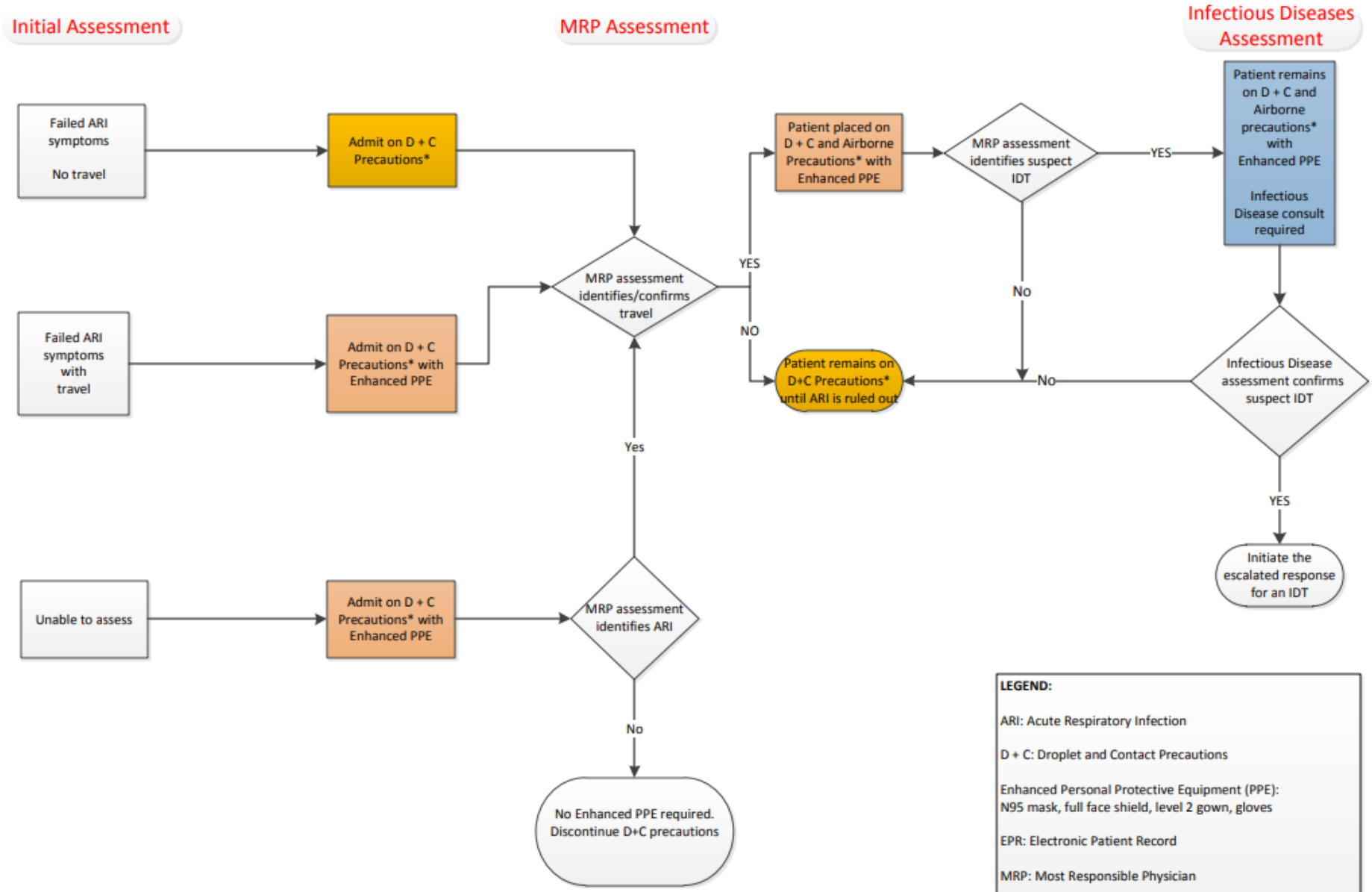
Acute Respiratory Illness (ARI) Screen ○ Pass ○ Fail

Travel & Symptom Screen ○ Pass ○ Fail

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

December 2016

Adult Critical Care Department Flow Map for Travel/Symptom Screening



*Ensure signage posted and precaution order in PowerChart

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

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

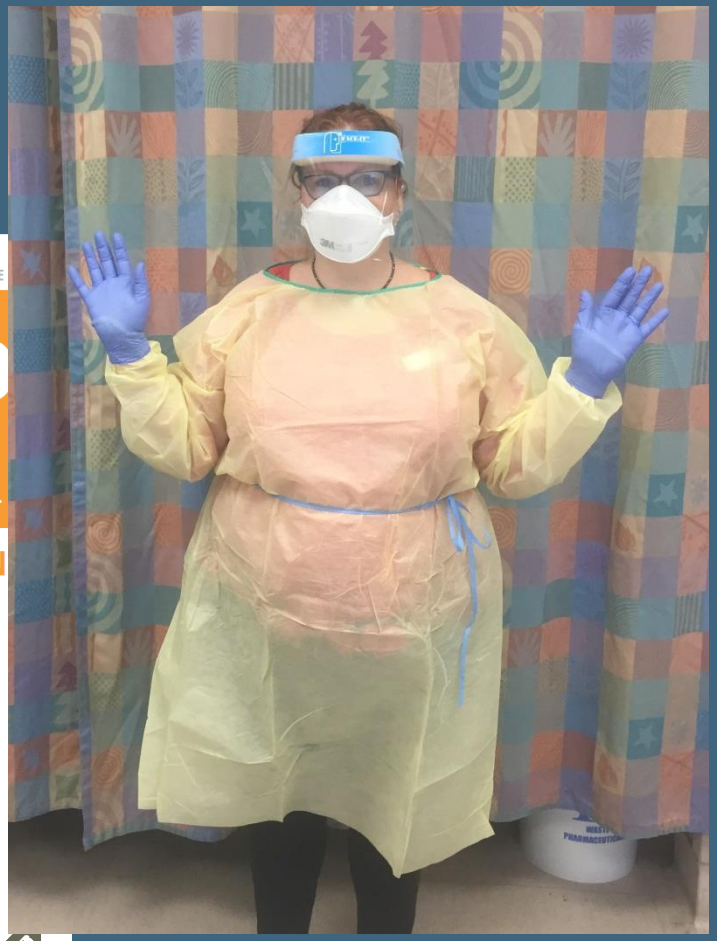
STOP

Visitors: Speak to a nurse before entering this room.

ROPLET + CONTACT PRECAUTION

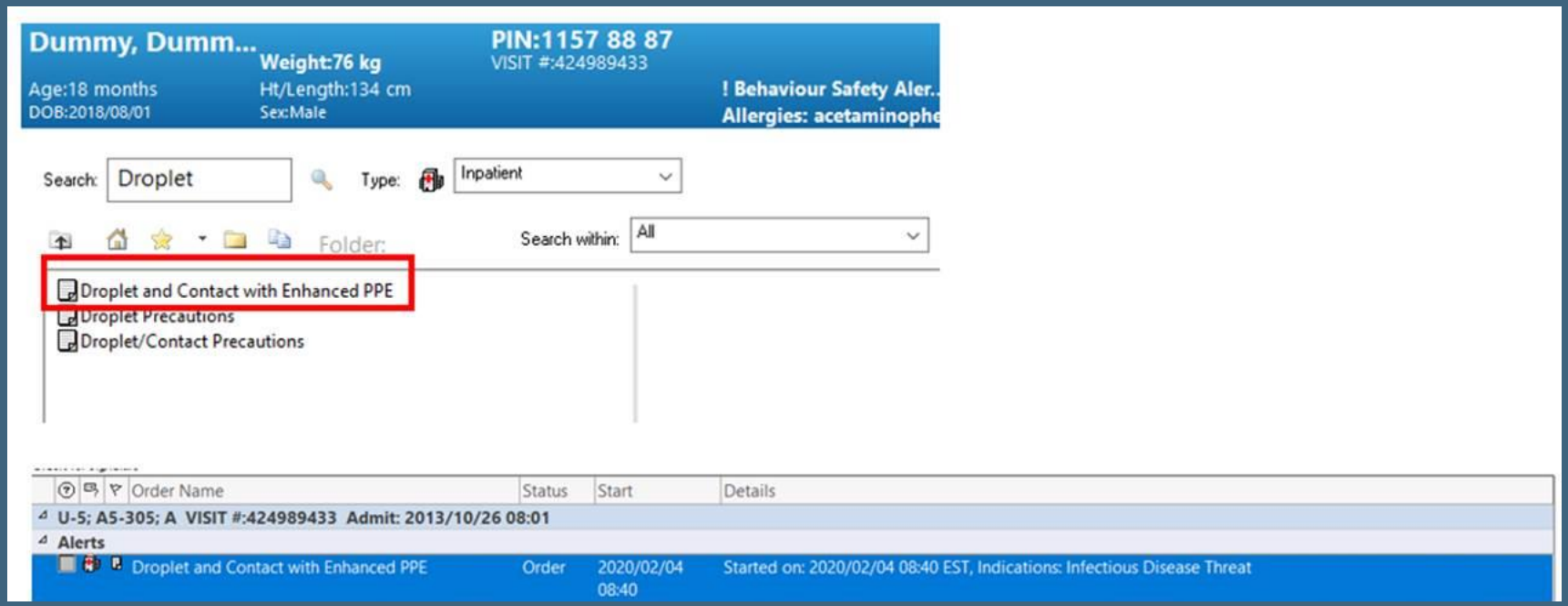
- Procedure/surgical mask and protective eyewear required within 2 metres of patient
- Gloves required for all patient/ patient environment contact
- Long-sleeved gown required if skin or clothing will contact patient/patient environment
- Patient to wear a procedure/surgical mask for transport
- Use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

OVER



Droplet + Contact with Enhanced PPE

- Order as Droplet/Contact with **Enhanced PPE**



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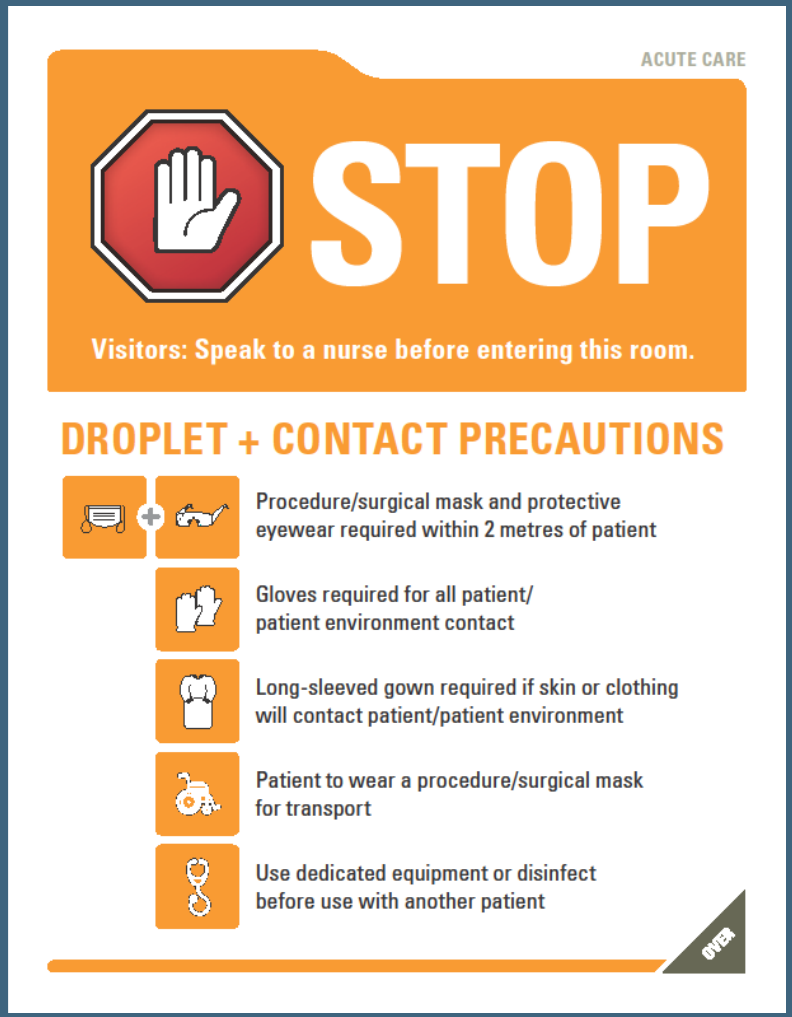
Droplet + Contact Precautions

- Acute respiratory infection (undiagnosed)
- Pneumonia
- Influenza



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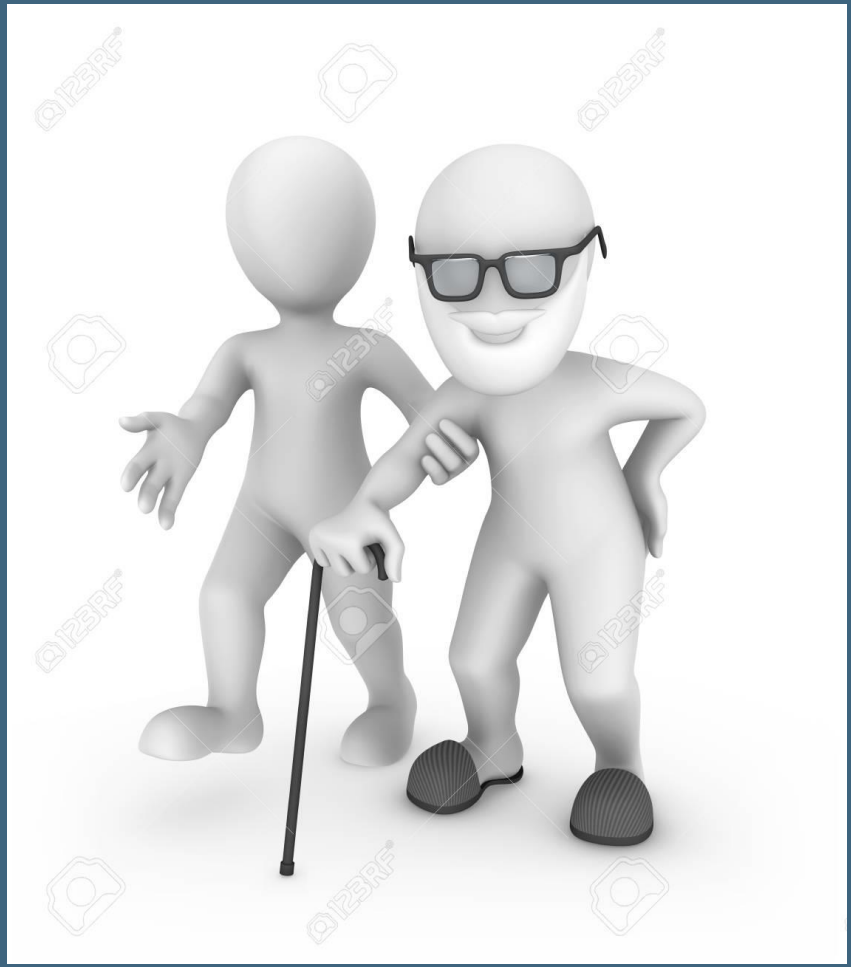
Droplet + Contact Precautions

- 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

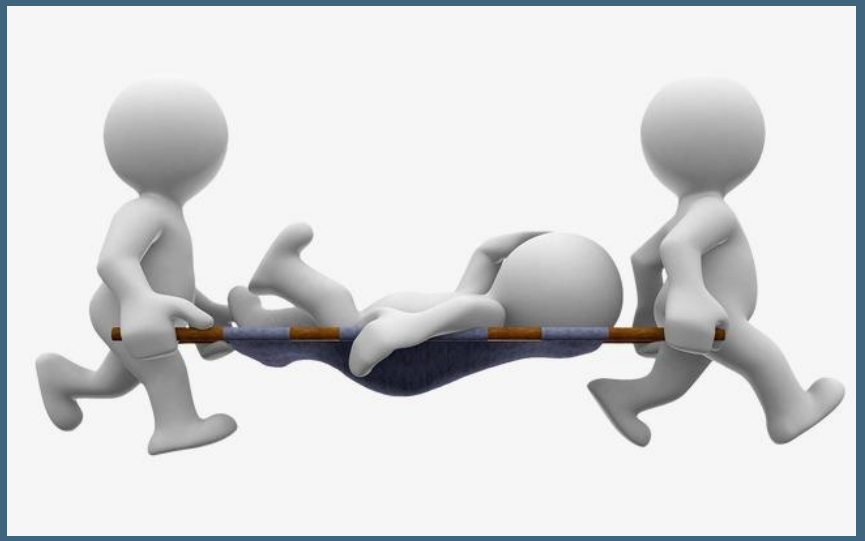
- Wear gloves and gown if providing DIRECT care
- Wear procedure/surgical mask and eye protection within 2 metres of patient
- Visitors are to perform hand hygiene prior to entering and exiting the room and removal of PPE



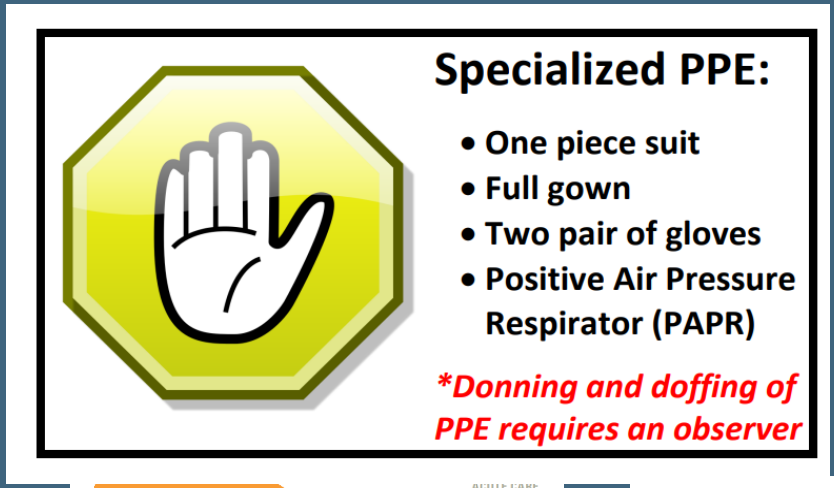
Droplet + Contact Precautions

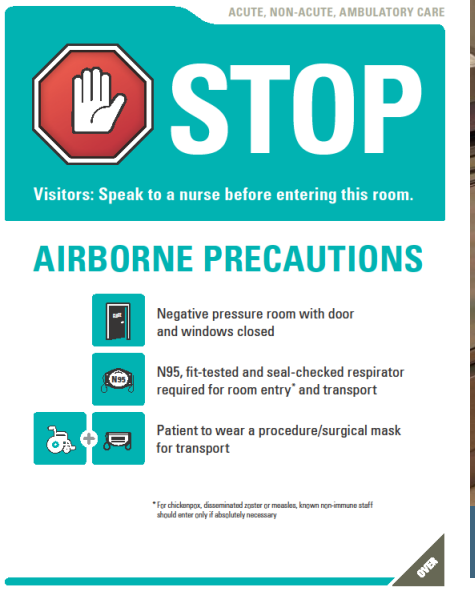
Transporting

- 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





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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

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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 infectioncontrollhsc@lhsc.on.ca

ONLINE CONSULT REQUEST FORM

London Health Sciences Centre

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*

Centre

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: • The quantity/form of the illicit drug or unknown substance • The type of packaging • The chance of exposure for the health care worker
Low Risk	• Intact dosage forms, i.e. pill, capsules • Unknown substance is contained in a sealed container/baggie • Low chance of exposure
High Risk	• 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

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Double bag the substance using a biohazard bag:

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Doffing PPE

Call Security:

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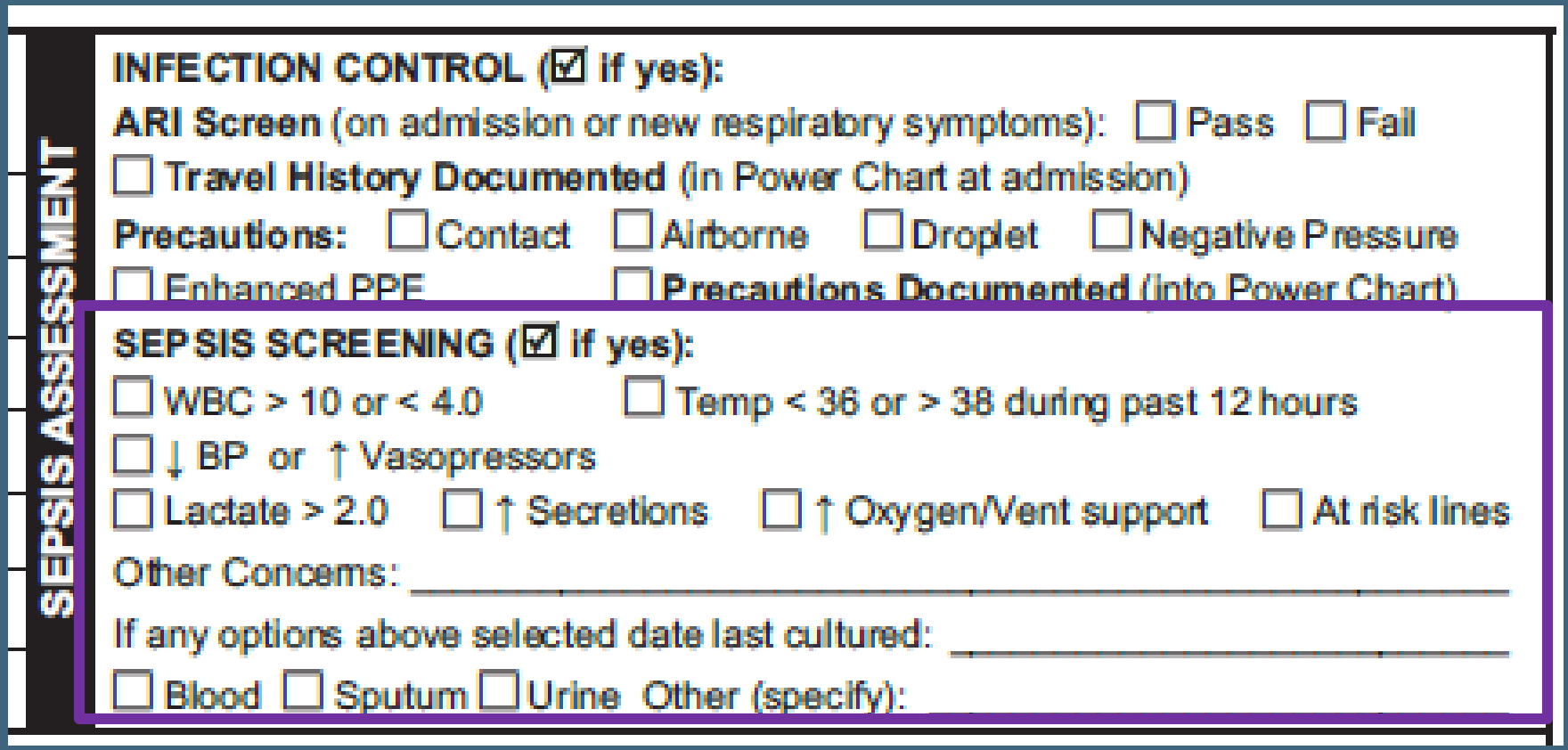
Sepsis Screen



Gentio-urinary

GENITO-URINARY

☐ PREGNANT ☐ POSTPARTUM ☐ ACTIVATE CCTC OBSTETRICAL FLOW SHEET

CATHETER: ☐ URETHRAL ☐ SUBRAPUBIC SIZE: _____ TYPE: _____ ☐ ILEALCONDUIT ☐ 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

_____

_____

Gastrointestinal

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: _____

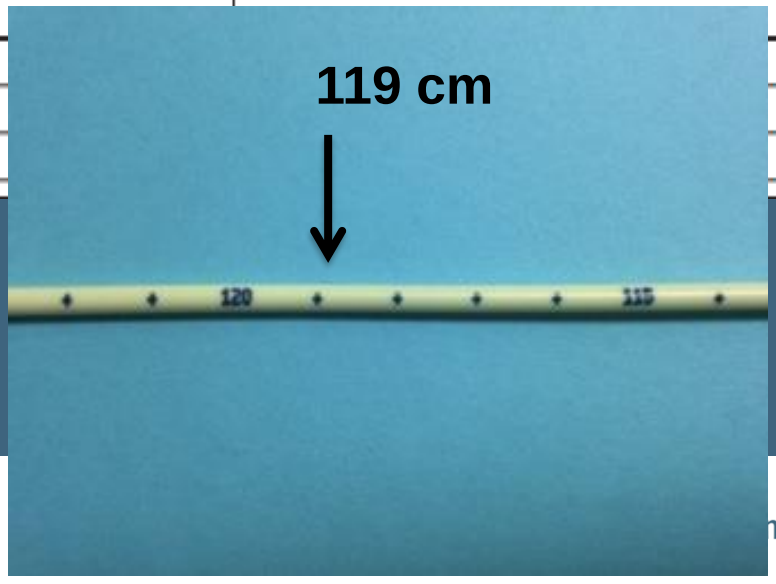
☐ Ileostomy ☐ Colostomy Stoma Appearance: _____

☐ Intensive Insulin ☐ DKA ☐ GI Prophylaxis: _____ ☐ Prokinetic: _____

OTHER DRAINS:

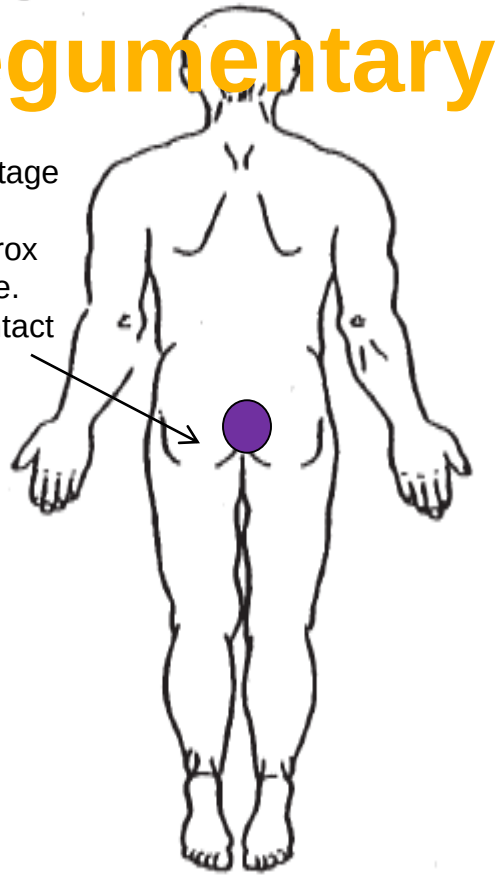
TYPE	LOCATION	SYSTEM	DRAINAGE
HMV	RUQ Abd	Suction	Scant, serosanguinous
G-Tube	RLQ Abd	Straight drainage bag	Thick, greenish yellow

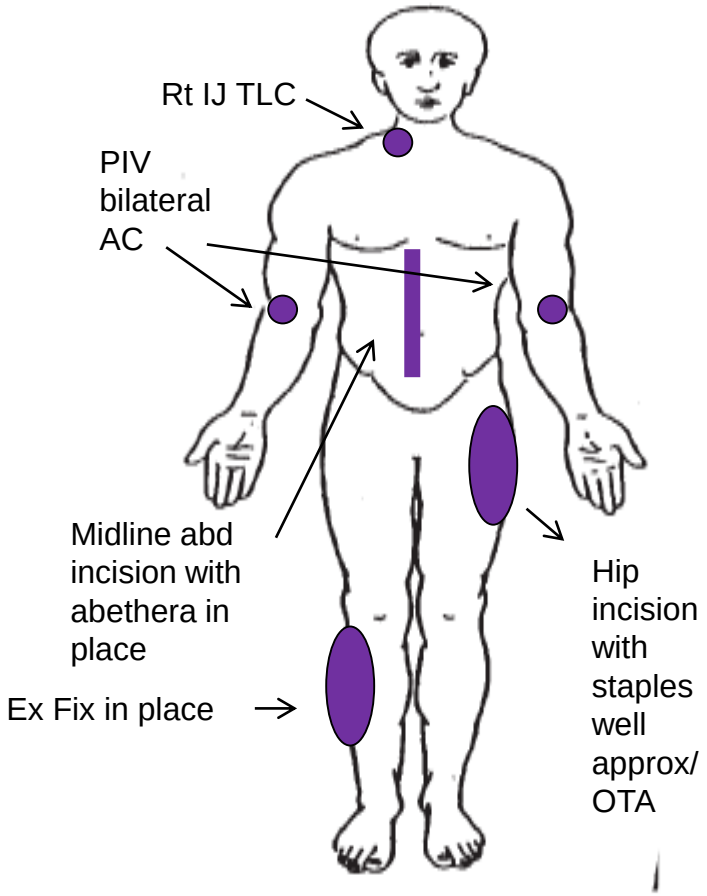
7, 2018



Integumentary

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: ☐ PREGNANCY RULED OUT BY: ☐ BLOOD TEST ☐ HYSTERECTOMY

ARMBAND ON PATIENT: ☐ YES ☐ NO _____ RESUSCITATION CODE: _____

BLOOD TRANSFUSION CONSENT: ☐ YES ☐ NO DATE: _____ (YYYY/MM/DD) ☐ CURRENT SAMPLE EXPIRES: _____ (YYYY/MM/DD) ☐ CURRENT SAMPLE NOT REQUIRED

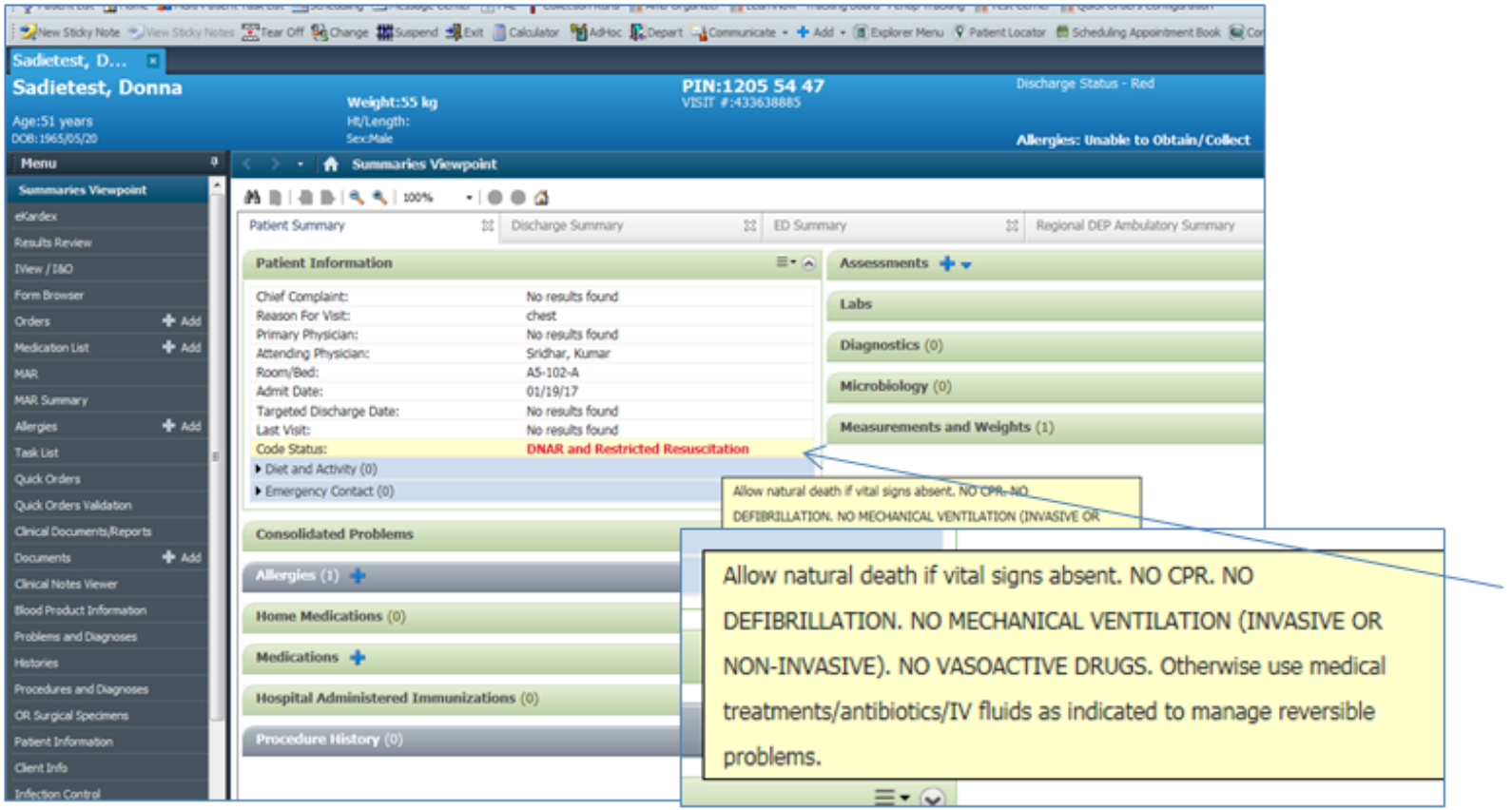
☐ EMOTIONAL / INFORMATIONAL SUPPORT PATIENT / FAMILY

CAREGIVER FOR ADL: ☐ 2 - 3 ☐ 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**



Hover over to view details

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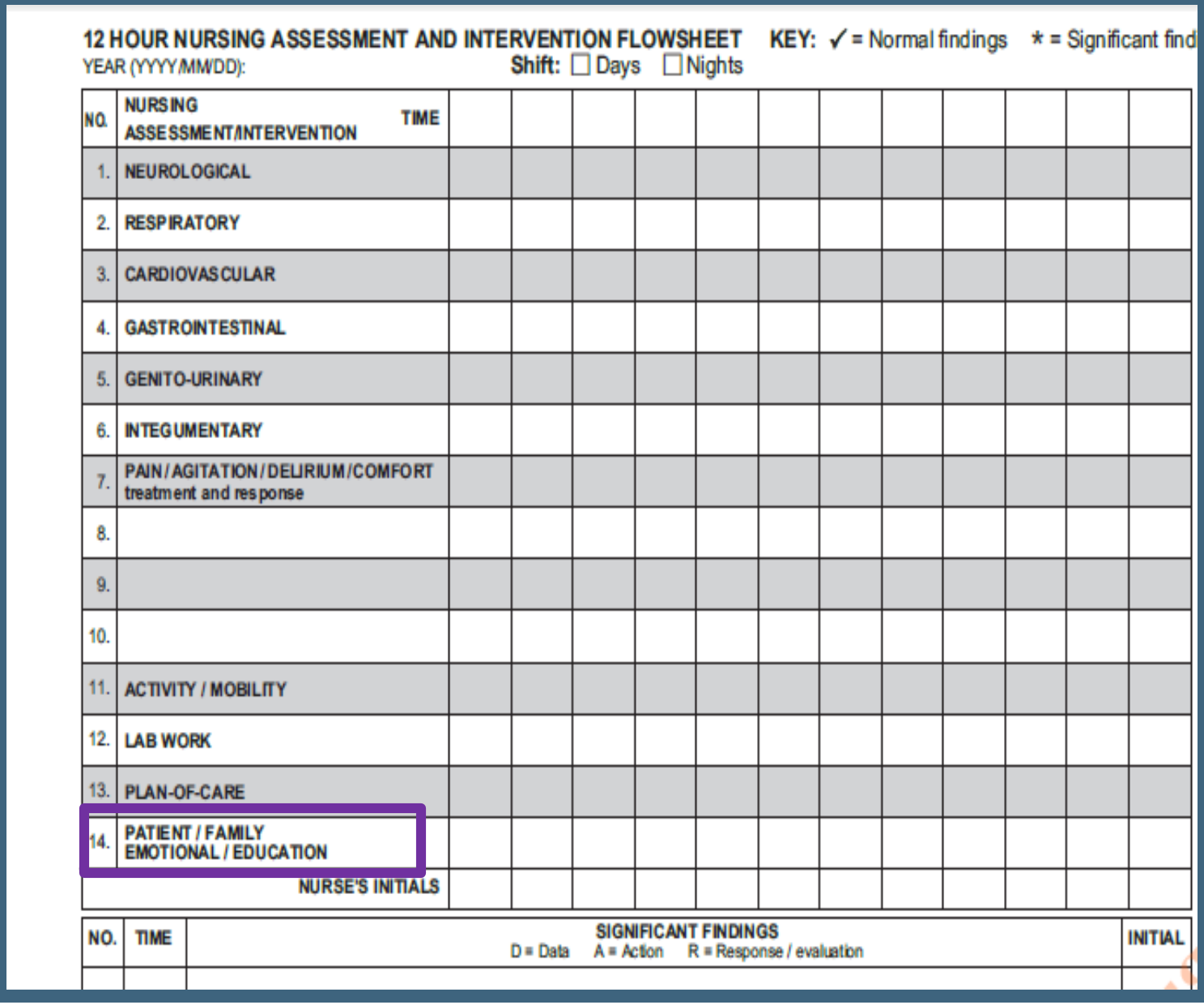


12 HOUR NURSING ASSESSMENT AND INTERVENTION FLOWSHEET KEY: ✓ = Normal findings * = Significant find

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 D = Data A = Action R = Response / evaluation	INITIAL

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?

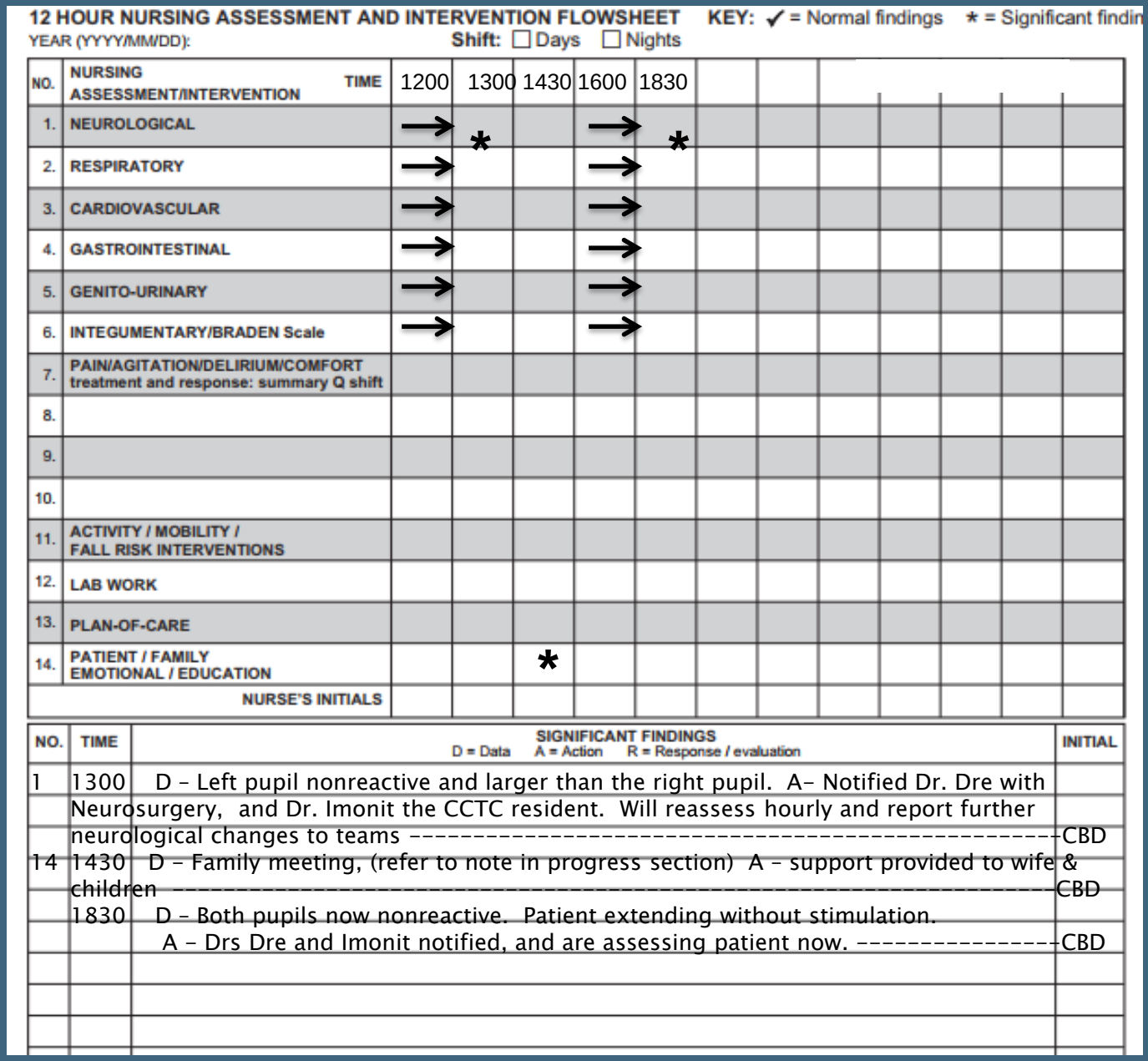
- The arrow means you have reassessed the findings and there has been ***NO CHANGE*** from the previous assessment and documentation

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.



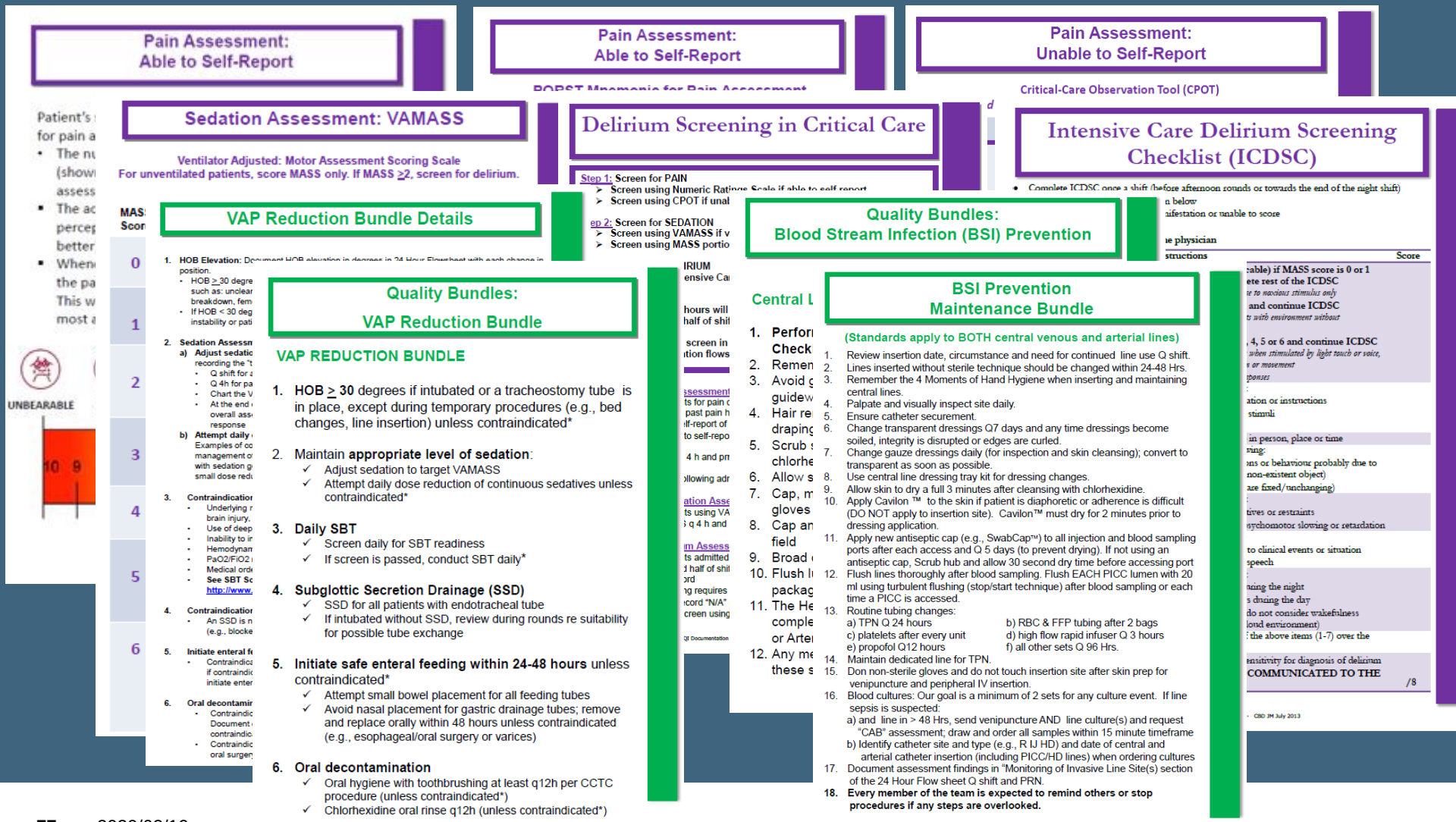
12 HOUR NURSING ASSESSMENT AND INTERVENTION FLOWSHEET KEY: ✓ = Normal findings * = Significant findin

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 D = Data A = Action R = Response / evaluation	INITIAL
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



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Patients, Families & Visitors
Health Professionals
What's New
Monographs
Standards of Nursing Care
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EduBriefs
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Courses & Events
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Medical Education
Employees Only
Research & Training
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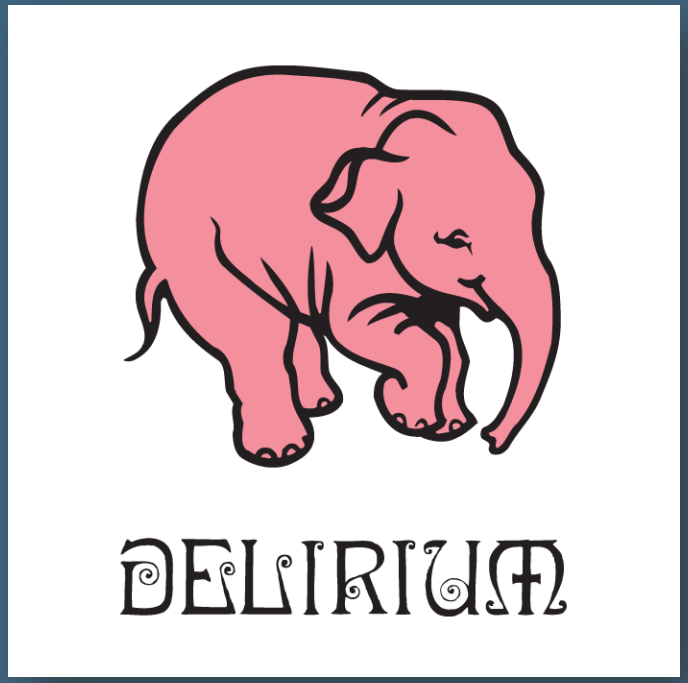
A-D
Arterial Line Monitoring
Bedside Assessment Tools:
Neuro Assessment
Neuro Assessment Tools
Pain, Sedation and Delirium Assessment Tools
Safety Bundles (CLI, VAP and Procedural Pause)
Patient Pain Communication Tool
Cardiovascular System Monitoring
Central Line Monitoring
Continuous Lateral Rotation Thearpy (CLRT)
Documentation
12 Hour Assessement 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 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 ICDSC = U/A)

Step 3: ICDSC Total _____ (circle + items)

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