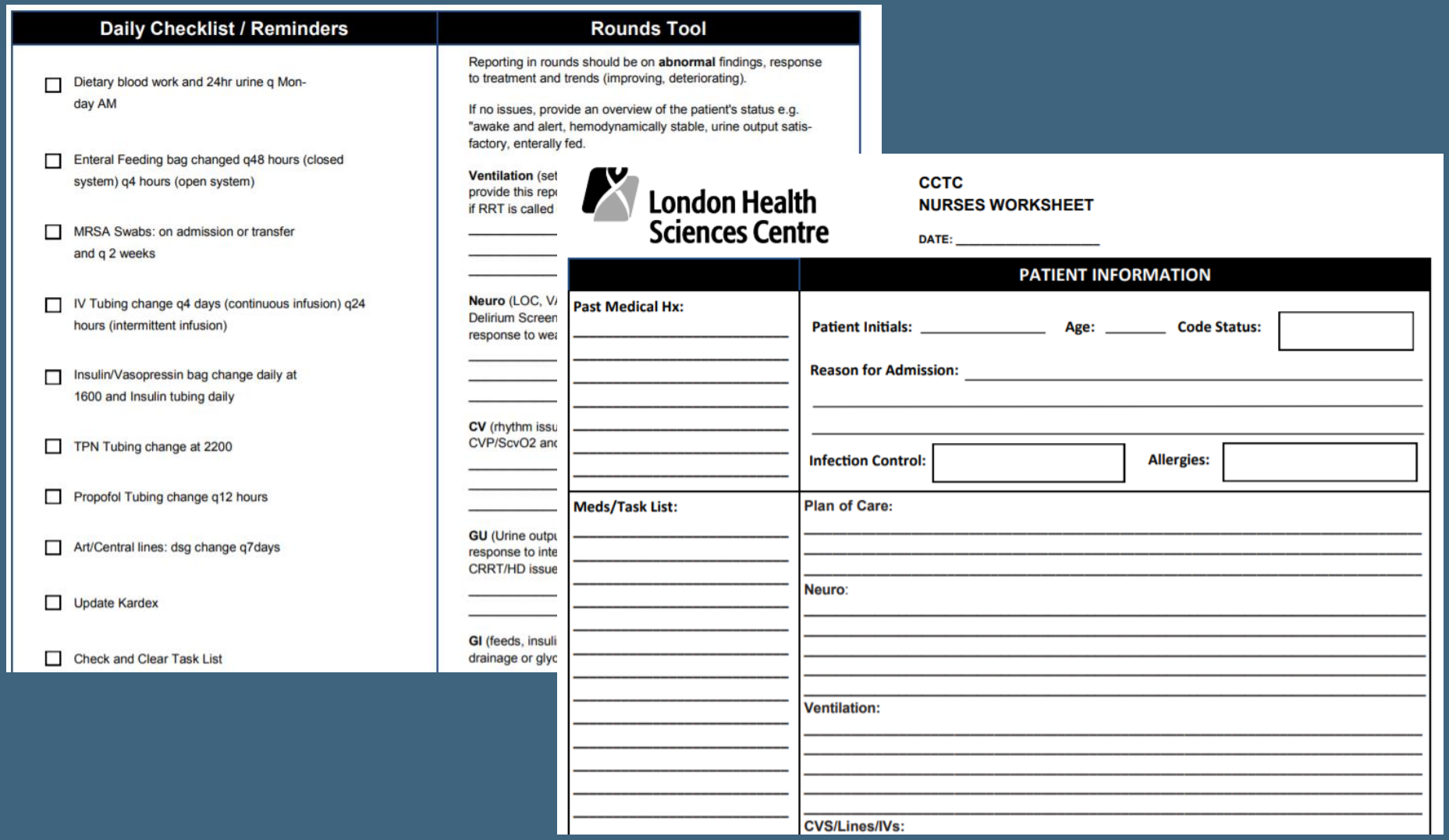
London Health Sciences Centre

THE CRITICAL CARE TRAUMA CENTRE: DOCUMENTATION

CRITICAL CARE NURSING PROGRAM ORIENTATION

SEPT 2019

CCTC Nurses Worksheet



Daily Checklist / Reminders

- ☐ Dietary blood work and 24hr urine q Monday AM
- ☐ Enteral Feeding bag changed q48 hours (closed system) q4 hours (open system)
- ☐ MRSA Swabs: on admission or transfer and q 2 weeks
- ☐ IV Tubing change q4 days (continuous infusion) q24 hours (intermittent infusion)
- ☐ Insulin/Vasopressin bag change daily at 1600 and Insulin tubing daily
- ☐ TPN Tubing change at 2200
- ☐ Propofol Tubing change q12 hours
- ☐ Art/Central lines: dsg change q7days
- ☐ Update Kardex
- ☐ Check and Clear Task List

Rounds Tool

Reporting in rounds should be on **abnormal** findings, response to treatment and trends (improving, deteriorating).

If no issues, provide an overview of the patient's status e.g. "awake and alert, hemodynamically stable, urine output satisfactory, enterally fed.

Ventilation (set
provide this rep
if RRT is called

Neuro (LOC, V
Delirium Screen
response to wea

CV (rhythm issu
CVP/ScvO2 and

GU (Urine outpu
response to inte
CRRT/HD issue

GI (feeds, insuli
drainage or glyc

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CCTC
NURSES WORKSHEET

DATE: _____

Past Medical Hx:

PATIENT INFORMATION

Patient Initials: _____ **Age:** _____ **Code Status:**

Reason for Admission: _____

Infection Control: **Allergies:**

Meds/Task List:

Plan of Care:

Neuro:

Ventilation:

CVS/Lines/IVs:

Critical Care Trauma

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
8. Promote Integumentary Integrity
9. Promote Buccal Integrity
10. Promote Oral Hygiene
11. Promote Hygiene
12. Continuous IV Infusions
13. Verify IVs
14. Independent Safety Check
15. Change IV Tubing
16. Filter IV Meds
17. Filter or Vent Micro Air (Special Circumstance
18. Change Dressings
19. Change Foley Catheter
20. Review Orders

- Standards of Nursing Care
- Procedures

ind educational institutions

including: Western University, Fanshawe College and partnering academic institutions. Many members of the critical care team are academically affiliated with faculties at Western University.

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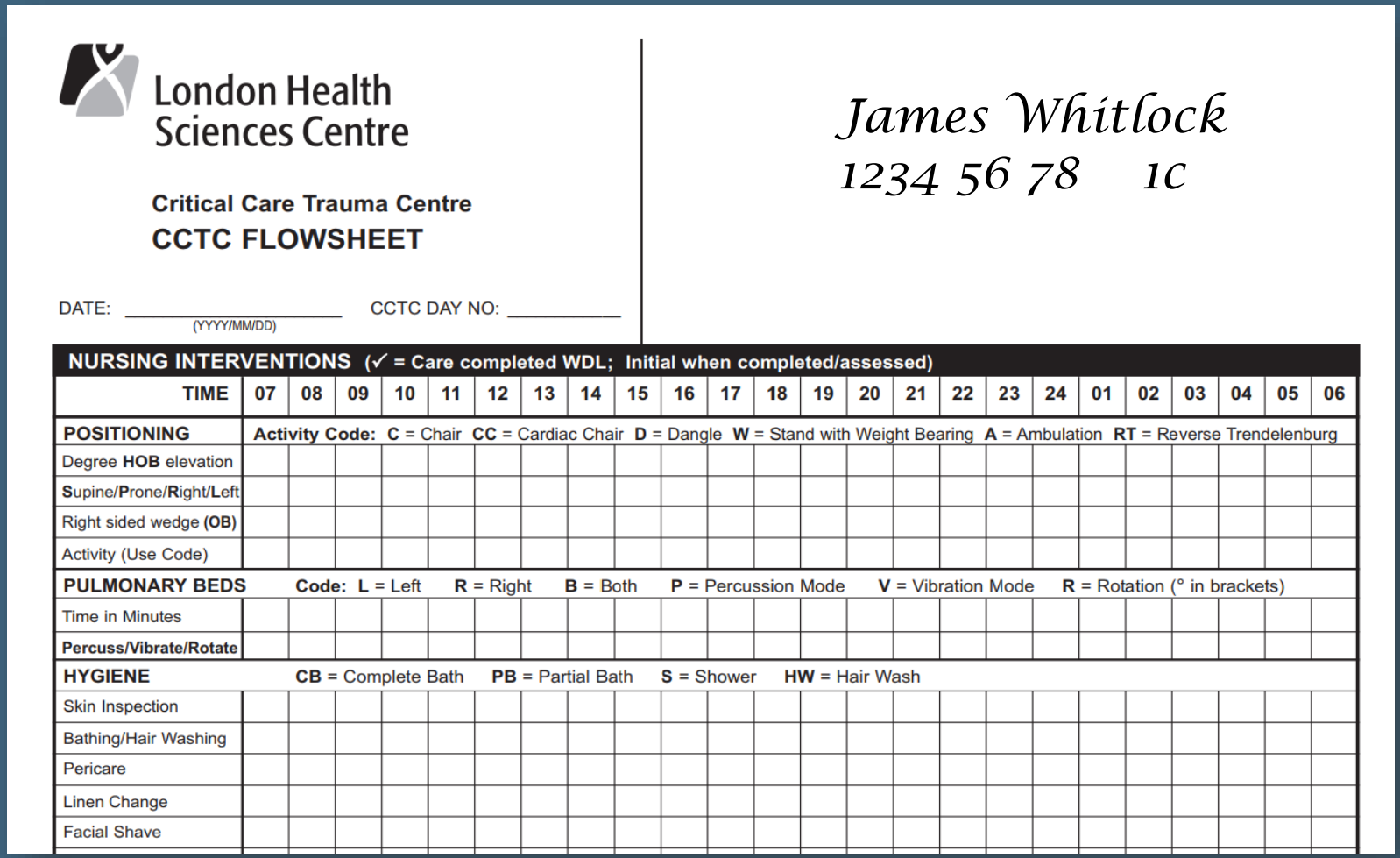
CCTC: 24 Hour Flowsheet



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Critical Care Trauma Centre

CCTC FLOWSHEET

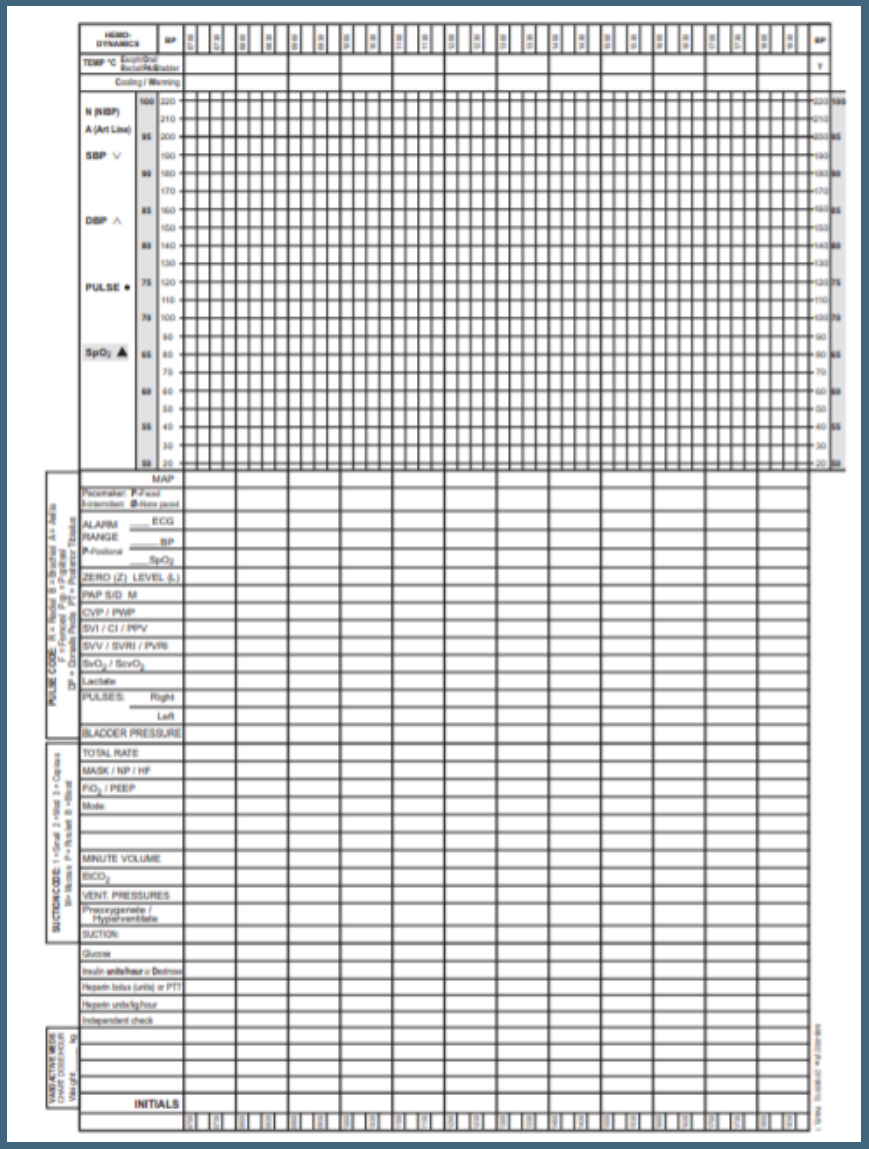
James Whitlock
1234 56 78 1C

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

NURSING INTERVENTIONS (✓ = Care completed WDL; Initial when completed/assessed)																								
TIME	**07**	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**01**	**02**	**03**	**04**	**05**	**06**
POSITIONING	**Activity Code: C** = Chair **CC** = Cardiac Chair **D** = Dangle **W** = Stand with Weight Bearing **A** = Ambulation **RT** = Reverse Trendelenburg																							
Degree **HOB** elevation																								
Supine/**P**rone/**R**ight/**L**eft																								
Right sided wedge **(OB)**																								
Activity (Use Code)																								
PULMONARY BEDS	**Code: L** = Left **R** = Right **B** = Both **P** = Percussion Mode **V** = Vibration Mode **R** = Rotation (° in brackets)																							
Time in Minutes																								
Percuss/Vibrate/Rotate																								
HYGIENE	**CB** = Complete Bath **PB** = Partial Bath **S** = Shower **HW** = Hair Wash																							
Skin Inspection																								
Bathing/Hair Washing																								
Pericare																								
Linen Change																								
Facial Shave																								

Vital Signs: (Panels 1 & 3)

- Panel 1: Day shift
- Panel 3: Night shift



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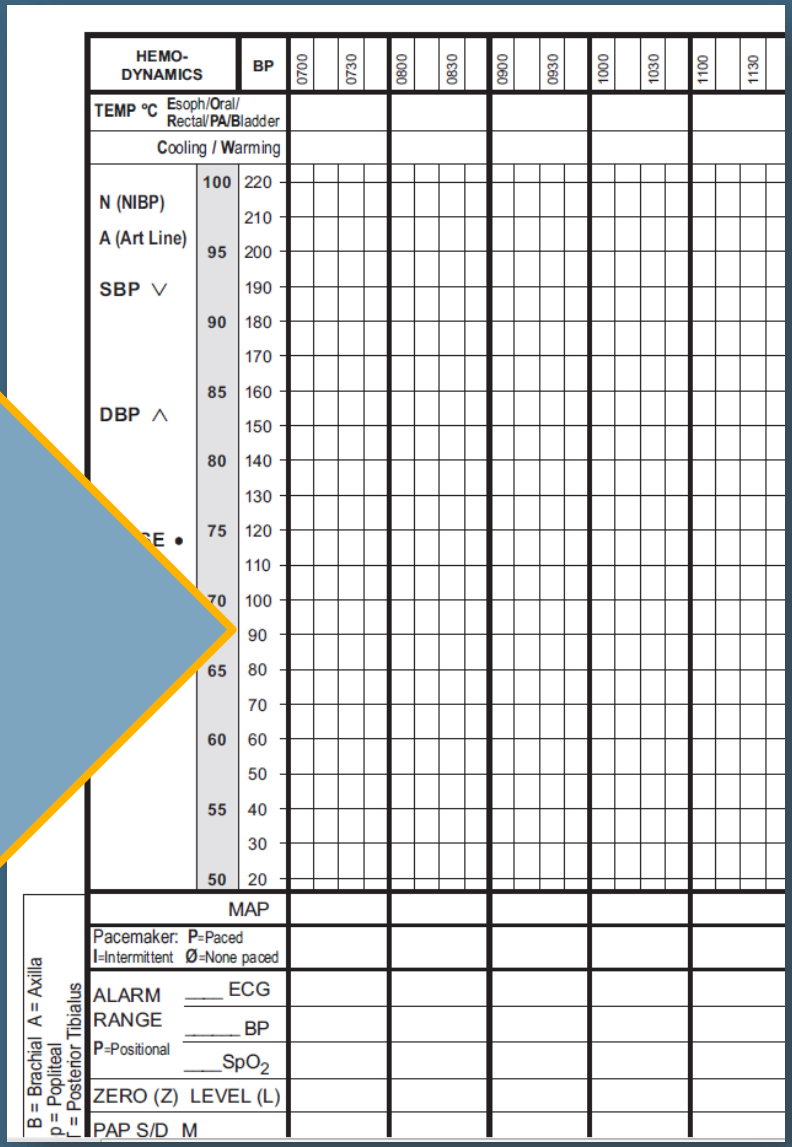
Graphic Record

- Time scale is in half hour increments, starting at 0700
- Temp – numeric
- SpO_2 – triangle
- MAP is numeric
- Use **Λ V** for BP (N for NIBP and A for Art Line)



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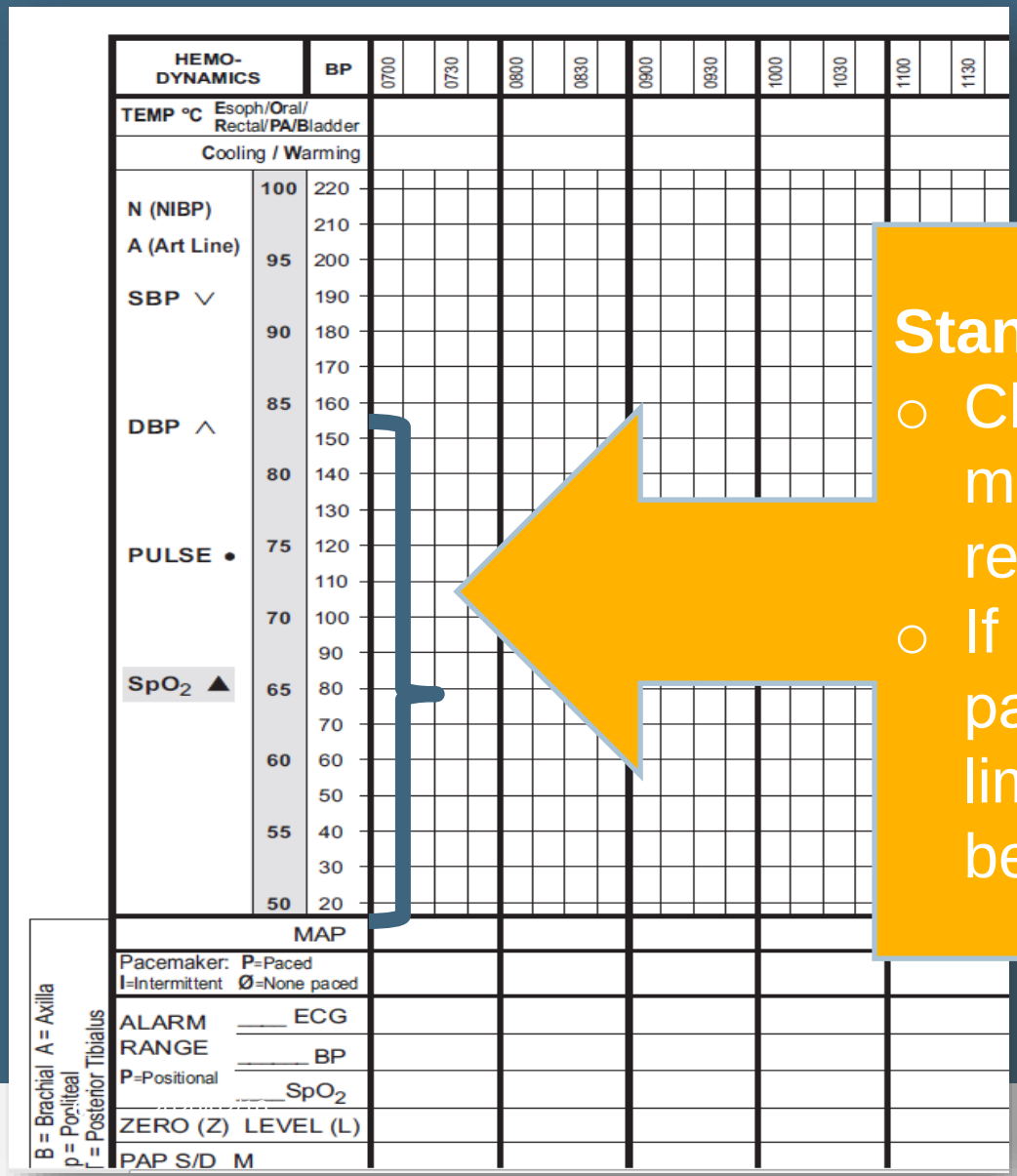
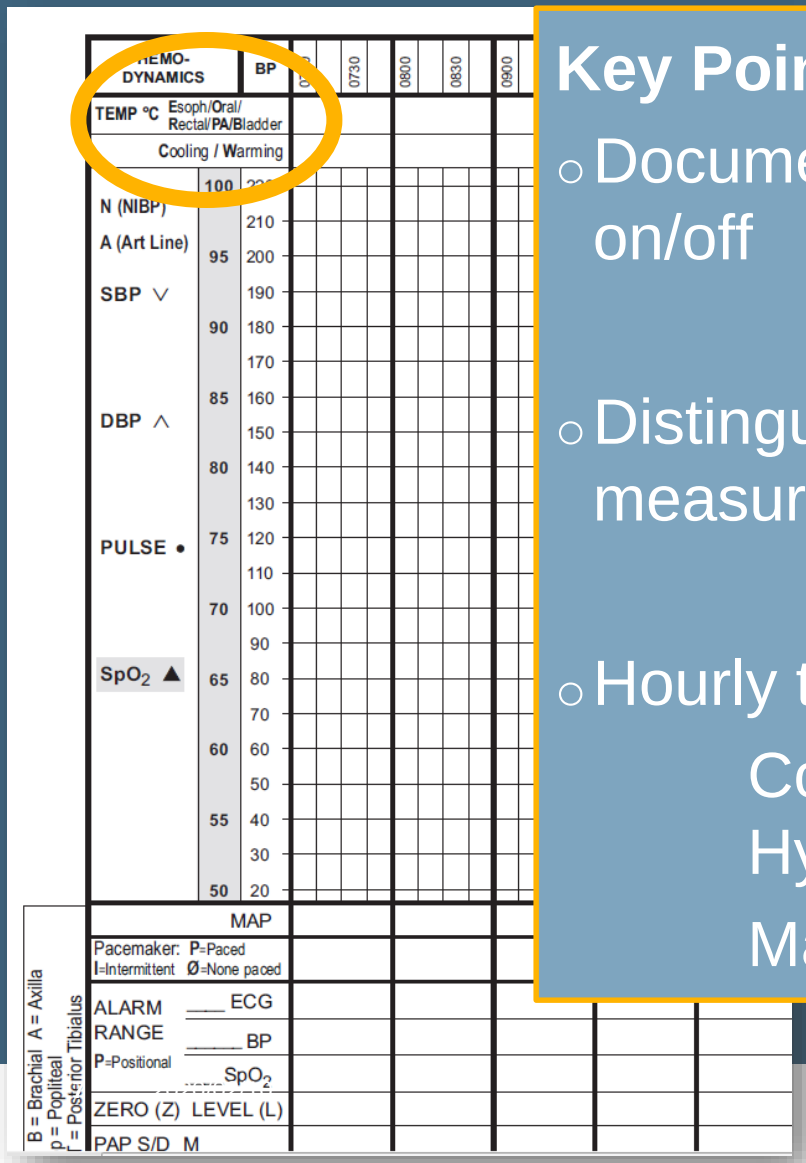
Graphic Record



Standards:

- Chart abnormal results more frequently to reflect changes
- If VS are outside the patient's acceptable limits, a DAR note must be written

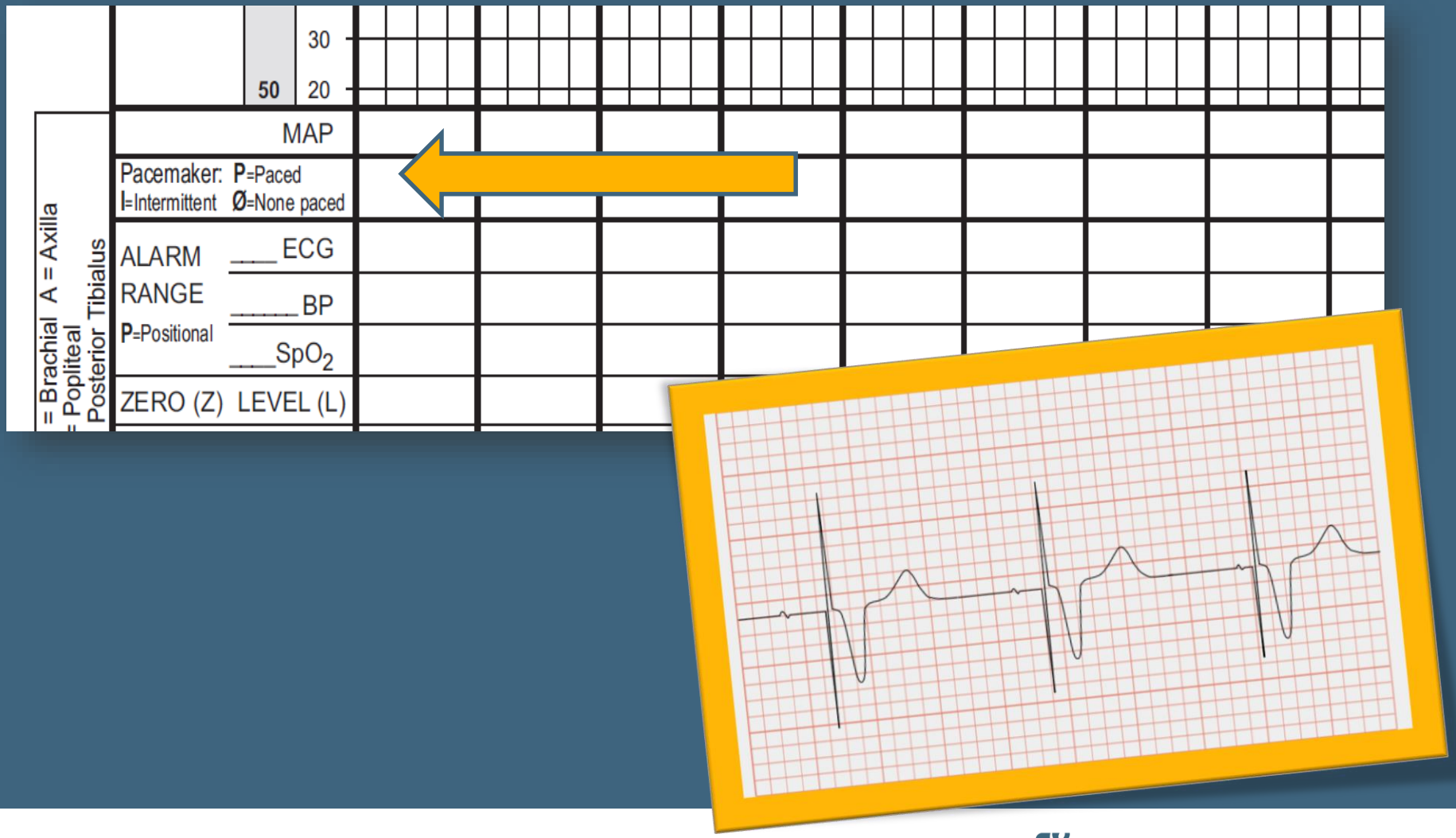
Graphic Record



Key Points:

- Document cooling or warming blanket on/off
- Distinguish where temperature measurement is obtained
- Hourly temp documentation is required:
  - Cooling/warming blanket use
  - Hypothermia protocol
  - Massive transfusion protocol (MTP)

Pacemakers



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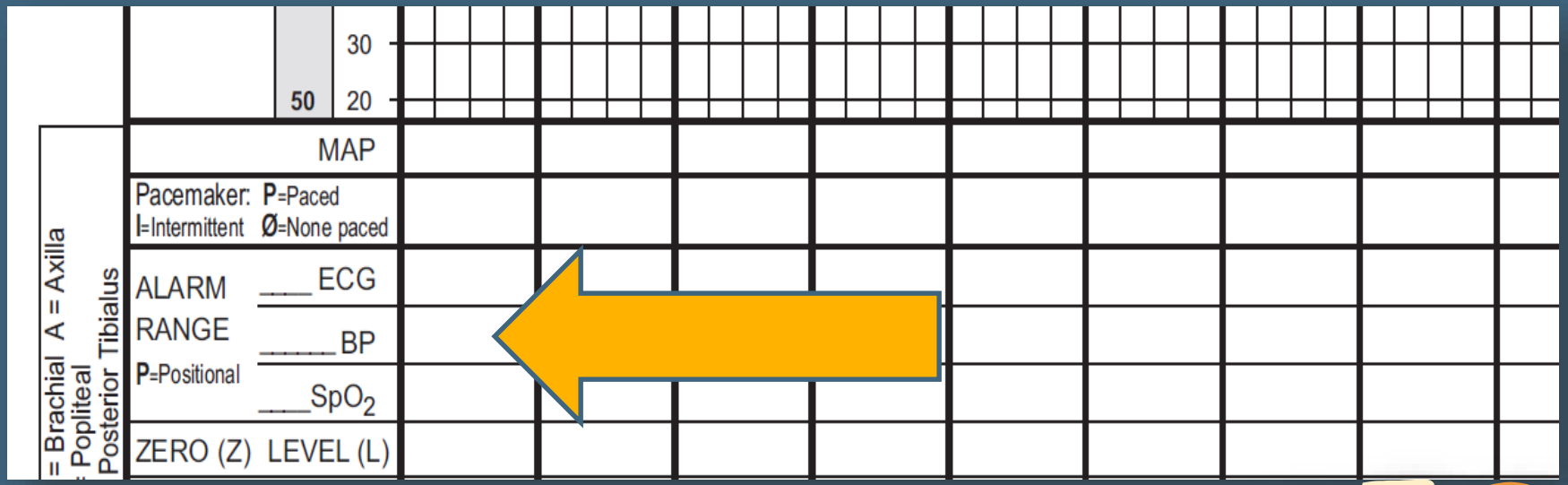
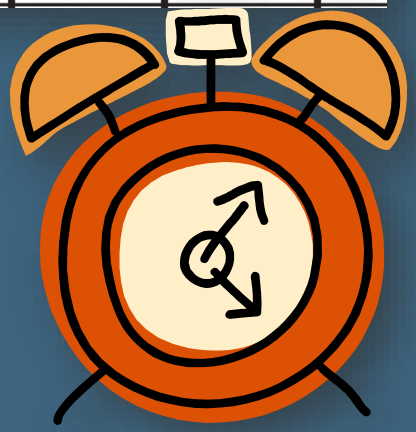
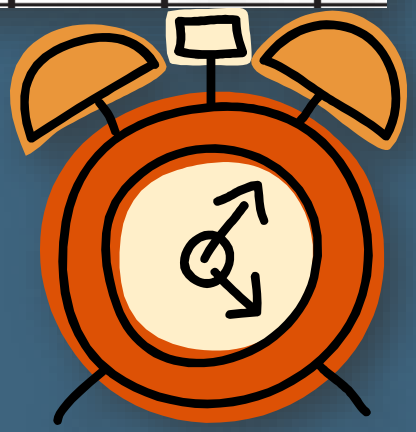
Alarm Ranges





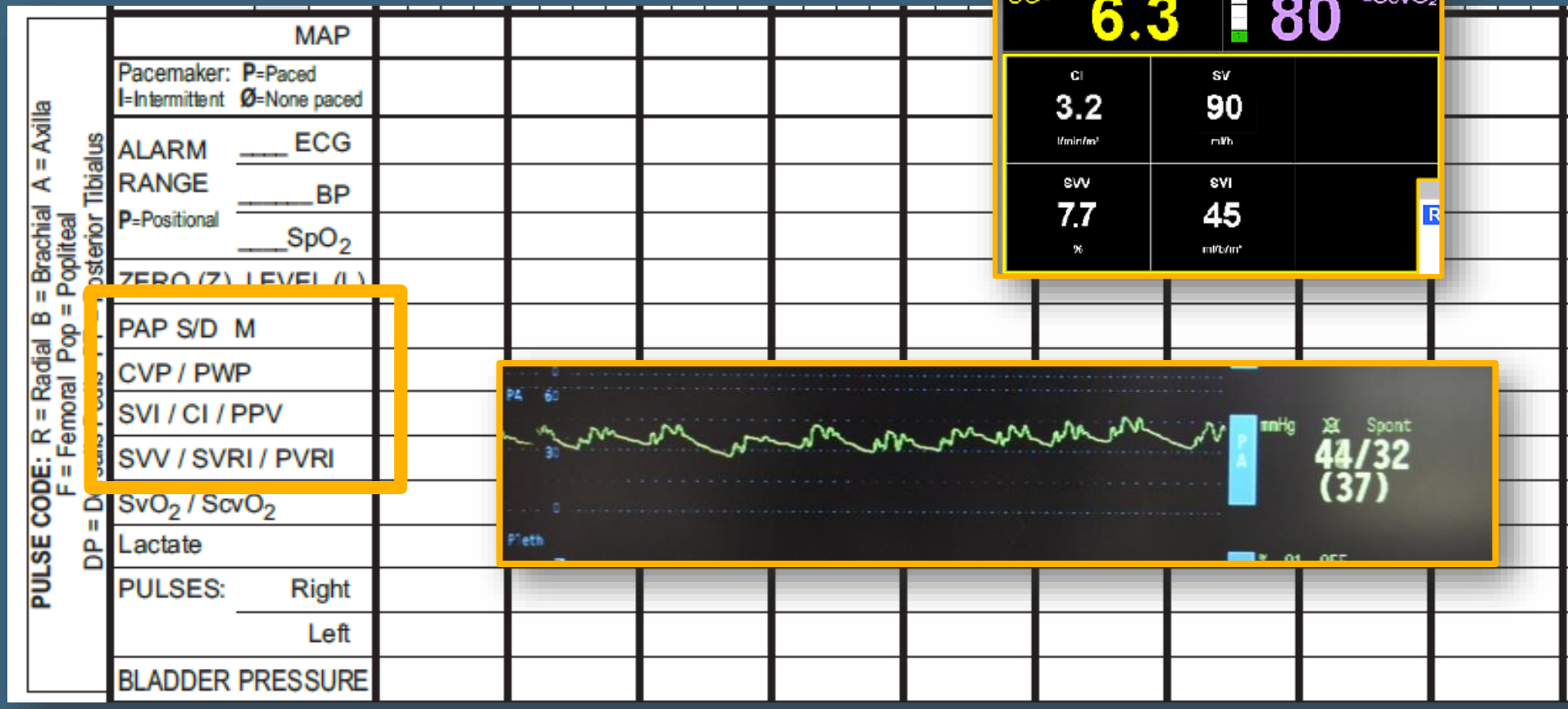
Alarm Ranges

	50	30 / 20										
	MAP											
	Pacemaker: P=Paced I=Intermittent Ø=None paced											
= Brachial A = Axilla = Popliteal Posterior Tibialus	ALARM 50-150 ECG	→	→	→	→							
	RANGE 65-110 (MAP) BP	→	→	→	→							
	P=Positional 92%-100% SpO_2	→	→	↓ *88%	→							
	ZERO (Z) LEVEL (L)											



Leveling and Zeroing

Hemodynamic Measurements & Calculations



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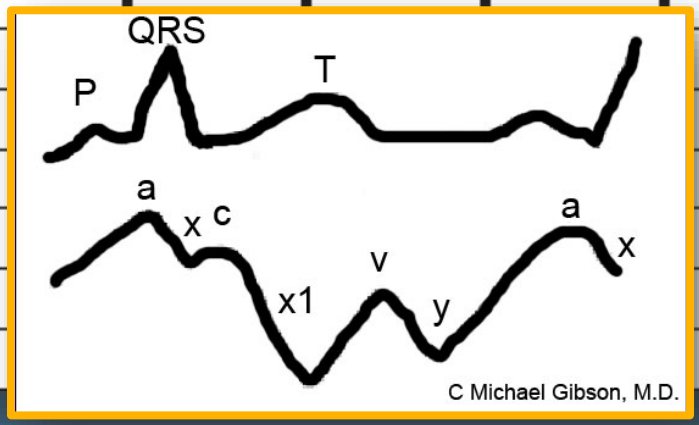
Central Venous Pressure:

MAP								
Pacemaker: P=Paced I=Intermittent Ø=None paced								
ALARM ____ ECG								
RANGE _____ BP								
P=Positional ____ SpO_2								
ZERO (Z) LEVEL (L)								
PAP S/D M								
CVP / PWP	6							
SVI / CI / PPV								
SVV / SVRI / PVRI								
SvO_2 / $ScvO_2$								
Lactate								
PULSES: Right								
Left								
BLADDER PRESSURE								

PULSE CODE: R = Radial B = Brachial A = Axilla F = Femoral Pop = Popliteal DP = Dorsalis Pedis PT = Posterior Tibialus



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Mixed Venous/Central Venous Blood Gases

MAP								
Pacemaker: P=Paced I=Intermittent Ø=None paced								
ALARM ____ ECG								
RANGE _____ BP								
P=Positional ____ SpO_2								
ZERO (Z) LEVEL (L)								
PAP S/D M								
CVP / PWP								
SVI / CI / PPV								
SVV / SVRI / PVRI								
SvO_2 / $ScvO_2$	75%							
Lactate								
PULSES: Right								
Left								
BLADDER PRESSURE								

PULSE CODE: R = Radial B = Brachial A = Axilla F = Femoral Pop = Popliteal DP = Dorsalis Pedis PT = Posterior Tibialus

Pulses

PULSE CODE: R = Radial B = Brachial A = Axilla F = Femoral Pop = Popliteal DP = Dorsalis Pedis PT = Posterior Tibialus									
	MAP								
	Pacemaker: P=Paced I=Intermittent Ø=None paced								
	ALARM ____ ECG								
	RANGE _____ BP								
	P=Positional ____ SpO_2								
	ZERO (Z) LEVEL (L)								
	PAP S/D M								
	CVP / PWP								
	SVI / CI / PPV								
	SVV / SVRI / PVRI								
	SvO_2 / $ScvO_2$								
	Lactate								
	PULSES: Right	R/DP ✓							
	Left	R/DP ✓							
	BLADDER PRESSURE								

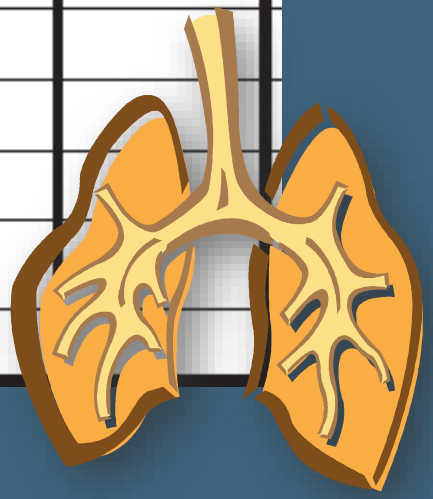
Pulses

PULSE CODE: R = Radial B = Brachial A = Axilla F = Femoral Pop = Popliteal DP = Dorsalis Pedis PT = Posterior Tibialus

MAP								
Pacemaker: P=Paced I=Intermittent Ø=None paced								
ALARM ____ ECG RANGE _____ BP P=Positional ____ SpO_2								
ZERO (Z) LEVEL (L)								
PAP S/D M								
CVP / PWP								
SVI / CI / PPV								
SVV / SVRI / PVRI								
SvO_2 / $ScvO_2$								
Lactate								
PULSES: Right	R/DP ✓	→	→	R ✓DP*				
Left	R/DP ✓	→	→	R/DP ✓				
BLADDER PRESSURE								

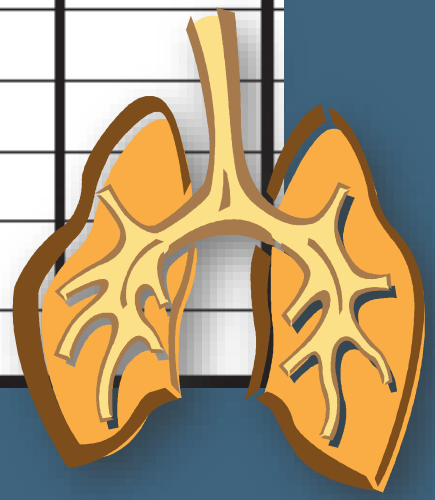
Ventilator Settings

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood						
	TOTAL RATE					
	MASK / NP / HF					
	FiO_2 / PEEP					
	Mode:					
	MINUTE VOLUME					
	$EtCO_2$					
	VENT. PRESSURES					
	Preoxygenate / Hyperventilate					
	SUCTION:					



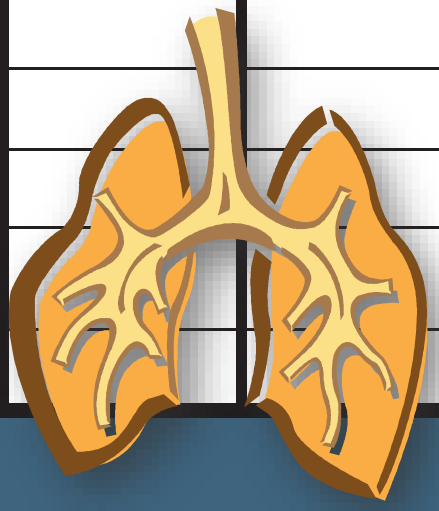
Ventilator Settings

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood						
	TOTAL RATE					
	MASK / NP / HF					
	FiO_2 / PEEP					
	Mode:					
	MINUTE VOLUME					
	$EtCO_2$					
	VENT. PRESSURES					
	Preoxygenate / Hyperventilate					
	SUCTION:					



Respiratory Monitoring

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood	
	TOTAL RATE
	MASK / NP / HF
	FiO_2 / PEEP
	Mode:
	MINUTE VOLUME
	$EtCO_2$
	VENT. PRESSURES
	Preoxygenate / Hyperventilate
	SUCTION:



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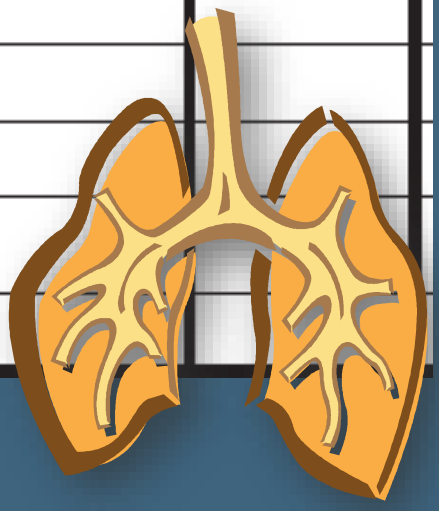
SPONT

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood						
	TOTAL RATE	45				
	MASK / NP / HF					
	FiO_2 / PEEP	0.5 / 5				
	Mode: SPONT	10				
	MINUTE VOLUME	17.1				
	$EtCO_2$					
	VENT. PRESSURES	39 / 4.5				
	Preoxygenate / Hyperventilate					
	SUCTION:					



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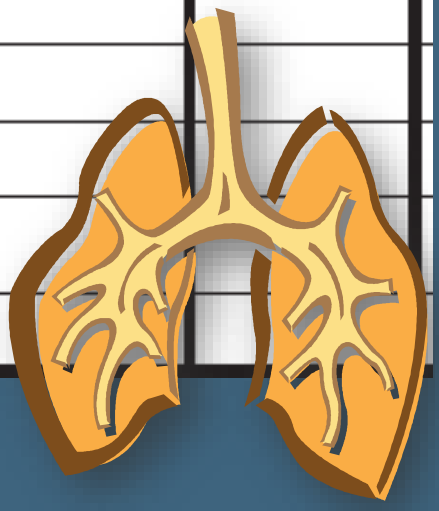
P-CMV

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood						
	TOTAL RATE	18				
	MASK / NP / HF					
	FiO_2 / PEEP	1.0 / 5				
	Mode: **P-CMV** **Rate**	18				
	PC	20				
	MINUTE VOLUME	9.0				
	$EtCO_2$					
	VENT. PRESSURES	39 / 4.5				
	Preoxygenate / Hyperventilate					
	SUCTION:					



Suctioning

SUCTION CODE: 1 = Small 2 = Mod 3 = Copious M= Mucous P = Purulent B = Blood						
TOTAL RATE						
MASK / NP / HF						
FiO_2 / PEEP						
Mode:						
MINUTE VOLUME						
$EtCO_2$						
VENT. PRESSURES						
Preoxygenate / Hyperventilate						
SUCTION:						

Infusions

VASOACTIVE MEDS CHART DOSE/HOUR Weight ____ kg																							
Glucose																							
Insulin **units/hour** or **Dextrose**																							
Heparin bolus (units) or PTT																							
Heparin units/kg/hour																							
Independent check																							
INITIALS																							
	0700		0730		0800		0830		0900		0930		1000		1030		1100		1130				

Glucose Control

VASOACTIVE MEDS CHART DOSE/HOUR Weight ____ kg																									
	Glucose	6.4										7.3													
	Insulin u/hr or Dextrose	2			→				→			↑ 3													
	Heparin bolus (units) or PTT																								
	Heparin units/kg/hour																								
	Independent check																								
	INITIALS																								
		0700		0730		0800		0830		0900		0930		1000		1030		1100		1130		1200		1230		1300

Heparin Infusion

VASOACTIVE MEDS
CHART DOSE/HOUR
Weight ____ kg

Glucose																								
Insulin **u/hr** or **D**extrose																								
Heparin bolus (unit) or PTT	65																							
Heparin units/kg/hour	18	→		→		→																		
Independent check																								
INITIALS																								
	0700		0730		0800		0830		0900		0930		1000		1030		1100		1130		1200		1230		1300

Vasoactive Medication

	Glucose																	
	Insulin **u/hr** or **D**extrose																	
	Heparin bolus (units) or PTT																	
	Heparin units/kg/hour																	
	ndependent check																	
VASOACTIVE MEDS CHART DOSE/HOUR Weight ____ kg																		
	INITIALS																	
		0700	0730	0800	0830	0900	0930	1000	1030	1100	1130	1200	1230	1300	1330	1400	1430	

Vasoactive Medications

VASOACTIVE MEDS
CHART DOSE/HOUR
Weight 75 kg

	0700	0730	0800	0830	0900	0930	1000	1030	1100	1130	1200	1230	1300
Glucose													
Insulin **u/hr** or **D**extrose													
Heparin bolus (units) or PTT													
Heparin units/kg/hour													
Independent check													
Norepinephrine mcg/min	5		→		↑ 7								
Vasopressin units/hr	1.8		→		→								
INITIALS													

Don’t forget to sign

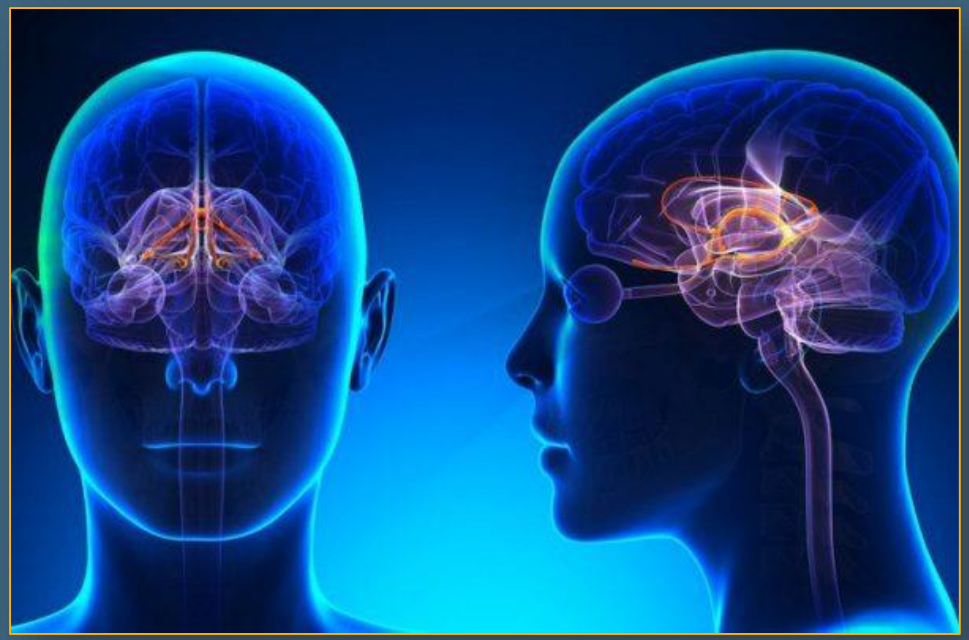
VASOACTIVE MEDS
CHART DOSE/HOUR
Weight ____ kg

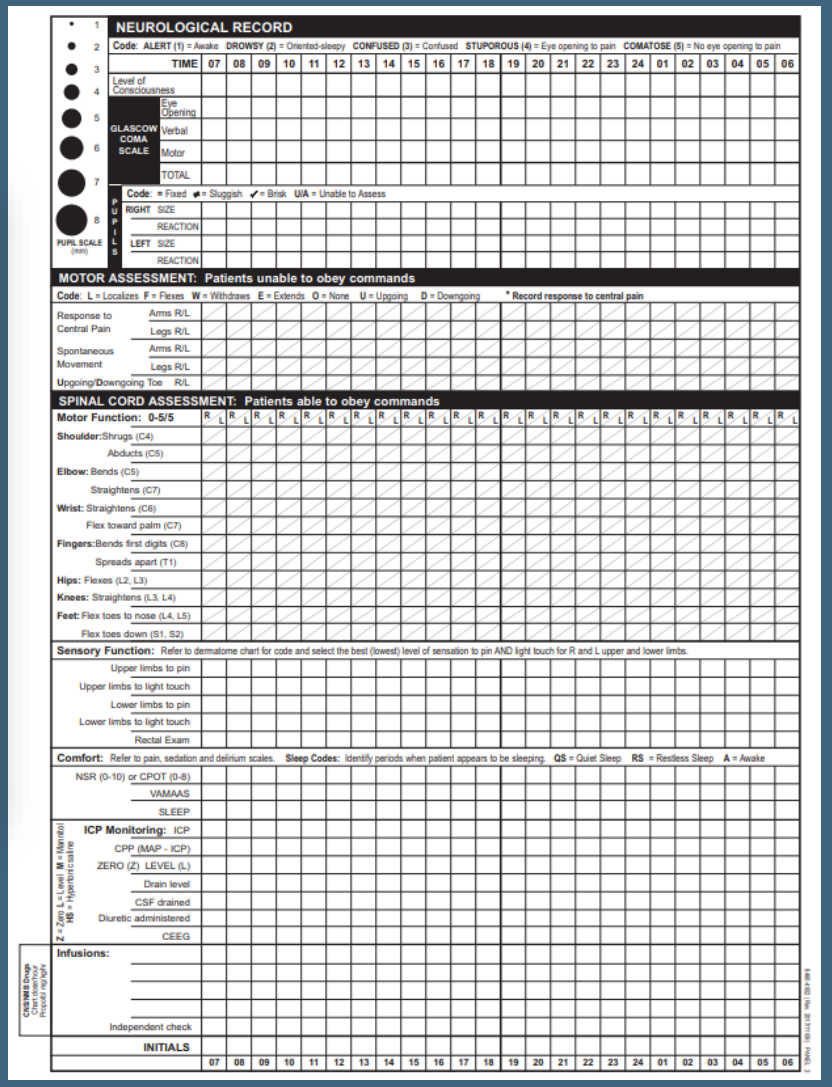
Glucose								
Insulin **u/hr** or **D**extrose								
Heparin bolus (units) or PTT								
Heparin units/kg/hour								
Independent check								
INITIALS	RSP							
	0700 0730	0800 0830	0900 0930	1000 1030	1100 1130	1200 1230	1300


Brain
Breaks

Neurological Record

(Panel 2)





NEUROLOGICAL RECORD

Code: ALERT (1) = Awake DROWSY (2) = Oriented-sleepy CONFUSED (3) = Confused STUPOROUS (4) = Eye opening to pain COMATOSE (5) = No eye opening to pain

TIME 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06

Level of Consciousness

GLASGOW COMA SCALE: Eye Opening; Verbal; Motor; TOTAL

PUPILS — Code: = Fixed = Sluggish ✓ = Brisk U/A = Unable to Assess

RIGHT SIZE; REACTION

LEFT SIZE; REACTION

PUPIL SCALE (mm) 1 2 3 4 5 6 7 8

MOTOR ASSESSMENT: Patients unable to obey commands

Code: L = Localizes F = Flexes W = Withdraws E = Extends O = None U = Upgoing D = Downgoing * Record response to central pain

Response to Central Pain — Arms R/L; Legs R/L

Spontaneous Movement — Arms R/L; Legs R/L

Upgoing/Downgoing Toe R/L

SPINAL CORD ASSESSMENT: Patients able to obey commands

Motor Function: 0-5/5 (R L)

Shoulder: Shrugs (C4)

Abducts (C5)

Elbow: Bends (C5)

Straightens (C7)

Wrist: Straightens (C6)

Flex toward palm (C7)

Fingers: Bends first digits (C8)

Spreads apart (T1)

Hips: Flexes (L2, L3)

Knees: Straightens (L3, L4)

Feet: Flex toes to nose (L4, L5)

Flex toes down (S1, S2)

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

Upper limbs to pin

Upper limbs to light touch

Lower limbs to pin

Lower limbs to light touch

Rectal Exam

Comfort: Refer to pain, sedation and delirium scales. Sleep Codes: Identify periods when patient appears to be sleeping. QS = Quiet Sleep RS = Restless Sleep A = Awake

NSR (0-10) or CPOT (0-8)

VAMAAS

SLEEP

ICP Monitoring: ICP

CPP (MAP - ICP)

ZERO (Z) LEVEL (L)

Drain level

CSF drained

Diuretic administered

CEEG

Z = Zero (L = Level M = Mannitol) HS = Hypertonic saline

Infusions:

Independent check

INITIALS

07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06

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Glascow Coma Scale (GCS)

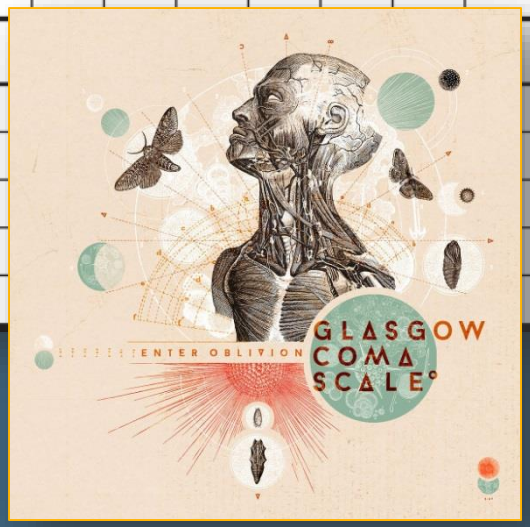
NEUROLOGICAL RECORD

Code: **ALERT (1)** = Awake **DROWSY (2)** = Oriented-sleepy **CONFUSED (3)** = Confused **STUPOROUS (4)** = Eye opening to pain **COMATOSE (5)** = No eye ope

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	0
Level of Consciousness	4																					
GLASCOW COMA SCALE – Eye Opening																						
GLASCOW COMA SCALE – Verbal																						
GLASCOW COMA SCALE – Motor																						
GLASCOW COMA SCALE – TOTAL																						

Code: = Fixed ≠ = Sluggish ✓ = Brisk **U/A** = Unable to Assess

PUPILS		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	0
RIGHT	SIZE																						
	REACTION																						
LEFT	SIZE																						
	REACTION																						



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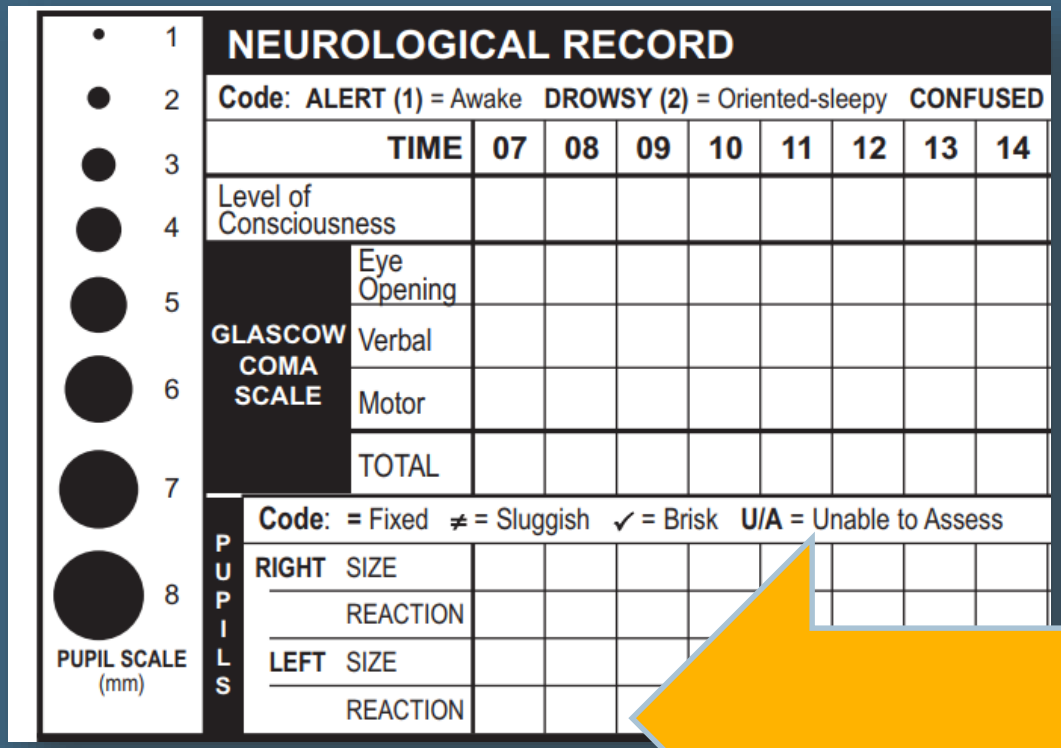
Pupil Assessment

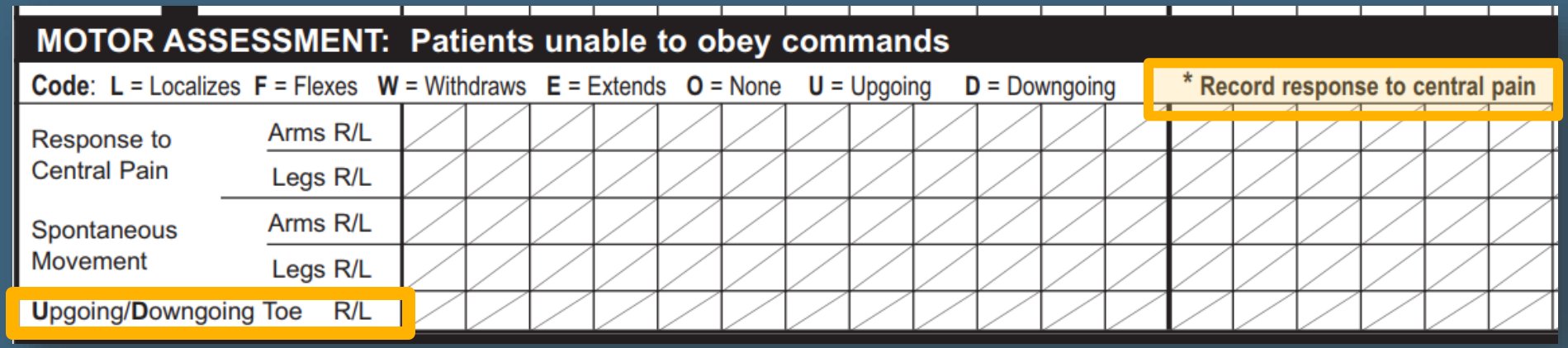


NEUROLOGICAL RECORD									
Code: ALERT (1) = Awake DROWSY (2) = Oriented-sleepy CONFUSED									
	TIME	07	08	09	10	11	12	13	14
Level of Consciousness									
GLASCOW COMA SCALE	Eye Opening								
	Verbal								
	Motor								
	TOTAL								
Code: = Fixed ≠ = Sluggish ✓ = Brisk U/A = Unable to Assess									
PUPILS RIGHT	SIZE								
	REACTION								
LEFT	SIZE								
	REACTION								

PUPIL SCALE (mm): 1 2 3 4 5 6 7 8

- All neurological assessments
- Document the size and reaction for each pupil
- Check for consensual response

Motor Assessment



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

- Minimum q shift for all patients until awake and findings normal
- With every neurological assessment
- Increase monitoring for any neurological change PRN

Spinal Cord Assessment

SPINAL CORD ASSESSMENT: Patients able to obey commands										
Motor Function: 0-5/5	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
Shoulder: Shrugs (C4)										
Abducts (C5)										
Elbow: Bends (C5)										
Straightens (C7)										
Wrist: Straightens (C6)										
Flex toward palm (C7)										
Fingers: Bends first digits (C8)										
Spreads apart (T1)										
Hips: Flexes (L2, L3)										
Knees: Straightens (L3, L4)										
Feet: Flex toes to nose (L4, L5)										
Flex toes down (S1, S2)										
Sensory Function: Refer to dermatome chart and record the lowest level for both upper and lo										
Upper limbs to pin										
Upper limbs to light touch										
Lower limbs to pin										
Lower limbs to light touch										
Rectal tone **P**resent / **A**bsent										

Bedside Resources

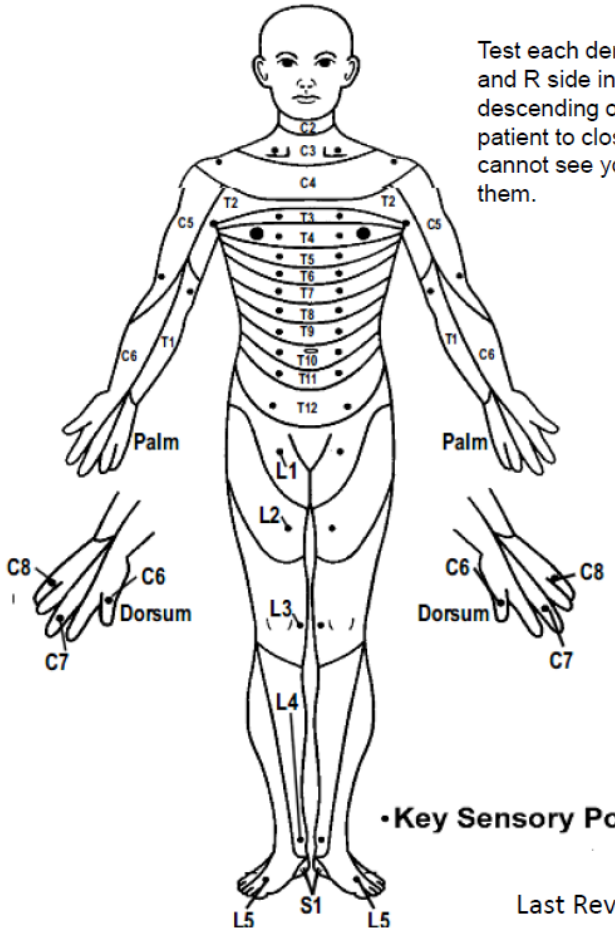
Neurological Assessment Tools

Glasgow Coma Scale			
Eye Opening	**Verbal Response**	**Motor Response**	**Score**
		Obeys	6
	Oriented	Localizes	5
Spontaneously	Confused	Withdraws	4
To voice	Inappropriate	Abnormal Flexion	3
To pain	Incomprehensible	Abnormal Extension	2
No eye opening	No vocalization	No Movement	1
___/4	____/5	____/6	__/15

Motor Scoring Scale	
5	Able to overcome strong resistance (normal strength)
4	Able to overcome mild resistance (mild weakness)
3	Supports limb against gravity but not resistance
2	Moves but not against gravity
1	Muscle flicker but no movement
0	No muscle movement
__/5	**Score**

Sensory Assessment/Spinal Cord Testing

Test sensation twice, once for pin and once for light touch . Use a whisp of tissue for light touch and blunt end needle for pain/pin. Record the highest level of sensation using the dermatome chart below.



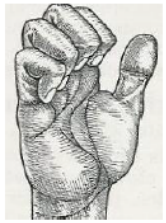
Test each dermatome on L and R side in anatomical descending order. Ask patient to close eyes so they cannot see you touching them.

Last Reviewed April 16, 2014

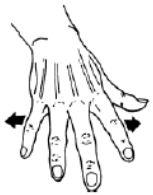
Motor Assessment/Spinal Cord Testing

Level of Function:

C8: Bend fingers toward palm at first digit joint



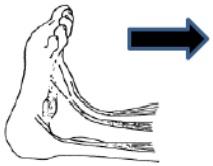
T1: Spread fingers apart



L2, L3: Bend hip

L3, L4: Straighten knee

L4, L5: Dorsiflexion (pull toes toward nose)

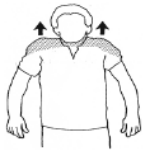


S1, S2: Plantar flexion (point toes downward)

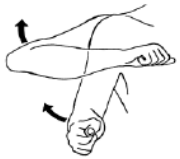
Motor Assessment/Spinal Cord Testing

Level of Function:

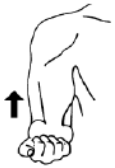
C4: Shrug shoulder



C4, C5: Abduct shoulder



C5: Bend elbow



C6, C7: Extend wrist

C7: Straighten elbow

C7, C8: Bend wrist toward palm

Pain Assessment: Unable to Self-Report

Critical-Care Pain Observation Tool (CPOT)

Score each item 0, 1 or 2 out of 2. Total the sum of the four items to produce a CPOT score of 0-8/8

Indicator	Assessment	Score	Description
Facial Expression (score 0, 1 or 2)	Relaxed, Neutral	0	• No muscle tension observed
	Tense	1	• Presence of frowning, brow lowering, orbit tightening or contraction of upper eyelid; or, • Any other change (e.g., opening eyes or tearing during noxious procedures)
	Grimacing	2	• All above facial movements plus eyelids tightly closed (may present with mouth open or biting ETT)
Body Movement (score 0, 1 or 2)	Absence of movement/normal position	0	• Does not move at all (doesn't necessarily mean absence of pain); or, normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	• Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	• Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Ventilator Compliance (ventilated patient) **OR** *Vocalization (non-intubated)* (score 0, 1 or 2)	Tolerating ventilator or movement; *or, talking in normal tone or no verbal sound*	0	• Alarms not activated, easy ventilation; or, *Talking in normal tone or no sound*
	Coughing but tolerating ventilator; *or, sighing or moaning*	1	• Coughing, alarms may be activated but stop spontaneously; or, *Sighing, moaning*
	Fighting ventilator; or, *crying out or sobbing*	2	• Asynchrony, blocking ventilator, alarms frequently activated; or, *Crying out, sobbing*
Muscle Tension (evaluate by passive flexion and extension of upper limbs when patient is at rest or during turning) (score 0, 1 or 2)	Relaxed	0	• No resistance to passive movements
	Tense, rigid	1	• Resistance to passive movements
	Very Tense or rigid	2	• Strong resistance to passive movements, incapacity to complete them
TOTAL SCORE		___/8	Sum of scores from each of the 4 categories.

Sedation Assessment: VAMAAS

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

MAAS Score	Description of MAAS	VA Score	Description of VA
0	Unresponsive to pain Does not move to noxious stimulus.	A	Minimal coughing; few alarms; tolerates movement
1	Opens eyes and/or moves to pain only Opens eyes ***OR*** raises eyebrows ***OR*** turns head towards stimulus ***OR*** moves limbs with noxious stimulus.	B	Coughing, frequent alarms when stimulated; settles with voice or removal of stimulus
2	Opens eyes and/or moves to voice Opens eyes ***OR*** raises eyebrows ***OR*** turns head towards stimulus ***OR*** moves limbs when touched or name is spoken.	C	Distressed, frequent coughing or alarms; high RR with normal/ low PaCO2
3	Calm and cooperative No external stimulus is required to elicit movement ***AND*** patient is adjusting sheets or clothes purposefully and follows commands.	D	Unable to control ventilation; difficulty delivering volumes; prolonged coughing
4	Restless but cooperative; follows commands No external stimulus is required to elicit movement ***AND*** patient is picking at sheets or tubes ***OR*** uncovering self & follows commands		
5	Agitated; attempts to get out of bed; may stop behaviour when requested but reverts back No external stimulus is required to elicit movement ***AND*** patient is attempting to sit up ***OR*** moves limbs out of bed ***AND*** does not consistently follow commands (e.g. will lie down when asked but soon reverts back to the attempts to sit up or move limbs out of bed).		
6	Dangerously agitated; pulling at tubes or lines, thrashing about; does not obey commands No external stimulus is required to elicit movement ***AND*** patient is attempting to sit up ***OR*** thrashing side to side ***OR*** striking staff ***OR*** trying to climb out of bed ***AND*** doesn't calm down when asked.		

Pain Assessment: Able to Self-Report

PQRST Mnemonic for Pain Assessment

P (provokes, precipitates):
- Location of pain
- What brings it on (e.g., activity, specific movement, eating, breathing)?
- What relieves it?

Q (quality):
- What is the quality of the pain (in the patient's own words)?
- Prompt only if necessary, to determine if pain is dull, sharp, stabbing, pins and needles, "electrical", etc.

R (radiation, referral):
- Does the pain move to any other spot?
- Are there any other symptoms with the pain (e.g., nausea, vomiting, shortness of breath)?

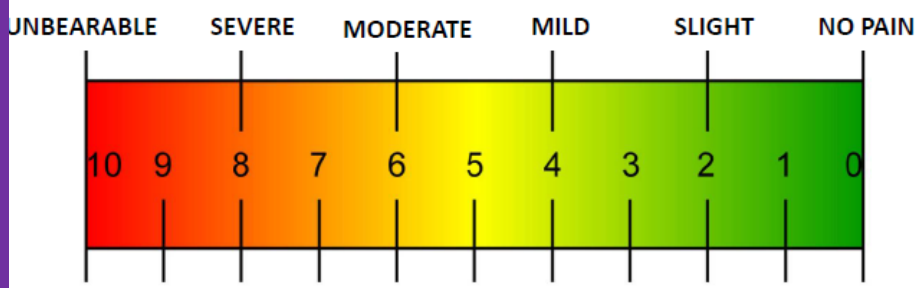
S (severity):
- How does the patient rate the severity of the pain on a scale of 1-10?

T (time):
- When did the pain start?
- Has this pain occurred before?
- Is the pain intermittent or constant?

Pain Assessment: Able to Self-Report

An individual's self-report provides is the primary evidence for the determination of pain.

- The numeric (0-10 out of 10) or visual analogue (shown below) should be included in the pain assessment whenever the patient can self-report.
- The actual score is not as important as the patient's perception of change during reassessment (worse or better).
- When pain is reported by the patient, the characteristics of the pain should be evaluated using the PQRST mnemonic (next page). This will help to identify the cause of the pain and the most appropriate treatment plan.



Comfort & Central Nervous System: Infusions

Comfort: Refer to pain, sedation and delirium scales. **Sleep Codes:** Identify periods when patient appears to be sleeping. **QS** = Quiet Sleep **RS** = Restless Sleep **A** = Awake

NSR (0-10) or CPOT (0-8)

VAMAAS

SLEEP

ICP Monitoring: ICP

CPP (MAP - ICP)

ZERO (Z) LEVEL (L)

Drain level

CSF drained

Diuretic administered

CEEG

Z = Zero **L** = Level **M** = Mannitol **HS** = Hypertonic saline

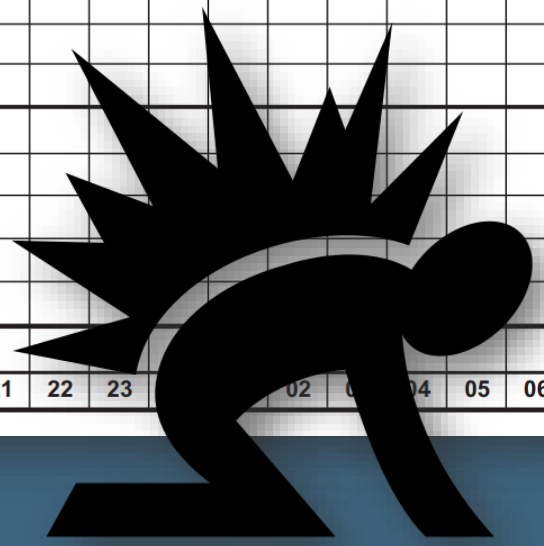
Infusions:

CNS/NMB Drugs
Chart dose/hour
Propofol mg/kg/hr

Independent check

INITIALS

07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 02 04 05 06



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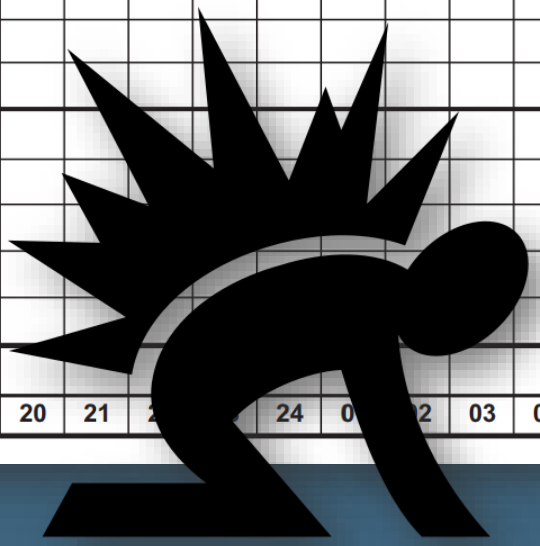
Comfort & Central Nervous System: Infusions

Comfort: Refer to pain, sedation and delirium scales. **Sleep Codes:** Identify periods when patient appears to be sleeping. **QS** = Quiet Sleep **RS** = Restless Sleep **A** =

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
NSR (0-10) or CPOT (0-8)																						
VAMAAS																						
SLEEP																						
ICP Monitoring: ICP																						
CPP (MAP - ICP)																						
ZERO (Z) LEVEL (L)																						
Drain level																						
CSF drained																						
Diuretic administered																						
CEEG																						
Infusions: *Propofol mg/kg/h*	3	→	→	2																		
Rocuronium mg/h	45	→	→	→																		
Hydromorphone mg/h	1.5	→	→	→																		
Independent check																						
INITIALS																						

Z = Zero **L** = Level **M** = Mannitol **HS** = Hypertonic saline

CNS/NMB Drugs Chart dose/hour Propofol mg/kg/hr



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Intracranial Pressure Monitoring

ICP Monitoring:	ICP
	CPP (MAP - ICP)
	ZERO (Z) LEVEL (L)
	Drain level
	CSF drained
	Diuretic administered
	CEEG

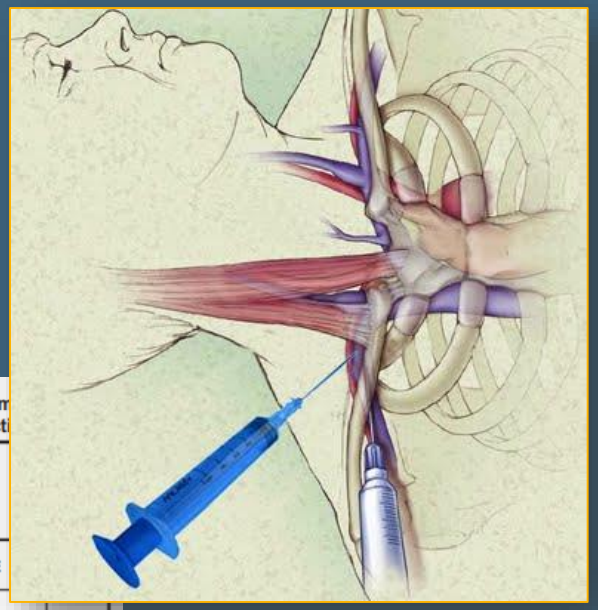
Z = Zero **L** = Level **M** = Mannitol **HS** = Hypertonic saline

Intracranial Pressure Monitoring:

Z = Zero L = Level M = Mannitol HS = Hypertonic saline

ICP Monitoring: ICP	19
CPP (MAP - ICP)	60
ZERO (Z) LEVEL (L)	L/Z
Drain level	10
CSF drained	12
Diuretic administered	M
CEEG	✓

Intravascular Device Monitoring:
(Panel 6)



A. INTRAVASCULAR DEVICE MONITORING: Record all peripheral, central venous and arterial devices in place at adm
Document the insertion of all CENTRAL VENOUS and ARTERIAL lines here. Document the insertion of PERIPHERAL IVs in Secti

Insert Time = CCTC insertion time or NA if unknown **Insert Location** = Location of insertion (e.g., CCTC, ED) or NA if unknown/unsure.
Compliance Documented = Y or N. Only record Y if sterile technique documented by checklist or progress note.
Observed Break: DAR note to describe break is required if YES (e.g., femoral line inserted during CPR, field disrupted).
Printed Waveform/ScvO2: REQUIRED upon insertion AND admission for all IJ, SC and femoral lines. ✓ to confirm completion.
Print Inserter's Name: MD, RRT or RN **Line Issues:** enter * in column and DAR if compliance unknown, break in technique occurs or other line concerns exist.

INSERT DATE	INSERT TIME	LIST ALL NEW ARTERIAL, CENTRAL VENOUS AND PERIPHERAL LINES	INSERT LOCATION	COMPLIANCE DOCUMENTED	OBSERVED BREAK	WAVEFORM / ScvO2 CONFIRMATION	INSERTER'S NAME	

B. Documentation of peripheral IV insertion in CCTC * DAR complications for unsuccessful/successful attempts; use Peripheral IV Insertion Protocol.

INSERT DATE	INSERT TIME	VEIN LEVEL	SITE	GAUGE	# ATTEMPTS	BLOOD RETURN	NAME AND INITIAL CONFIRMING COMPLIANCE

C. ONGOING MONITORING OF INTRAVASCULAR LINES: Document Q shift assessment, starting on shift after initial documentation.
Line Code: ✓ = WDL D/C = Discontinued **Dressing Code:** ✓ = D&I D = Loss of integrity S = Soiled Δ = Changed
* **and DAR** in AI record for any site or patency issue or if accidental dislodgement. **Line Issue:** * and DAR if identified on previous/current shift. Continue * and DAR until resolution is documented.
Waveforms: Post arterial and CL waveform at the start of each shift to document waveform quality and confirm vascular placement for all arterial and IJ, SC and femoral venous lines.

INSERT DATE	LIST ALL ARTERIAL, CENTRAL VENOUS AND PERIPHERAL IVs	ASSESSMENT TIME AND CODE (Days)						ASSESSMENT TIME AND CODE (Nights)					
		LINE ISSUES	WAVE POSTED					LINE ISSUES	WAVE POSTED				

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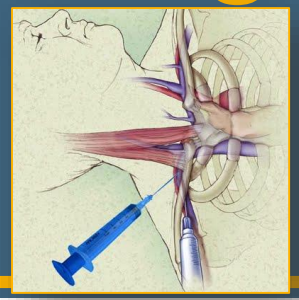
Intravascular Device Monitoring: Initial Documentation



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Compliance Documented = Y or N. Only record Y if sterile technique documented by checklist or progress note.
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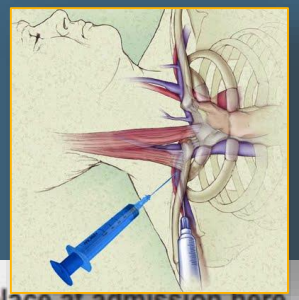
Printed Waveform/ScvO2: REQUIRED upon insertion AND admission for all IJ, SC and femoral lines. ✓ to confirm completion.
Print Inserter's Name: MD, RRT or RN **Line Issues:** enter * in column and DAR if compliance unknown, break in technique occurs or other line concerns exist.

INSERT DATE	INSERT TIME	LIST ALL NEW ARTERIAL, CENTRAL VENOUS AND PERIPHERAL LINES	INSERT LOCATION	COMPLIANCE DOCUMENTED	OBSERVED BREAK	WAVEFORM / ScvO2 CONFIRMATION

- Central line placement must be confirmed with an $ScVO_2$

- All central lines must be connected to a closed pressure monitor system at time of insertion and have waveform confirmation

Intravascular Device Monitoring: Initial Documentation



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Insert Time = CCTC insertion time or NA if unknown **Insert Location** = Location of insertion (e.g., CCTC, ED) or NA if unknown/unsure.
Compliance Documented = Y or N. Only record Y if sterile technique documented by checklist or progress note.
Observed Break: DAR note to describe break is required if YES (e.g., femoral line inserted during CPR, field disrupted).
Printed Waveform/ScvO2: REQUIRED upon insertion AND admission for all IJ, SC and femoral lines. ✓ to confirm completion.
Print Inserter's Name: MD, RRT or RN **Line Issues:** enter * in column and DAR if compliance unknown, break in technique occurs or other line concerns exist.

INSERT DATE	INSERT TIME	LIST ALL NEW ARTERIAL, CENTRAL VENOUS AND PERIPHERAL LINES	INSERT LOCATION	COMPLIANCE DOCUMENTED	OBSERVED BREAK	WAVEFORM / ScvO2 CONFIRMATION	INSERTER'S NAME	LINE ISSUES
Jun 17	1715	R I/J Triple Lumen Cath	CCTC	Yes	No	✓	Dr D. Houser	No

Intravascular Device Monitoring: Ongoing Monitoring

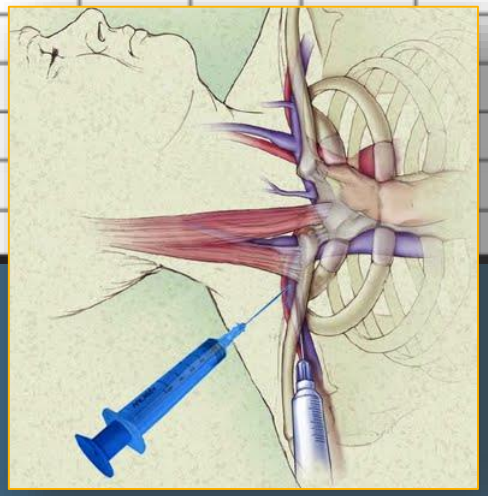
C. ONGOING MONITORING OF INTRAVASCULAR LINES: Document Q shift assessment, starting on shift after initial documentation.

Line Code: ✓ = WDL D/C = Discontinued **Dressing Code:** ✓ = D&I D = Loss of integrity S = Soiled Δ = Changed

*** and DAR** in AI record for any site or patency issue or if accidental dislodgement. **Line Issue:** * and DAR if identified on previous/current shift. Continue * and DAR until resolution is documented.

Waveforms: Post arterial and CL waveform at the start of each shift to document waveform quality and confirm vascular placement for all arterial and IJ, SC and femoral venous lines.

INSERT DATE	LIST ALL ARTERIAL, CENTRAL VENOUS AND PERIPHERAL IVs	ASSESSMENT TIME AND CODE (Days)						ASSESSMENT TIME AND CODE (Nights)					
		LINE ISSUES	WAVE POSTED					LINE ISSUES	WAVE POSTED				
INITIAL COMPLETION													



Intravascular Device Monitoring: Ongoing Monitoring

C. ONGOING MONITORING OF INTRAVASCULAR LINES: Document Q shift assessment, starting on shift after initial documentation.

Line Code: ✓ = WDL D/C = Discontinued **Dressing Code:** ✓ = D&I D = Loss of integrity S = Soiled Δ = Changed

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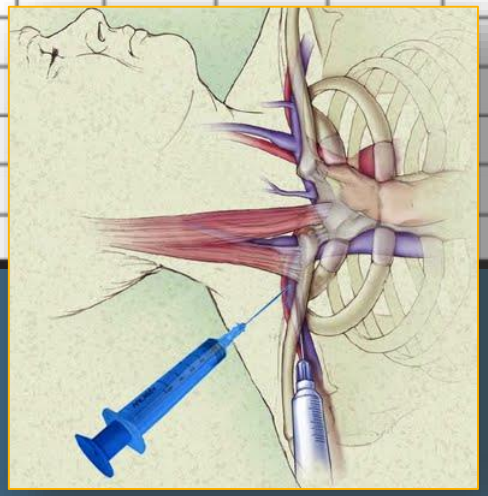
Waveforms: Post arterial and CL waveform at the start of each shift to document waveform quality and confirm vascular placement for all arterial and IJ, SC and femoral venous lines.

INSERT DATE	LIST ALL ARTERIAL, CENTRAL VENOUS AND PERIPHERAL IVs	ASSESSMENT TIME AND CODE (Days)						ASSESSMENT TIME AND CODE (Nights)					
		LINE ISSUES	WAVE POSTED	0800				LINE ISSUES	WAVE POSTED				
Jun 17	Rt I/J Triple Lumen Cath		✓	✓									
Jun 17	Lt Radial Art Line		✓	✓									
Jun 16	Lt hand 20 g PIV			Δ									
Jun 16	Rt hand 18 g PIV			* D/C									
INITIAL COMPLETION													



Intravascular Device Monitoring: Peripheral IV

B. Documentation of peripheral IV insertion in CCTC * DAR complications for unsuccessful/successful attempts; use Peripheral IV Insertion Protocol.

INSERT DATE	INSERT TIME	VEIN LEVEL	SITE	GAUGE	# ATTEMPTS	BLOOD RETURN	NAME AND INITIAL CONFIRMING COMPLIANCE

NURSING INTERVENTIONS (initial when completed/assessed; *significant findings and document on A/I Flowsheet)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Peripherally Infusing Vasoactive Medications: Date Started: Time started:																								
Site: Gauge: Medication: Ultrasound Confirmed: ☐ Yes ☐ No																								
✓ Blood Return																								
Phlebitis Scale																								
Infiltration Scale																								
Consultant/Senior																								

Indications for Central Venous Catheter (CVC)

A CVC is required for the administration of vasopressors or vesicants that do not meet criteria for peripheral vasopressor protocol. During acute resuscitation, placement can be deferred for up to 2 hours to facilitate insertion safety and prompt reversal of shock. If appropriate vascular access can not be established within 5 minutes, intraosseous insertion should be considered.

A Central Venous Line is required in the following situations:

1. More than one vasopressor is required
2. Maximum dose of single agent norepinephrine or dopamine has been reached, dosing requirements increasing/patient is unstable or required longer than 24 hours
3. Unable to establish or maintain two peripheral IVs that comply with peripheral vasopressor protocol
4. Additional access sites are needed for fluid or medications
5. Concern over IV site quality exists
6. Recommended for medications that are hypertonic, high or low pH or concentrated electrolyte solutions
7. PICC lines are not suitable replacements for central venous lines in patients requiring multiple agents, ongoing resuscitation, vasopressors use or frequent blood sampling

Arterial Lines

1. Required when continuous IV infusions of vasoactive drugs are used
2. An exception to the arterial line policy **can be considered** for patients who meet peripheral vasopressor protocol; arterial lines are preferred for accurate and frequent BP measurements
3. Order must be entered with the name of the approving Consultant entered into Power Chart **using the Crit Care Peripheral Vasopressor power plan.** The order will task to the nurse for renewal every 12 hours. AI documentation confirming this review is required every shift.

Protocol for Peripheral Vasopressors

Acceptable Indications:

- Vasopressor use expected to be short
- Single agent norepinephrine (maximum 12 mcg) or dopamine (maximum 10 mcg/kg/min) for a maximum 24 hours
- **Must be ordered via Crit Care Peripheral Vasopressor order set and approved by CCTC Consultant (days) or Senior (nights)**. The order will task to the nurse to review every 12 hours. AI documentation confirming the review is required.
- Notify Charge Nurse if a vasopressor is infusing peripherally

Site Requirements:

- Forearm or upper arm only (no lower extremity /hand/anticubital fossa)
- Minimum 20 gauge with blood return; assess before starting and Q shift
- Must have second back up line that meets same criteria
- No other medication can be administered in same line

Monitoring Requirements:

- Assess and document Infiltration and Phlebitis Scales Q1H and PRN
- Initiate Extravasation Protocol/notify MD **immediately for all site concerns**
- Complete AEMS for **ALL** site or insertion complications for PERIPHERAL or CENTRAL VENOUS LINE adverse events

Peripheral IV Insertion Standards

VEIN LEVEL ASSESSMENT

Level 1:
Visible, easy to palpate, large in size

Level 2:
Visible, easy to palpate, moderate in size, previous IV site

Level 3:
Visible, easy to palpate, small size, previous IV site, limited veins (some sclerosed)

Level 4:
Difficult to see, can be palpated, age > 70, previous therapy has resulted in poor veins

Level 5:
Vein not visible, cannot be palpated, may require multiple techniques

Peripheral IV Insertion Bundle

1. Match operator skill to vein level assessment
2. Change operator after 2 attempts
3. Wear gloves (PPE)
4. Clip hair (don't shave) if necessary
5. 30 second scrub: 2% chlorhexidine/70% alcohol
6. Air dry one minute
7. Ensure **no touch after cleaning** (if touch is required, sterile gloves must be worn and aseptic technique maintained).
8. Document in graphic record. Include confirmation of compliance (aseptic) bundle.
9. If inserted under imperfect conditions (e.g. resuscitation), * and DAR and notify team to change site as soon as possible
10. Access all ports and maintain dressings aseptically.

Infiltration Scale *DAR if >0

0 No symptoms

1 Skin blanched
Edema < 2.5 cm in any direction, cool to touch, with or without pain

2 Skin blanched
Edema 2.5 – 15 cm in any direction, cool to touch, with or without pain

3 Skin blanched, translucent
Gross Edema > 15 cm in any direction, cool to touch, mild-moderate pain, possible numbness

4 Skin blanched, translucent
Skin tight, leaking, skin discolored, bruised, swollen, gross edema > 15 cm in any direction, deep pitting tissue edema, circulatory impairment, moderate – severe pain, infiltration of any amount of blood product, irritant, or vesicant

PHLEBITIS SCALE

1+ Pain at Site

2+ Pain and redness at site

3+ Pain, redness and swelling at site with palpable cord of less than 7.5 cm

4+ Pain, redness and swelling at site with palpable cord of 7.5 cm or greater


Brain
Breaks

Restraints

RESTRAINTS	Code: + = On - = Off																							
Wrist ✓ CSM R / L																								
Ankle ✓ CSM R / L																								
Magnetic Restraint																								

Restraints

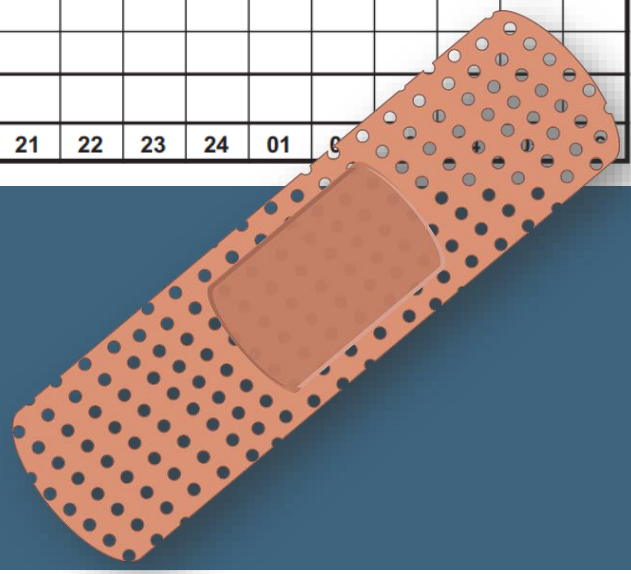
RESTRAINTS	Code: + = On - = Off																								
Wrist ✓ CSM R / L	+	+	✓	✓*	-																				
Ankle ✓ CSM R / L	+	+	✓	✓	-																				
Magnetic Restraint																									

Other Dressings/Care

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

INITIALS																						
	07	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**01**			

8460-4922 (Rev. 2017/04/27) PANEL 6



London Health Sciences Centre

Nursing Interventions

(Panel 5)

London Health Sciences Centre

Critical Care Trauma Centre

CCTC FLOWSHEET

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

INTERVENTIONS (✓ = Care completed WDL; Initial when completed/assessed)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Activity Code: C = Chair CC = Cardiac Chair D = Dangle W = Stand with Weight Bearing A = Ambulation RT = Reverse Trendelenburg																								
Code: L = Left R = Right B = Both P = Percussion Mode V = Vibration Mode R = Rotation (° in brackets)																								
CB = Complete Bath PB = Partial Bath S = Shower HW = Hair Wash																								
TB = Teeth Brushed S = Oral care with swab L = Lubricant																								
Code: D = Drops O = Ointments C = Eyelids Closed																								
Stool Code: - = Small + = Large S = Soft D= Diarrhea H = Hard **Impaction Code:** H = Hard S = Soft N = None																								
Identify L = Left or R = Right and drainage tube number AT = Adhesive Tape AF = Anchor Fast TT = Trach Ties																								
SpO_2 Monitor Site Change																								
VTE PROPHYLAXIS **Code:** + = On - = Off GCS = Graduated Cmpression Stockings IPC = Intermittent Pneumatic Compression																								
Mechanical Compression Devices																								
• Skin ✓ Legs																								
MUSCULOSKELETAL **Code:** + = On - = Off																								
Splints Upper Extremities																								
Splints Lower Extremities																								
ROM Leg																								
ROM Arm																								
CATHETER CHANGE **Code:** R = Regular Foley S = Silicone T = Thermistor																								
Catheter Change																								
Drainage Bag Change																								
INITIALS																								
	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06

Nursing Interventions

London Health Sciences Centre

Critical Care Trauma Centre

CCTC FLOWSHEET

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

NURSING INTERVENTIONS (✓ = Care completed WDL; Initial when completed/assessed)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
POSITIONING	**Activity Code:** **C** = Chair **CC** = Cardiac Chair **D** = Dangle **W** = Stand with Weight Bearing **A** = Ambulation **RT** = Reverse Trendelenburg																							
Degree **HOB** elevation																								
Supine/**P**rone/**R**ight/**L**eft																								
Right sided wedge **(OB)**																								
Activity (Use Code)																								
PULMONARY BEDS	**Code:** **L** = Left **R** = Right **B** = Both **P** = Percussion Mode **V** = Vibration Mode **R** = Rotation (° in brackets)																							
Time in Minutes																								
Percuss/Vibrate/Rotate																								

Nursing Interventions

London Health Sciences Centre

Critical Care Trauma Centre

CCTC FLOWSHEET

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

NURSING INTERVENTIONS (✓ = Care completed WDL; Initial when completed/assessed)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
POSITIONING	**Activity Code:** **C** = Chair **CC** = Cardiac Chair **D** = Dangle **W** = Stand with Weight Bearing **A** = Ambulation **RT** = Reverse Trendelenburg																							
Degree **HOB** elevation																								
Supine/**P**rone/**R**ight/**L**eft																								
Right sided wedge **(OB)**																								
Activity (Use Code)																								
PULMONARY BEDS	**Code:** **L** = Left **R** = Right **B** = Both **P** = Percussion Mode **V** = Vibration Mode **R** = Rotation (° in brackets)																							
Time in Minutes																								
Percuss/Vibrate/Rotate																								

Nursing Interventions
Hygiene

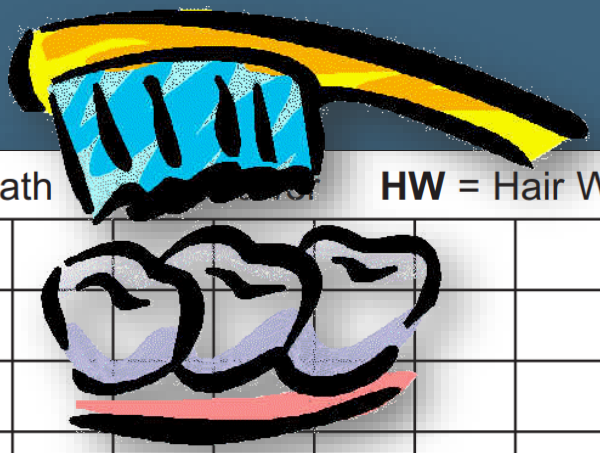
HYGIENE	**CB** = Complete Bath **PB** = Partial Bath **S** = Shower **HW** = Hair Wash
Skin Inspection	
Bathing/Hair Washing	
Pericare	
Linen Change	
Facial Shave	
Collar Care	
ORAL CARE	**TB** = Teeth Brushed **S** = Oral care with sw
Oral Inspection	
Oral Care (use code)	
EYE CARE	**Code**: **D** = Drops **O** = Ointments **C** =
Lubricant	

Nursing Interventions Hygiene

HYGIENE	CB = Complete Bath PB = Partial Bath S = Shower HW = Hair Wash									
Skin Inspection		*								
Bathing/Hair Washing		CB/HW								
Pericare		✓								
Linen Change		✓								
Facial Shave		✓								
Collar Care		✓								
ORAL CARE	**TB** = Teeth [illegible] d **S**							ricant		
Oral Inspection										
Oral Care (use code)										
EYE CARE	**Code: D** = Drops **O** =							ed		
Lubricant										

- Spinal collars are removed q shift for skin care and inspection
- Findings not WDL are documented in the AI record.

Nursing Interventions
Oral Care



HYGIENE	**CB** = Complete Bath	**PB** = Partial Bath	**HW** = Hair Wash
Skin Inspection			
Bathing/Hair Washing			
Pericare			
Linen Change			
Facial Shave			
Collar Care			
ORAL CARE	**TB** = Teeth Brushed	**S** = Oral care with swab	**L** = Lubricant
Oral Inspection			
Oral Care (use code)			
EYE CARE	**Code**: **D** = Drops	**O** = Ointments	**C** = Eyelids Closed
Lubricant			

Nursing Interventions
Eye Care

HYGIENE	**CB** = Complete Bath	**PB** = Partia	ir Wash
Skin Inspection			
Bathing/Hair Washing			
Pericare			
Linen Change			
Facial Shave			
Collar Care			
ORAL CARE	**TB** = Teeth Brushed	**S** = Oral care with swab	**L** = Lubricant
Oral Inspection			
Oral Care (use code)			
EYE CARE	**Code**: **D** = Drops	**O** = Ointments	**C** = Eyelids Closed
Lubricant			

Nursing Interventions
Bowel Routine

BOWEL ROUTINE	Stool Code: - = Small + = Large S = Soft D= Diarrhea H = Hard												
Stool Record													
Impaction ✓													
Fecal Drainage: Tubing Flush													

Nursing Interventions: Respiratory

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

Chest Tube Drainage

OUTPUT										
HOUR	URINE		L CT #1	Drain	L CT #2	Drain				
0600 0700			(850)	0	(675)	0				
0700 0800										
0800 0900			(900)	50	(750)	75				
0900 1000										
1000 1100			(920)	20	(800)	50				
1100 1200										
1200 1300										
1300										

Nursing Interventions: VTE Prophylaxis (Venous ThromboEmbolism)

VTE PROPHYLAXIS		Code: + = On − = Off GCS = Graduated Cmpression Stockings IPC = Intermittent Pneumatic Compre																			
Mechanical Compression Devices																					
* Skin ✓ Legs																					
MUSCULOSKELETAL		**Code**: + = On − = Off																			
Splints	Upper Extremities																				
	Lower Extremities																				
ROM	Leg																				
	Arm																				
CATHETER CHANGE		**Code**: R = Regular Foley S = Silicone T = Thermistor																			
Catheter Change																					
Drainage Bag Change																					
INITIALS																					
		07	08	09	10	11	12													02	

Nursing Interventions: Musculoskeletal

VTE PROPHYLAXIS	Code: + = On - = Off GCS = Graduated Cmpression Stockings																				
Mechanical Compression Devices																					
* Skin ✓ Legs																					

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

CATHETER CHANGE	Code: R = Regular Foley S = Silicone T = Thermister																				
Catheter Change																					
Drainage Bag Change																					
INITIALS																					
	07	08	09	10	11	12	13	14	15	16	17									01	02

Nursing Interventions: Catheter Change

VTE PROPHYLAXIS	Code: + = On − = Off GCS = Graduated Cmpressio																				
Mechanical Compression Devices																					
* Skin ✓ Legs																					
MUSCULOSKELETAL	**Code**: + = On − = Off																				
Splints Upper Extremities																					
Splints Lower Extremities																					
ROM Leg																					
ROM Arm																					
CATHETER CHANGE	**Code**: **R** = Regular Foley **S** = Silicone **T** = Thermistor																				
Catheter Change																					
Drainage Bag Change																					
INITIALS																					
	07	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**01**	**02**	**0**

Nursing Interventions: Catheter Change

VTE PROPHYLAXIS	**Code**: + = On - = Off **GCS** = Graduated Cmpressio																				
Mechanical Compression Devices																					
* Skin ✓ Legs																					
MUSCULOSKELETAL	**Code**: + = On - = Off																				
Splints Upper Extremities																					
Splints Lower Extremities																					
ROM Leg																					
ROM Arm																					
CATHETER CHANGE	**Code**: **R** = Regular Foley **S** = Silicone **T** = Thermistor																				
Catheter Change								Δ S													
Drainage Bag Change								Δ													
INITIALS								RSP													
	07	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**01**	**02**	**03**

Prevention of Catheter Associated Urinary Tract Infection (CAUTI): Maintenance Bundle

- ☐ Reassess need for bladder catheter Q shift.
- ☐ Secure catheter to thigh to prevent trauma.
- ☐ Disinfect drainage tube connection before reconnection if system is inadvertently disconnected.
- ☐ Ensure that urine is draining without obstruction or kink.
- ☐ Maintain drainage bag below the level of the bladder without contacting the floor.
- ☐ Protect drainage bag valve from contamination when bag is emptied.
- ☐ Maintain perineal hygiene routine.
- ☐ Change Foley catheter if positive urine culture obtained.

Fluid Balance
(Panel 4)

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

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE											OUTPUT										
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300 1400										
											1400 1500										
											1500 1600										
											1600 1700										
											1700 1800										
											TOTAL										

▷ 0600-1800 Intake: _____ Output: _____ Net 12 Hour Balance: _____

INTAKE											OUTPUT										
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											1800 1900										
											1900 2000										
											2000 2100										
											2100 2200										
											2200 2300										
											2300 2400										
											2400 0100										
											0100 0200										
											0200 0300										
											0300 0400										
											0400 0500										
											0500 0600										
											TOTAL										

▷ 1800-0600 Intake: _____ Output: _____ Net 12 Hour Balance: _____

NET 24 HOUR BALANCE: _____

Fluid Balance

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

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE											OUTPUT										
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300 1400										
											1400 1500										
											1500 1600										
											1600 1700										
											1700 1800										
											TOTAL										

▷ 0600-1800 Intake: _____ Output: _____ Net 12 Hour Balance: _____

London Health Sciences Centre

Fluid Balance

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

Previous 24 Hour Balance: _____ Cumulative Balance: _____

INTAKE											OUTPUT										
Main-tenance	IV Meds							P.O.	Tube Feeds	Meds & Flush P/G/O	HOUR	URINE									
											0600 0700										
											0700 0800										
											0800 0900										
											0900 1000										
											1000 1100										
											1100 1200										
											1200 1300										
											1300 1400										
											0300 0400										
											0400 0500										
											0500 0600										
											TOTAL										

▷ 1800-0600 Intake: _____ Output: _____ Net 12 Hour Balance: _____

NET 24 HOUR BALANCE: _____

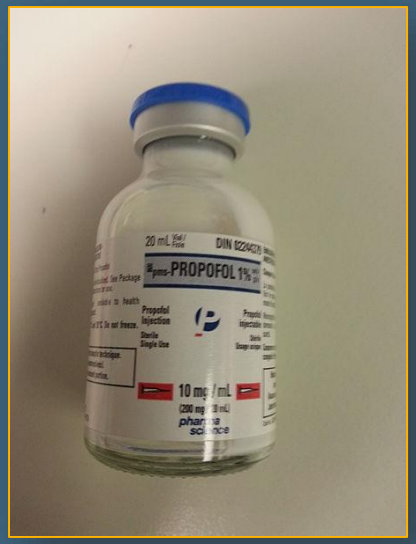
8460-4922 (Rev. 2017/04/27) PANEL 4

IV Tubing Change

- For continuous infusions, we change IV tubing every 96 hours.
- Insulin bags and Vasopressin bags and tubing are to be changed every 24 hours (at 1600).

IV Tubing Change

- Change vented Propofol tubing every 12 hours
- Change TPN bags & tubing every 24 hours (at 2200)



TPN Tubing

2-in-1 **Lipids separate**

For the amino acid/dextrose component, use 0.2 or 0.22 micron in-line filter (**2C8571** or 2C8858)

For the lipid component, use a non-DEHP set (**2C1145**)

You may continue to use this Y-extension to connect the 2 solutions together to connect to one lumen
It is non-DEHP

3-in-1 **Lipids included (one bag)**

For the SmofKabiven product, use non-DEHP 1.2 micron with in-line filter (**2H8486**)

London Health Sciences Centre