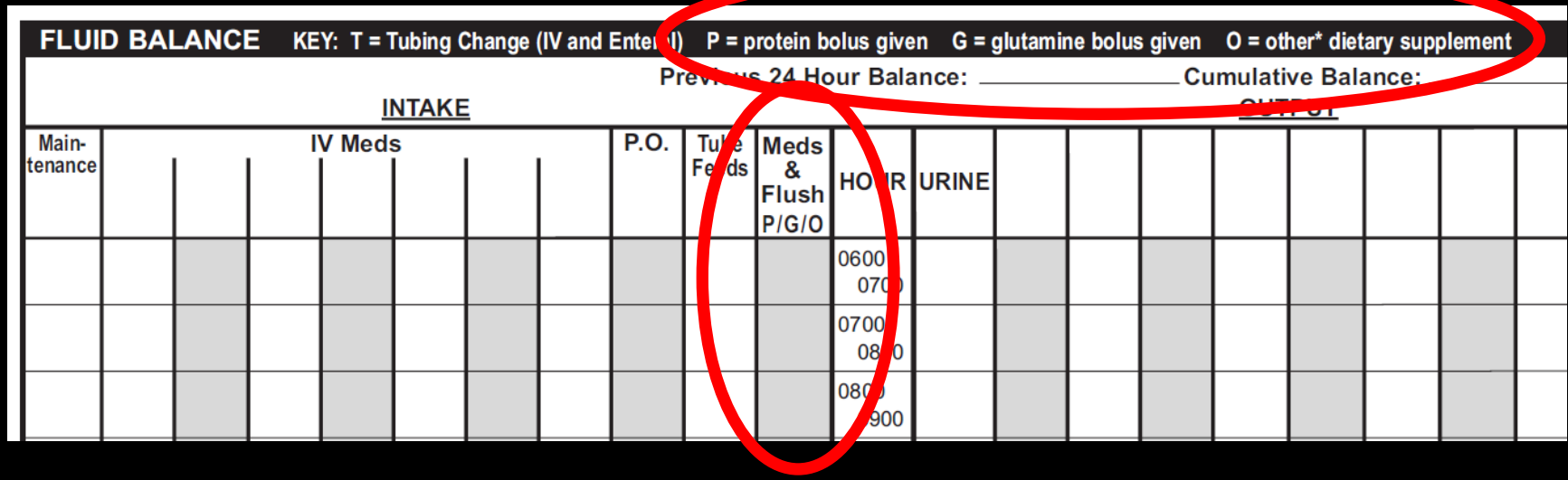
Upcoming Revisions to CCTC 24 Hour Graphic (Approximate date: May 2014)

For information on CCTC Procedures, Nursing Standards, Protocols or Bedside Assessment tools, refer to CCTC Website

Fluid Balance
(Panel 4)

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								

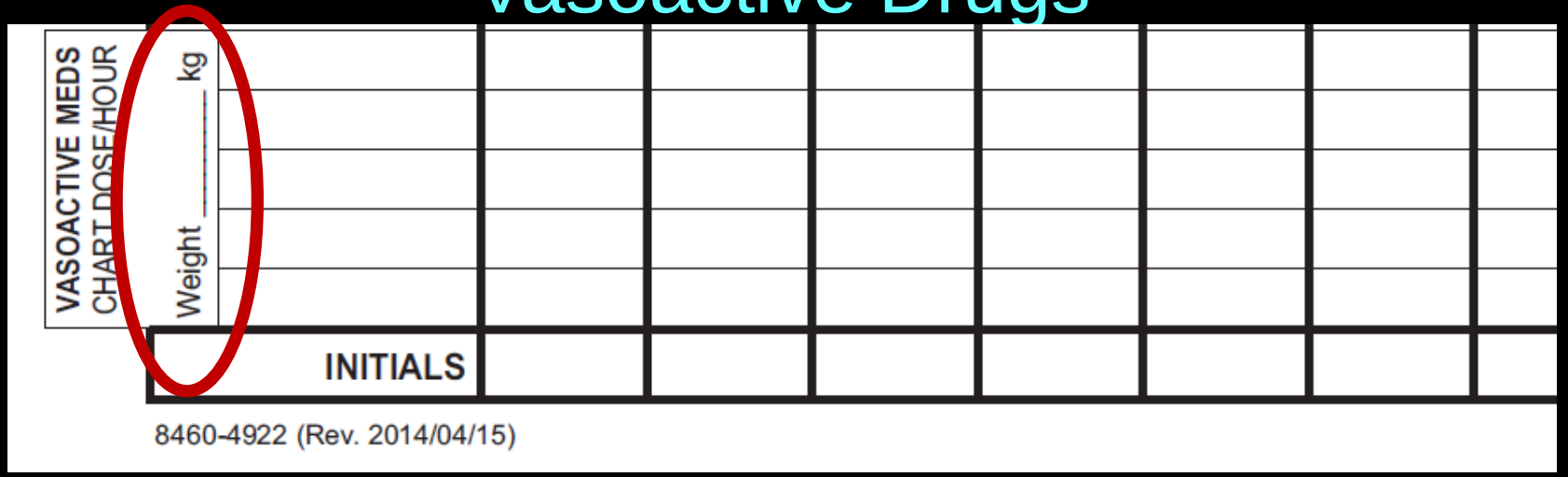
We can no longer enter enteral feeding supplements onto the MAR in the electronic world.

Revision:

Record enteral feeding flushes in the medication/flush column as P (protein), G (glutamine) or O (other dietary supplement). If other is chosen, describe the supplement being used.

Cardiorespiratory Sections (Panels 1 and 3)

Vasoactive Drugs



Changes:

Enter the weight that is being used to determine dose/kg/hr. This weight should be the same as entered in Power Chart. Update Power Chart as required to ensure both weights match. Power Chart weight will be used by providers for medication orders.

A 5th line has been added for infusions (other than comfort meds which are charted in the neurological section).

Place to Track Dextrose Bolus

GLUCOSE	10	2.8	
INSULIN u/hr or DEXTROSE	4	↓1 D 25 ml	

Change:

Insulin or dextrose administration can be added to the tracking line to enhance the evaluation of glycemic response. You either enter the dose in u/hr or record “D” to indicate 50% dextrose bolus was given. Continue to sign for drugs on MAR.

Practice Reminder

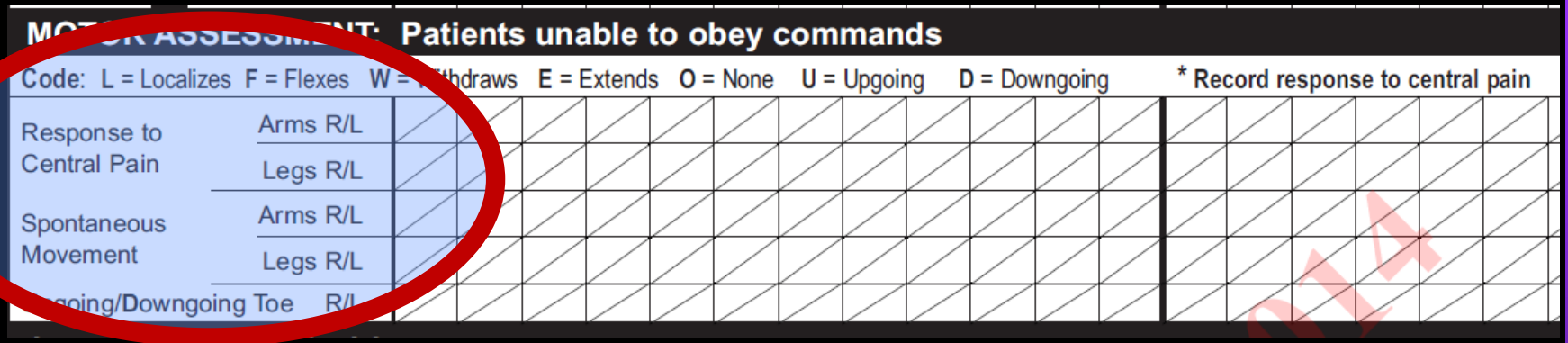
Always consider/rule out hypoglycemia for any change in neurological status including seizure.

Any low blood glucose reading by lab or glucometer should always be treated STAT. A confirmation sample should be sent to the lab to verify that the glucose was truly low, however, the confirmation sample should not delay treatment. A single low blood glucose value ***should be presumed accurate*** and treatment instituted immediately ***while awaiting the lab result***.

Administration of a bolus of dextrose will not cause harm even if the low reading was erroneous or the patient was in DKA.
Delay in the treatment of a truly low glucose (e.g., while awaiting confirmation results) can lead to irreversible neurological injury.

Neurological Assessment
Spinal Cord Testing
Pain and Sedation
(Panel 2)

Motor Assessment:
Patients Unable to Obey Commands

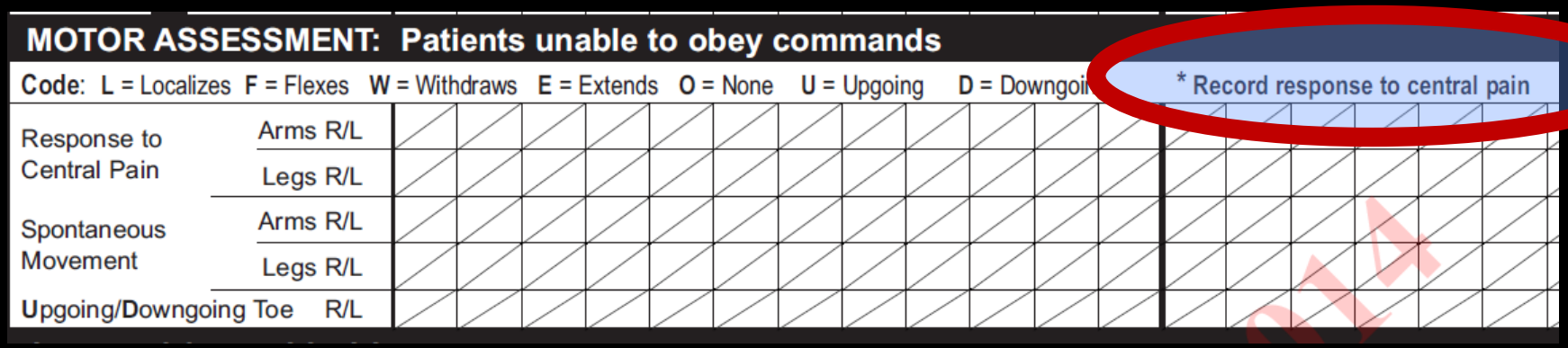


Change:

Motor assessment for the patient UNABLE to obey commands has been divided into response to central pain AND spontaneous response.

This will help to describe those patients who do not respond to pain but do have spontaneous movement.

Practice Reminder



MOTOR ASSESSMENT: Patients unable to obey commands														
Code: L = Localizes F = Flexes W = Withdraws E = Extends O = None U = Upgoing D = Downgoi													* 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													

Always assess the patient for response to:

1. Normal voice first
2. Loud voice (if no response to normal voice)
3. Light touch (if no response to voice)
4. Pain (only if no response to voice or light touch)

Painful stimulation should always be central first.

Practice Reminder

Clinical notes (DAR) that clearly describe the patient's response to specific neurological assessment tests provides more meaningful information that assessment tools such as the GCS.

Change from the previous assessment is the most important finding.

Neurological assessment should be performed together between incoming and outcoming nurses.

Practice Reminder

Central pain provides an opportunity to assess for symmetry of response and reduces likelihood that response may be due to spinal reflex.

More than one method can be used for assessment of central pain. Try more than one method if the patient does not respond to your first attempt.

Central Pain Testing

While sternal rub does not specifically test the central nerves, it does provide an opportunity to observe for symmetrical response to a noxious stimulus.

Central nerves can be assessed using the trapezius squeeze, supraorbital pressure or mandibular pressure. Overuse of any one method may lead to bruising or soft tissue injury.

Supraorbital pressure is not recommended if raised ICP is a concern and facial or orbital trauma may be a contraindication for supraorbital or mandibular pressure.

High spinal cord injury above T4 may limit the use of sternal rub or trapezius squeeze.

Neuro Section: Comfort Section

Comfort: Refer to pain, sedation and delirium scales.					**Sleep Codes:** Identify periods when patient appears to be sle								
NSR (0-10) or CPOT (0-8)													
VAMAAS													
SWAP Pass/Fail													
EPS/NMS (+* or -)													
SLEEP													

Change:

Pain scores are now on a single line. Circle the tool that you are using and enter the number.

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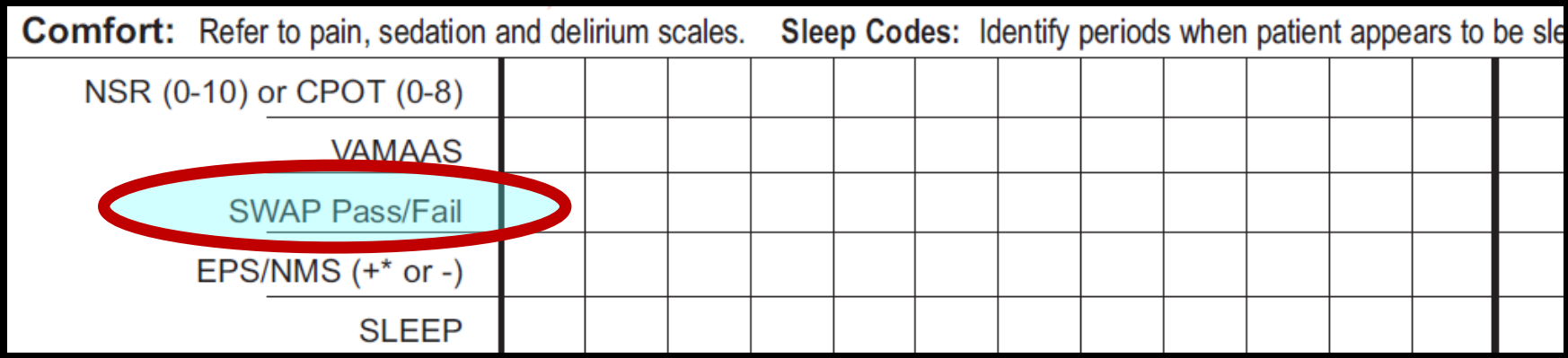
Change:

You will notice the AI/Graphic/bedside tools refer to VAMAAS versus VAMASS. VAMAAS is the correct abbreviation for this tool.

All tools including VAMAAS are on bedside laminated cards and on the CCTC website (What's New or Standards links)

Sedation Weaning Assessment Protocol (SWAP)



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SLEEP												

Change:

The new analgesia and sedation orders require each patient to be SCREENED at least once per shift for his/her readiness for automatic sedation weaning trials. The screening tool is called the SWAP (Sedation Weaning Assessment Protocol).

The results of the SWAP are entered as Pass/Fail

Daily Sedation Weaning Assessment Protocol (SWAP)

- ✓ **CONTRAINDICATED in patients requiring deep sedation (e.g., 0-1A)**
- ✓ RN/RRT to collaborate at the start of each shift to review SWAP/SBT goals
- ✓ Document assessment and weaning plan in 24 hour assessment record
- ✓ Record response to sedation weaning in AI record under "comfort/sedation" parameter

Is the patient's reason for ventilation resolved or partially resolved?

Is the PaO_2/FiO_2 > 200 on $FiO_2 \leq .5$ and PEEP $\leq$ 10 cm H_20?

Is the patient hemodynamically stable?
(may be on stable doses of vasoactive drugs)

Is the patient's VAMASS score $\leq$ 3A?

Is the patient on continuous analgesic or sedative infusions?

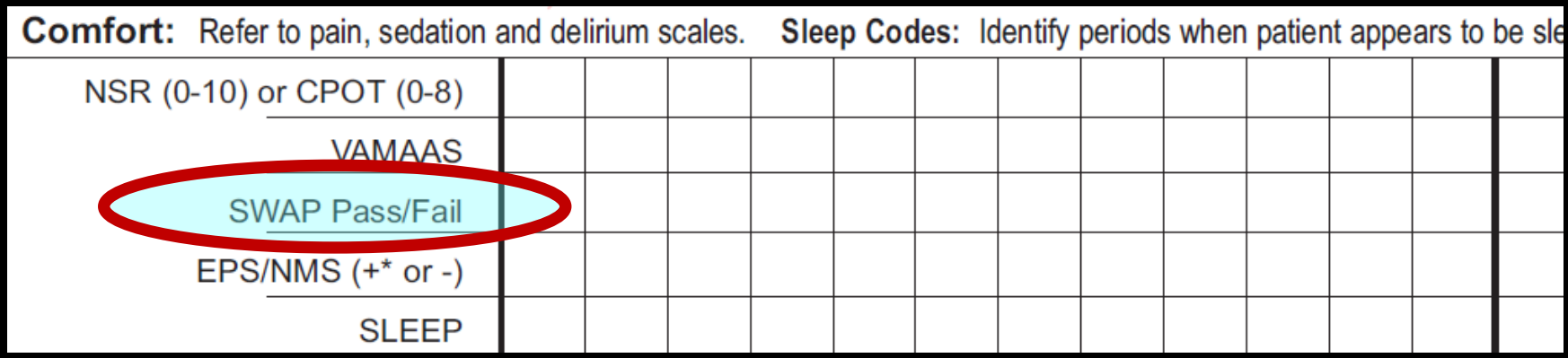
If *YES* to all of these questions:

- Wean sedation and narcotic as per weaning orders
- Document response to weaning in AI record

If *No* to any of these questions:

- Review sedation goals during morning rounds
- Document reason why sedation weaning is contraindicated
- Use the lowest dose of sedation required to achieve pain and MAAS targets

Sedation Weaning Assessment Protocol (SWAP)



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Change:

If a patient passes the screen, weaning attempts (as per the analgesia and sedation orders) are initiated automatically by the RN. Sedation weaning attempts should be coordinated with the RRT SBT.

If a patient fails the screen, analgesia and sedation plans should be discussed during morning rounds. Weaning trials or medication reductions may still be ordered.

Practice Reminder

Every patient is expected to have at least one DAR note each shift that outlines their response to comfort medications, any weaning attempts/response to weaning and or reasons why weaning is contraindicated.

Obstetrical Section

OBSTETRICAL CARE (refer to postpartum checklist for WDL definitions) * if not WDL (requires DAR note)																
Lochia (✓ if WDL, or * and DAR)																
Fundal Height (✓ if WDL, or * and DAR)																
Perineum (✓ if WDL, or * and DAR)																
Abdominal Incision																
Pre Eclampsia/Eclampsia Assess (headache, vision, epigastric, pain, patellar reflex) ✓ assessed * DAR abnormal																

All patients with preeclampsia or eclampsia (or who are receiving **M**g$S0_4$ treatment) must be assessed q 1 h for presence of headache, vision changes, epigastric pain and patellar reflexes.

Headache, visual changes, epigastric pain and/or hyperreflexia are signs of worsening preeclampsia.

Obstetrical Section

Definition Review:

Preeclampsia: new onset of hypertension and either proteinuria or end-organ dysfunction after 20 weeks of gestation in a previously normotensive woman

Eclampsia: Preeclampsia PLUS generalized seizure that is not due to another neurological cause

The treatment for preeclampsia is birth.

$MgSO_4$ Use

$MgSO_4$ is indicated to prevent progression of preeclampsia to eclampsia (defined by onset of seizures). It is the drug of choice for the treatment of seizures due to eclampsia (this is the one indication where benzodiazepines are not the first line anticonvulsants).

$MgSO_4$ is not used for the management of hypertension alone. Drugs such as labetolol or hydralazine are used.

$MgS0_4$ Toxicity

Reflex testing is also important if a patient is receiving $MgS0_4$ as decreased reflexes (hyporeflexia) may indicate $MgS0_4$ toxicity. Toxicity risk increases in renal failure.

$MgS0_4$ can also cause respiratory depression/arrest or hypotension and cardiac arrest. Sudden hemodynamic instability or cardiac arrest during $MgS0_4$ therapy is treated with calcium chloride.

Postpartum Eclampsia

Preeclampsia or eclampsia is usually a complication of pregnancy, but symptoms of preeclampsia/eclampsia can develop or worsen > 2 days and up to 6 weeks postpartum. Preeclampsia/eclampsia should be considered in the differential diagnoses of any pregnant or post partum patient with hypertension and headache, visual changes, epigastric pain, proteinuria, organ dysfunction or seizures.

The first line treatment for the seizures due to eclampsia is $MgS0_4$ even if seizure onset is postpartum.