Daily Outline – Just an Outline ☺

Q1 Hour Interventions/Charting: Hourly Rounding/Safety Check

Q4 Hour Interventions/Charting: IV Assessment/Pain/Wounds /NG Tubes (including flushing and residuals)/Drains/ Artificial Airways/Focused Assessments (These are follow-up assessments to anything you found abnormal on your initial shift assessment)

Q12 Hour Interventions/Charting: Shift Assessments/Interventions Tab (Including fall risk and Braden skin assessment)

Real Time Interventions/Charting: ADLs, Ambulation, Positioning/Is and Os/Meds/Any procedure you perform

Follow-Up Assessments/Charting: 1 hour after pain or nausea interventions

Typical Day:

0645: Arrive to Unit/Update your "brain" to prepare for day/Introduce yourself to your nurse

0700-0730: Report

0730-0830: Finish organizing day – come up with a plan and discuss it with your nurse and perform head-to-toe assessment and vitals.

0830-1000: Gathering medications/equipment to give those meds (independent) and Medication administration (always with a nurse).

1000-1200: All charting in computer.

1200-1600: Q4 hour Interventions/Charting/Work on Care Plan

1600-1800: Q4 hour Interventiosn/Charting/Assure that your charting has been co-signed and try not to chart much after 1600 to ensure your nurse has time to look over and co-sign your work. Continue working on Care Plan

1800-1900 : Prepare for the next shift. Check in on your patients and make sure they do not need anything. Prepare yourself to give report. Make sure you have gathered all info that you need and be able to give report from your brain only.

1900-1930: Give report.

Pt. Name/Rm:	Weight:	Precautions:	Nurse/CNA:
Sex/Age/Dx:	Code Status:	Allergies/Rxn:	Date:

800	900	1000	1100	1200	1300	1400	1500	1600	1700	1800

VITAL SIGNS

Time:				
BP				
T				
HR				
RR				
SpO2				
O2				
I/O				

CARE/ADLs

□ Linen □ Glucose

□ Bath □ IS

□ Oral □ Turn

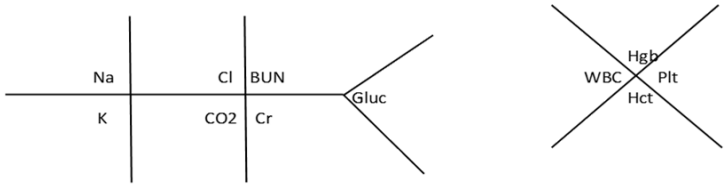
□ Cath Care □

Activity Orders:

Diet:

B %: L%: D%

LABS



Otherl labs:

IV/PCA,solution, rate:

ASSESSMENT

Neuro	CV:
Respiratory:	Renal:
GI:	Musculoskeletal:
Pain:	Skin:

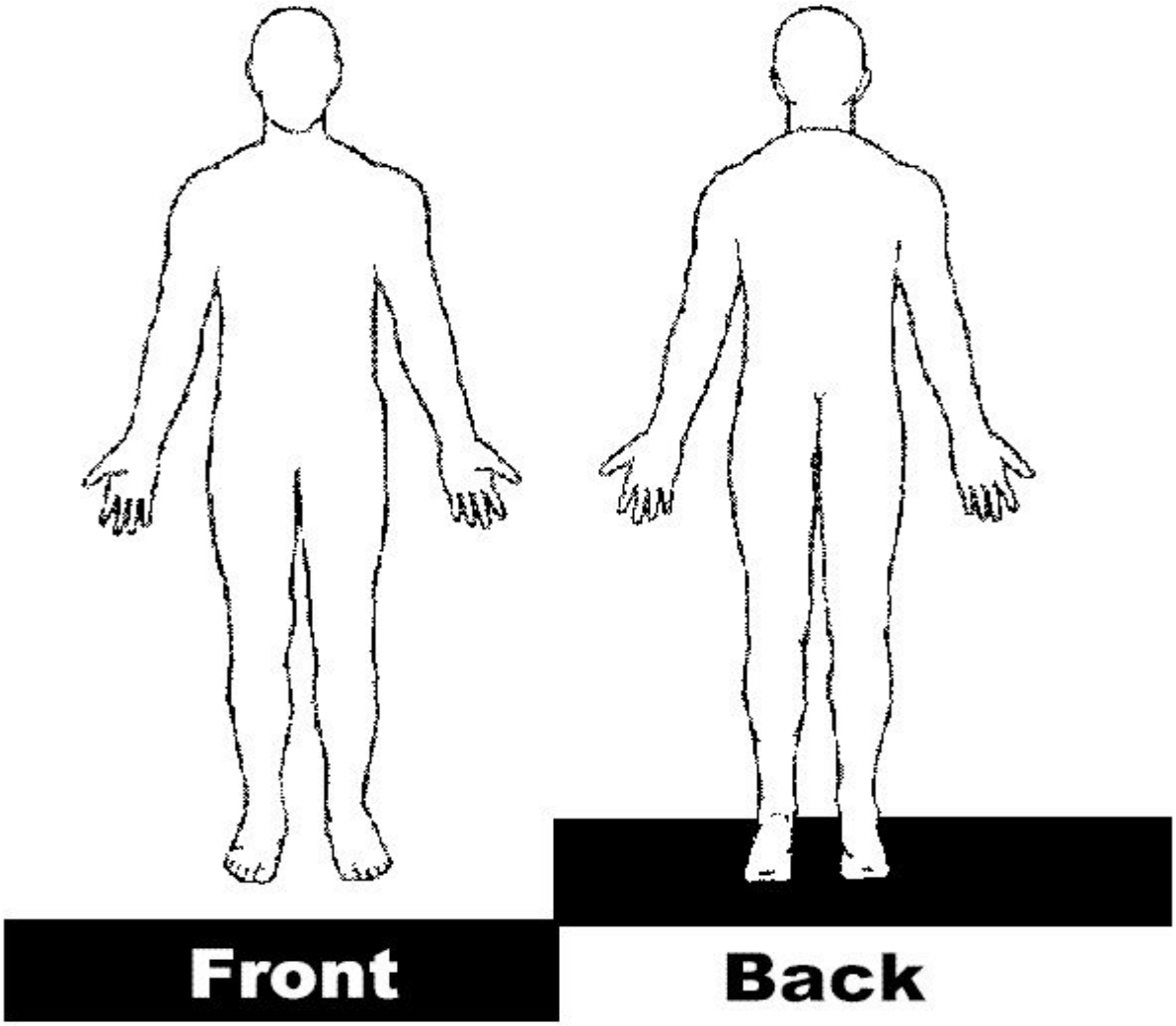
REPORT / NOTES / ORDERS

Topic: Lines, Drains, Airway, Wounds and Wires Developed: 8.22.12

Objectives: To identify use of common medical devices.

To describe basic safety measures associated with medical device use.

To describe assessment and location of alterations in patient skin integrity.



Instructions:

Part I: Assess patient for the following items and use the diagrams above to draw an arrow to location and label:

1. Intravenous lines
2. Drains
3. Chest tube
4. Telemetry leads
5. Airway and/or oxygen tubing
6. Wounds, pressure ulcers, and/or incisions
7. Urinary and/or bowel diversions
8. Feeding tubes
9. DVT compression device
10. Other: _____

Part II: Describe in a short paragraph the purpose *and* safety considerations of each identified item.

Giving Report

General Information

- Patient name/Drip Weight
- Room #/Precautions
- Age/Gender
- Service
- Code Status/Allergies
- Admitting diagnosis (Why they are in hospital and events while here)
- Patient History (Medical and Sugical)

Systems:

- Neuro/MS/Activity/Fall Risk
- CV: Temp/BP/Pulse/Rhythm
- Resp: O2 Demands/O2 Sats/IS
- GI: Last BM/Diet
- GU: Foley?/Adequate output?
- Skin: IV Sites/Solution/Wounds?
- Pain: Score/Last medication?/PCA?
- Labs: What is being done?

Future Plans (Plan of Care)

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