REMINDERS (Revision)

Daily Awakening from Sedation (AM)

CC-CAM (AM)

Weight (0600)

RHYTHM STRIP (0400, 0800, 1600, 2000 & PRN)

ROUNDING (Q1H)

Nurse will do **Even hour** and **PCT** will do **Odd hour.**
Document **EVERY HOUR** from 7AM – 9PM
Document **EVERY 2HOURS** from 10PM – 6AM

TURN & ELEVATE (Q2H)

Nursing Assistant/PCT document turns **Every 2Hours**
RNs document TURNS -> **2x per shift**
(If there is no PCT, RN will document TURN every 2hours)

VITAL SIGN (CCU Q2H; TELE Q4H; A/A Q8H)

RASS (Q4H & PRIOR and 30Mins after Administration of Sedation)

SCD MAINTENANCE (QSHIFT)

VAP ORAL CARE (0000/0400/0800/1200/1600/2000)

EDUCATION (1300, 2100)

BRADEN SCALE (1400)

PATIENT CARE FLOW SHEET / HYGIENE (0600, 1400)

CARE PLAN (1400, 2000)

DRESSING CHANGES (EVERY THURSDAY & 24HOURS AFTER insertion)

WEEKLY WOUND MEASUREMENT (QWednesday, 1400)

TIP SHEETS

ADMISSION

Go to NAVIGATOR (left side) -> Choose ADMISSION tab -> Complete documentation

To verify all required documents are completed:
Click BLUE arrow (Right middle side) -> Summary -> Admit Info -> Complete documentation

ASSESSMENTS

Shift Assessment
Go to FLOWSHEET (left side) -> click ASSESSMENT tab -> Charting type -> choose Shift Assessment

Update Assessment
Go to FLOWSHEET (left side) -> click ASSESSMENT tab -> Charting type -> Reassessment

OR ASSESSMENT
If patient comes from ED -> OR -> IMCU/CCU, Do Admission Assessment
If patient goes to OR from our unit -> Do FOCUS Assessment (Reassessment)

Fall Risk Assessment
Go to Flowsheet (left side) -> Screenings -> scroll down to Fall Risk Scale -> click cascade -> choose John Hopkins Fall Risk assessment tools -> click Add (arrow) -> Accept -> Document -> FILE

REMINDER : Choose John Hopkins Fall Risk Assessment Tools (NOT Morse Fall Risk Assessment Tools)

Aspiration Risk Assessment
Go to Flowsheet (left side) -> Screenings -> scroll down to Aspiration Risk Tool -> Document-> FILE

REMINDER: DO NOT do PUREE Challenge. Keep patient NPO, Notify MD, and consult order for Speech Pathologist

BLOOD TRANSFUSION

ACKNOWLEDGE the Orders:
Go to SUMMARY (left side) -> click OVERVIEW tab -> Scroll down to Orders to be Acknowledge -> Acknowledge All *(DO NOT acknowledge Respiratory Orders)*

ADD "Blood Admin" Flowsheet:
Go to FLOWSHEETS (left side) -> Go to the search box (right side) -> Type Blood Admin -> ENTER

Release Transfusion:
Go to FLOWSHEETS-> Blood Admin tab -> Click "Release Transfusion Report" -> scroll to Blood Products -> select "Release" a unit of blood.

Prepare" = slip prints in blood bank. "Transfuse" = slip prints on unit.
The transfuse slip is what the nurse/NA/US brings to blood bank to pick up blood.

Start Transfusion:
Go to Flowsheet -> Blood Admin -> scroll down to Transfuse RBC -> click syringe in the 'Rate' row -> Scan patient -> Scan 4 barcodes in the blood bag

REMINDER:
BE CAREFUL with the release button! Each time you click it, another blood product is prepared.

CARE PLAN

ADD new template:
Go to Care Plan (left side) -> Apply template -> Search template -> ACCEPT -> check boxes to apply to care plan -> ACCEPT

Document Care Plan:
Go to Care Plan (left side) -> Document Plan -> Click Progressing/NOT Progressing/Completed on apply to all goals without documentation -> NEXT (top/bottom right side) -> Click +ADD ALL on Progressing/Non Progressing (left side)-> Explain the reason why not progressing & include intervention -> SIGN NOTE & ACCEPT

RESOLVED Care Plan: (A MUST prior to Discharge a patient)
Go to Care Plan (left side) -> click the care plan topic -> click RESOLVE -> click Completed -> ACCEPT

CIWA

Go to Flowsheet (left side) -> Assessment tab -> Neurological (click cascade) -> CIWA -> Add -> ACCEPT -> Document

NOTE: When documenting CIWA, document VS in the VS flowsheet

CRITICAL LAB VALUES

Go to Flowsheet (left side) -> Vital sign -> scroll down to Lab Notification -> Document -> FILE

DISCHARGE

DISCHARGE DOCUMENTATION

Go to NAVIGATOR -> choose DISCHARGE tab -> Complete documentation.
Discharge progress can be seen on Discharge status (top list)

DISCHARGE DECEASED PATIENT

Go to NAVIGATOR -> choose Patient Expiration -> Complete documentation

Once completed -> Go to UNIT MANAGER (top left) -> click on patient's name -> DISCHARGE -> Discharge disposition: Expired -> verify the date & time of death under additional deceased info -> Request patient transport within the Discharge activity -> click 'PENDING'. Transport will complete the discharge -> Patient's name will be highlighted in Purple on unit manager.

REMINDER: DO NOT forget to RESOLVE all care plan (i.e. Change Outcome)
REMOVE IV lines (LDA) -> click Remove now
DO NOT REMOVE/DISCONTINUE WOUNDS

EDUCATION

ADD EDUCATION:

Go to Education (left side) -> click Education tab -> click 'Add Title' (bottom left side) -> search topic -> select topics and points -> ACCEPT

DOCUMENT EDUCATION:

Go to Education (left side) -> click Education tab -> select the topic and points (left side) -> Click Document (bottom Right side) -> document learner, readiness, method, response -> click 'Apply Defaults' -> FILE

RESOLVE EDUCATION:

Go to Education (left side) -> click Education tab -> select 'topic' education (left top) -> click 'RESOLVE'

EDUCATION (MEDICATION)

NEW MEDICATION EDUCATION

Go to MAR (left side) -> Click on the down arrows in the medication box to expand the information -> Click LEXICOMP hyperlink (lower right corner) -> PRINT (right corner).

Clinical References (Formerly KRAMES)

Go to Clinical Reference (left side) -> Click the diagnosis/problem related to the patient -> change Language (top right) -> the education list will show on the References/Attachments (left lower) -> 'Automatically' attached to Discharge Instruction.

FOLEY

Foley insertions will no longer prompt a LIP order. Nurses will need to enter orders for Urine Cx and Urine Analysis as Per Protocol/Cosign Required

FOLEY CARE

Go to Flowsheet (left side) -> Choose Assessment -> Click Integumentary -> Click Cascade (next to Integumentary) -> Click Hygiene -> ADD -> ACCEPT -> Look for Hygiene -> click on magnifying glass / select from the right side options -> Foley Care -> FILE (top left)

INTAKE/OUTPUT

Go to FLOWSHEETS (left) -> Intake / Output tab -> Document any intake and output (IV medication/Blood transfusion/drainage)-> FILE (top left)

LABS:

COLLECTING LABS:
Go to WORKLIST (left side) -> Click PRINT LABEL (USE patient's label with Date, Time & Initial) -> Click COLLECT -> INSERT Date & Time -> COLLECT

REMINDER:
Use ACTIVE ORDERS report to see all labs ordered -> Do Not completely rely on the worklists.
Chart Review Activity (lab tab) -> ONLY place to review the STATUS of lab order

LDA (LINES, DRAINS, AIRWAYS)

Go to FLOWSHEETS -> Open LDA tab -> Add LDA (top left) -> Search for item -> ACCEPT

To Remove:
Go to IV line -> Enter Removal Date, Time and Reason -> Status 'REMOVED'

To Hide 'REMOVED' LDA from Flowsheet:
Right click on black title row of the 'Removed' LDA -> Click COMPLETE

To Check Completed/Old LDA
Click "Hide Completed" button on the toolbar at the top

MEDICATIONS

ADMINISTER MEDICATIONS
Go to MAR (left side) -> Scan patient -> Scan medications -> adjust dose / define the site/ add comment (ex. HR or Pain) -> ACCEPT

For PCA/EPIDURAL:
First Add in LDA Flowsheet "UPHS Epidural Catheter" -> Document LDA assessment -> Go to MAR to admin the meds.

REMINDER:
START the infusion
Go to MAR (left side) -> Scan patient -> Scan medications -> select NEW BAG -> adjust dose / Define and Link the site / add comment (ex. HR or Pain) -> ACCEPT

TITRATION:
Go to FLOWSHEET (left side) -> Click Intake/Output tab -> select medication -> enter new rate -> Scan medication -> ACCEPT

To STOP infusion:
Go to FLOWSHEET (left side) -> click Intake / Output tab -> Enter Rate '0' -> FILE

SEND MESSAGE TO PHARMACY
Go to MAR -> Click Rx on selected medication -> Type message -> SEND

NOTE/INTERVENTION

Go to Notes (left) -> add note -> "type of note" drop down arrow -> Nursing -> document

COPY VALUE TO NOTE

Select value -> right click -> New Note -> Insert Data -> Type Note -> SIGN

To Select multiple values : Press Ctrl & Click the values

OR

PRE OP CHECKLIST
Go to NAVIGATOR -> choose TRANSFER tab -> Document Allergies, NPO, Vitals, LDA and Pre Procedure checklist

DEVICE INTEGRATION for POST OP Patients:

1. Check in patient to assigned room via Unit Manager AS SOON AS patient arrives
2. Anesthesia and CCU should be teaming up in placing the hardwire monitor
3. RN validates 1st set of VS (following the device integration process) -> this 1st set of VS becomes the anesthesia's final VS, which flows in to Anesthesia's transfer notes.
4. Select "FILE"

OTHER PHASE OF CARE:

1. Follow Device Integration as above, then RN release relevant orders
2. ENDO and Cardioversion procedures at bedside will be kept as Floor Phase of Care

ORAL CARE

Go to Flowsheet (left side) -> Choose Assessment -> Click Integumentary -> Click Cascade (next to Integumentary) -> Click Hygiene -> ADD -> ACCEPT -> Look for Hygiene -> Oral Care -> click on magnifying glass / select from the right side options -> select the options -> FILE (top left)

ORDERS (Emergency order ONLY)

PLACING AN ORDER

Go to ORDERS (left side) -> Type order name (Right side of the screen) -> Click on desired order -> ACCEPT -> Click SIGN (lower right corner) -> click on Filter Treatment team (Right top)-> Order Mode: click appropriate selection -> Ordering Provider -> ACCEPT

ORDER WOUND CONSULT

Go to Order (left side) -> type Wound consult (on the right side) -> ENTER -> IP Consult to wound care -> ACCEPT -> Reason: New Pressure ulcer -> ACCEPT -> SIGN -> Filter: Check the treatment team -> Order mode: RN only inpatient consult order -> Order Provider: choose MD -> ACCEPT

SIGNED & HELD ORDERS -> Releases by Receiving RN when the patient is physically ON the unit & Checked IN through the Unit Manager

Go to ORDERS (left side) -> Choose Signed & Held tab (top)-> -> Review orders -> Select orders (click on the little boxes)-> Release (You MUST release all orders at once)

Only "release" Signed/Held Orders for our phase of care which is "Floor."
Do not release for Dialysis, Radiology, OR, etc.

PAIN

Go to FLOWSHEETS (left) -> Vital sign tab -> Pain Assessment -> Document -> FILE (top left)

REMINDER: DO NOT FORGET to complete pain reassessment after interventions

RASS (RICHMOND AGITATION SEDATION SCALE)

Go to FLOWSHEETS (left) -> Vital sign tab -> click PAD Bundle (Pain, Agitation, Delirium Bundle) -> Document -> FILE (top left)

REQUIRED DOCUMENTATION

Click BLUE arrow (Right middle side) -> Summary -> Req Doc -> click on Overdue/Not completed lists -> Complete the documentation

RESTRAINTS

Go to FLOWSHEETS -> choose Restraint tab (top middle)-> Chart required documentation, including Additional Information must be completed -> FILE (top left)

REMINDER: DO NOT FORGET to renew Restraint

ROUNDING

Go to FLOWSHEETS (left) -> Vital sign tab -> Safe Environment -> Document -> FILE (top left)

SKIN CARE

Go to Flowsheet (left side) -> Choose Assessment -> Click Integumentary -> click Cascade (next to Integumentary) -> Click Skin Care Bundle -> ADD -> ACCEPT -> Look for Skin care bundle -> click on magnifying glass / select from the right side options -> select the options -> FILE (top left)

TIME OUT for Bedside Procedure

Go to NAVIGATOR (left side) -> choose Procedure Navigator tab (top right) -> Document

TURNS – **MUST** be completed **EVERY 2HOURS**

Go to FLOWSHEETS -> choose Patient Care Tech tab -> Skin Care Bundle -> Repositioning -> Document -> FILE (top left)

TPA

TPA – For patients who received TPA, orders default for a nursing to complete a bedside swallowing exam. **Please contact LIP to order a Speech Swallow Exam** instead.

TRANSFER

Go to NAVIGATOR (left side) -> choose TRANSFER tab -> Complete documentation

TRANSFERRING PATIENT
Go to NAVIGATOR (left side) -> Choose TRANSFER tab -> click Med/Order Rec status -> Transfer Med Rec reviewed by MD -> able to Transfer

TRANSFER PATIENT TO ANOTHER FACILITY
Go to SUMMARY (left side) -> Go to Search box (right side) -> Type Transfer Summary -> ENTER -> Click UPHS IP Inter-Facility Transfer Report -> Right click on the report & select PRINT
Required Documentations: MAR Report, Labs, POLST (if Any), Discharge (print AVS), NJ Universal Transfer form, Transfer consent, Doctor's order form, Transport form, Imaging (CD)
REMINDER: This report should be printed for all patients upon discharge to another facility

RECEIVING TRANSFERRED PATIENT (BED MANAGEMENT)
Go to UNIT MANAGER (Top left with bed icon) -> Look for Incoming Transfer (at the lower right bottom) -> Choose patient -> Right click -> Complete Transfer -> Document the date/time and bed number -> click TRANSFER (right bottom)

NJ UNIVERSAL TRANSFER FORM
Go to NOTES (left) -> Click New Note (top) -> Right click on blank Note (right side) -> choose SmartText -> Type 'NJ' -> ENTER -> click MCP NEW JERSEY UNIVERSAL TRANSFER FORM -> document -> SIGN

TRIPLE LUMEN CATHETER / PICC LINE DRESSING CHANGES

Go to FLOWSHEETS (left) -> click LDA tab -> select central venous catheter -> go to dressing/securement -> Dressing changed -> ACCEPT -> FILE (top left)

VITAL SIGNS

Go to FLOWSHEETS (left) -> Vital sign tab -> "Insert Col" (toolbar) to document PAST time OR "Add Col" to document CURRENT time -> Document vital sign -> click FILE (top left)
CORRECTION: click on the cell -> type new value -> FILE (top left)

VALIDATING VITAL SIGNS FROM SPACELABS

(**ONLY** for Hardwired patients, NOT Telepack)

Go to FLOWSHEETS (left) -> Vital sign tab -> click Show Device Data -> Review the values (***gray diagonal stripe*** within the cell) -> Select the validated column (highlighted)-> FILE (top left)

Time Interval: Click 2h link to import data every 2hours or 15m to import data every 15mins.
Go to FLOWSHEET (left side) -> VITAL SIGN tab -> click the Time interval (top right of the vital sign documentation) needed to ensure data transfer from spacelab.

To highlight an entire column -> click down arrow to the right of the time -> click File selected.

Fix incorrect data: click the value -> adjust the value manually before "FILING" or validating the Vital sign.

Note: Unvalidated vital signs will disappear after few hours.

CODE BLUE

DO NOT USE CODE NAVIGATOR AT PRESENT TIME

1. Use Current Code Record and Debriefing form -> FAX to I drive -> Scan Record into Chart Immediately. Debriefing will be sent to CCU CNL (Donna Covin) & It is not part of the chart.

2. Medications orders and Documentation -> located on Paper Code Record (NEED **MD SIGNATURE** on record)

3. Drips MUST be ordered in PennChart for continued use after successful resuscitation

4. Labs & Diagnostic tests need to be ordered in PennChart

5. Use Order set for **Arctic Sun** (AKA Targeted Temperature Management) if ordered
   Go to Orders (left side) -> type 'Hypothermia' -> Enter -> Select 'Post Cardiac Arrest Targeted Temperature Management Order Set' -> Select Orders -> SIGN

6. For EMR documentation:
   Go to Notes (left side) -> New Note (top left) -> Type 'Code' (right side) -> Select 'Code Documentation' -> Accept -> Type Summary of the event -> SIGN (Will be visible as significant event in patient history)

Rapid Response Team (RRT)

Medications MUST be ordered and documented in PennChart
Go to ORDERS (left side) -> Type 'RAPID' -> Enter -> Select 'Rapid Response Medications -> Accept -> Select medications -> Accept -> SIGN

RRT Flowsheet should be utilized for documentation
Go to Flowsheet (left side) -> Go to search box & Type 'RRT' -> Enter -> Complete Documentation -> Highlight/ Select all documentation -> 'Right Click' (to copy information from RRT flowsheet) -> choose NEW NOTE -> click Insert Data -> Add details of event below inserted information -> SIGN (It will be saved as Significant Event in Patient Story)

Record will be scanned to chart -> Continue current practice of faxing record to I drive -> Send Tracking Tool to CCU CNL (Donna Covin)

CODE STROKE

1. RN / Provider calls Operator -> Activate Code Stroke Alert
   (CT Tech will clear table for patient & Transport will be alerted to pick up patient and bring them to CT scan)
2. Get Patient ready for CT Scan -> MUST be on Bedside monitor, portable O2 if necessary (Maintain SpO2 > 92%)
3. Obtain IV access, Large bore (20g or 18g) preferable
4. DO NOT delay CT Scan for IV access or documentation!
5. Document in the **Stroke / TIA Assessment** flowsheet (Neuro check and Vital signs)
   Go to Flowsheet (left side) -> Go to the search box & type 'Stroke' -> Enter -> Select Stroke/TIA Assessment' -> Accept -> Complete documentation -> Highlight column -> Right click -> select New Note -> Click Insert Data -> Document events that precipitated the Code Stroke activation, Identify responding team and intervention that were completed during the event -> SIGN (This will show as a significant event in the flowsheet)

   'OR'

   (if the RN is NIH Stroke Scale certified)

   Go to Flowsheet (left side) -> Go to the search box & type 'NIH' -> Enter -> Select NIH Stroke Assessment -> Accept -> Complete documentation -> Highlight column -> Right click -> select New Note -> Click Insert Data -> Document events that precipitated the Code Stroke activation, Identify responding team and intervention that were completed during the event -> SIGN (This will show as a significant event in the flowsheet)

CARE of STROKE patient

1. Neuro checks should be documented in the Stroke/TIA Assessment flowsheet
2. Verify frequency of Neuro checks -> Review Orders
   REMINDER: You will NOT receive alerts for when Neuro checks are due!
3. NIH Stroke Scale should be documented BID on NIH Stroke Scale Assessment flowsheet
4. Complete Vital Signs as ordered
   REMINDER: You MUST verify Vital Signs frequency when reviewing orders, you will NOT receive alerts for when Vital Signs are due!
5. Patient should be on FALL precautions
6. Ensure patient has VTE prophylaxis (SCDs, Pharmacologic or Both)
7. Add NEW or UPDATE Stroke Care Plan (See Care Plan instructions)
8. Written Stroke Education MUST be given to patient -> DOCUMENT this under EDUCATION (See Education instructions)

CODE STEMI

PROCESS remains the same **EXCEPT** the RN will need to place a CASE REQUEST prior to Cath Lab transfer.

See **CODE STEMI policy and Inpatient Code STEMI Algorithm**

To place the Case Request

Go to Orders (left side) -> type 'CASE REQUEST' on search box (right side) -> Select 'Operative Case/Procedure request' -> Complete required fields to the best of your knowledge -> SAVE WORK (If incorrect information is entered, Cath Lab staff will adjust the CASE REQUEST post-procedure)