* **Precautn/Isoltn: chart once a shift**
  + Under this tab you will chart any precautions or isolation that the patient may have (i.e.: fall, aspiration, bleeding, withdrawal, droplet)
* **Elopement Risk: chart once a shift, if condition changes, or transfer to new unit**
  + Low, moderate, or high risk and any interventions in place
* **Pain: chart every 4 hours and after every intervention**
  + If patient has no pain check denies pain box
  + If pain: initiate site, chart location of pain, words to describe pain, pain interventions, pain scale
  + If patient is not lucid, can use the PAINAD pain scale or the ICU NONVERBAL pain scale
  + If patient on a PCA
    - Need to chart medication name, concentration, basal rate (if one), demand dose and interval (if one), lockout amount (1 hour limit), loading dose (if one), waste and credit when starting.
    - Every 4 hours need to document: all pump settings, sedation level, pain level, and respiratory rate. Add SpO2 if patient on a basal rate.
    - Clear PCA pumps every 8 hours with 2 nurses
* **Pain Goal: every day and with condition change**
  + Even if patient denies any pain, we have to chart a pain goal.
  + Pain goal is the pain level that the patient would be comfortable with handling.
* **Neurological: chart every 4 hours**
  + Glascow coma scale
  + MAAS: sedation
  + Pupils
  + Speech
  + Swallow
  + NEUROMUSCLE FUNCTN
    - Facial
    - All extremities (can do as whole group, or separate extremities if need to do to differences)
* **CVA Scales: only charted on when doing NIHSS on CVA patients**
  + Nurses dysphagia screening is under here
    - Nurses can do this screening anytime they have a concern for their patient’s swallowing ability without a physician’s order
* **Special Neuro:**
  + Only charted under when we have a patient on neuromuscular blockade and train of 4.
* **Cardiovascular: chart every 4 hours**
  + If having chest pain chart on chest pain tabs
  + Chart what rhythm patient is in
    - Continuous, (frequent, occasional, rare if have PVCs, PACs, etc.)
  + Heart rate
  + Heart sounds
  + Pulses
    - Apical, radial, dorsal pedals, post tibials
      * Can do radial, dorsal pedals, and post tibials for both together, or each extremity separate
  + Edema
    - Any area that has edema: amount and rating
  + Cardio Interventions
    - Alternate rest/activity, cardiac monitoring, oxygen therapy (if applicable), pain management, promote sleep
  + IABP- only if applicable
  + Pacemaker-only if applicable
* **Respiratory: chart every 4 hours**
  + Chest expansion
  + Sound/breathing
  + Anterior breath sounds
  + Posterior breath sounds
  + Respiratory Pattern
  + Oxygen (if applicable)
    - O2 flow, equipment, status
  + Cough
  + Acapella/Pep- if assist patient with use
  + HOB/degree
  + Pt C/O
  + Secretions- if applicable
  + Trach-if applicable
  + Respiratory care
    - Airway care, repositioned, cough/deep breathe
* **SM Chest Tubes: only if applicable**
  + Initiate site: chart status, suction level, drainage description, tube interventions, stop cock open, site assessment, surrounding skin, site dressing, drainage exterior, intervention
* **Ventilator: only if applicable**
  + Time intubated
  + Size tube, placement (#cm at the lip)
  + Vent mode and all settings
  + Any interventions
  + Extubation time
  + ORAL CARES EVERY 2 HOURS
* **EENT: only if applicable**
* **Gastrointestinal: chart every 4 hours**
  + Oral assessment
  + Bowel Sounds
  + Abdomen
  + Abdomen contour
  + Date of last BM
  + Bowel control
  + GI interventions as needed
  + POCT Guaiac if needed
  + Rectal bag if needed
  + GI tubes if needed
  + Tube feeding if needed
* **Renal/Urinary: chart every 4 hours**
  + How void, color, any interventions
* **SM Urinary Catheter: only if have a catheter**
  + Initiate new if placing a catheter, indication for maintenance, drainage status, urine appearance, daily site cleansing,
* **Musculoskeletal: chart every 4 hours**
  + Muscle strength/tone: all extremities together, or separate as needed
  + Motion
  + CMS checks: each extremity separate or all together
  + Pulses- will populate from cardiovascular
* **Fall Risk: chart every 8 hours and with any change in patient condition**
  + Cognitive assessment
  + Risk of injury assessment
  + Injury risk
  + Fall risk assessment scale
  + High fall risk interventions if needed
  + Fall risk interventions
* **Skin: every 4 hours**
  + Braden- only once a day
  + Braden score <18 interventions if needed
  + Skin assessment as needed
  + Any interventions in place
* **SM Pressure Ulcer: can only be initiated by WOCN. Once initiated, can be charted on by staff**
* **Psychosocial: chart every 4 hours**
  + Mood, affect, elopement risk, family is
  + Any interventions used
* **Suicide Risk: only if needed**
* **Reproductive: only chart on females under the age of 50**
* **IV Lines: use this only if there is no IV access and okay with MD**
* **SM IV lines**
  + Chart IV site, IV status, any interventions, appearance, dressing, drainage
  + Arterial lines, PA catheters under here as well.
* **AntiCoag Thera: only use if patient on anticoagulation therapy**
* **Incision/Wound: only chart if patient has any incisions/wounds. Chart every 4 hours if applicable**
  + Wound/incision, appearance, drainage, dressing
* **Ostomy: only if necessary**
* **Proc at Bedside: only if necessary**
* **Nutr by Nursing**
  + Patient’s diet, percent meal eaten, assistance needed, fluid restriction
* **Act Daily Living**
  + Mechanical VTE prophylaxis
  + Hygiene
  + Activity/position
    - TURNS MUST BE DOCUMENTED EVERY 2 HOURS WITH VENTS
* **Provider Notific: use anytime you have to call Dr. for any reason**
  + Any interventions done, MD response, ancillary consults
* **Age Specific Interventions**
  + Communication, safety/education
* **Restraints: only if necessary**
* **Behavioral Restraints: only if necessary**
* **Chrt + Care Rvw**
  + Hourly rounding
  + RN daily review
  + Lab work
  + Orders verified
  + Nsg shift note: can write any notes that pertain to care or situations that happen.
* **Downtime: only if necessary**
* **Cosign: only if necessary**
  + Document staff that you are orienting