

INTERVENTIONS

Once each shift, check interventions provided related to the goals on page 1.

N = Night (7p-7a) **D** = Day (7a-7p)

(Interventions in sections A-G are part of hospital care and documented elsewhere.)

<p>A. Safe Environment B. Communication C. Activity D. Personal Care E. Temperature Regulation F. Therapies G. Pediatric Entertainment/ Education</p>	<p>J. Delirium PREVENT DELIRIUM <i>Risk factors include: signs and symptoms of infection, sepsis and hypotension.</i> N D <input type="checkbox"/> <input type="checkbox"/> Use of glasses <input type="checkbox"/> <input type="checkbox"/> Use of hearing device <input type="checkbox"/> <input type="checkbox"/> Involved Care Partner/Family <input type="checkbox"/> <input type="checkbox"/> Provided activity <input type="checkbox"/> <input type="checkbox"/> Promoted adequate sleep cycle <input type="checkbox"/> <input type="checkbox"/> Reoriented <input type="checkbox"/> <input type="checkbox"/> LIP notified Positive CAM <input type="checkbox"/> <input type="checkbox"/> Other (comment)</p>	<p>O. OSA PREVENT OSA <i>Includes (as appropriate):</i> <ul style="list-style-type: none"> • Limit opioid use • Monitor for pain • Address pain/sedation mismatch • Monitor O2 saturation • Avoid supine position • Monitor respiratory status. N D <input type="checkbox"/> <input type="checkbox"/> CPAP/BIPAP IN USE N D <input type="checkbox"/> <input type="checkbox"/></p>
<p>H. Fall Risk PREVENT FALL N D <input type="checkbox"/> <input type="checkbox"/> Yellow identifiers in place <input type="checkbox"/> <input type="checkbox"/> MIS patient profile updated <input type="checkbox"/> <input type="checkbox"/> Information given to pt/family <input type="checkbox"/> <input type="checkbox"/> More frequent observation <input type="checkbox"/> <input type="checkbox"/> Assistive devices at hand (may include cane, walker, glasses, hearing aids, etc.) <input type="checkbox"/> <input type="checkbox"/> Moved closer to nurses' station <input type="checkbox"/> <input type="checkbox"/> Attended while toileting <input type="checkbox"/> <input type="checkbox"/> Bed alarm <input type="checkbox"/> <input type="checkbox"/> Chair alarm <input type="checkbox"/> <input type="checkbox"/> Cushioned floor mat <input type="checkbox"/> <input type="checkbox"/> Low bed (criteria: fall risk + anticoagulants, > age 80, and/or osteoporosis) <input type="checkbox"/> <input type="checkbox"/> PT/OT/RPh Screening referral <input type="checkbox"/> <input type="checkbox"/> Other (comment)</p>	<p>K. Isolation MAINTAIN APPROPRIATE ISOLATION ENVIRONMENT <i>Includes (as appropriate):</i> <ul style="list-style-type: none"> • signs posted • patient education provided • appropriate garb worn • reminded others about precautions • equipment cleaned N D <input type="checkbox"/> <input type="checkbox"/></p>	<p>P. Aspiration/Reflux PREVENT ASPIRATION/REFLUX <i>Includes (as appropriate):</i> <ul style="list-style-type: none"> • Upright and support with feeding • Supervise at meals • Check diet order • SLP or nutrition referral • Safety equipment at bedside N D <input type="checkbox"/> <input type="checkbox"/></p>
<p>I. Skin Integrity MAINTAIN OR IMPROVE SKIN INTEGRITY N D <input type="checkbox"/> <input type="checkbox"/> Frequent turning/repositioning <input type="checkbox"/> <input type="checkbox"/> Positioning devices <input type="checkbox"/> <input type="checkbox"/> Support surface <input type="checkbox"/> <input type="checkbox"/> Specialty offloading surfaces <input type="checkbox"/> <input type="checkbox"/> Topical skin protectants <input type="checkbox"/> <input type="checkbox"/> Incontinent containment devices <input type="checkbox"/> <input type="checkbox"/> Head of bed low ($\leq 30^\circ$) <input type="checkbox"/> <input type="checkbox"/> Repositioned medical devices <input type="checkbox"/> <input type="checkbox"/> Heels elevated off bed <input type="checkbox"/> <input type="checkbox"/> Nutrition support/assistance <input type="checkbox"/> <input type="checkbox"/> Consider nutrition referral <input type="checkbox"/> <input type="checkbox"/> Other (comment)</p>	<p>L. Suicide Risk PREVENT SUICIDE N D <input type="checkbox"/> <input type="checkbox"/> 1:1 observation (at arm's length) <input type="checkbox"/> <input type="checkbox"/> Constant observation (in view) <input type="checkbox"/> <input type="checkbox"/> Other (comment)</p>	<p>Q. End of Life PROVIDE COMFORT AND SUPPORT AT END OF LIFE <i>Identify unique comfort/symptom measures including (as appropriate):</i> <ul style="list-style-type: none"> • Increased family involvement • Use of Bereavement materials • Involvement of Chaplain • Involvement of Palliative Care Team • Referral to Hospice N D <input type="checkbox"/> <input type="checkbox"/></p>
	<p>M. Alcohol Withdrawal Risk SEE CIWA FLOWSHEET</p>	<p>R. Restraint Use SEE RESTRAINT FLOWSHEET</p>
	<p>N. Elopement/Abduction PREVENT ELOPEMENT/ABDUCTION <i>Includes (as appropriate):</i> <ul style="list-style-type: none"> • Place close to nurses' station • Fill out safety threat/security form • Have patient dressed in hospital attire • Place monitor • Alert all staff N D <input type="checkbox"/> <input type="checkbox"/></p>	<p>Other: N D <input type="checkbox"/> <input type="checkbox"/> N D <input type="checkbox"/> <input type="checkbox"/></p>

COMMENTS:

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