QUICK CARE TIPS

PO Fluid Intake:

BEVERAGES	UNIT OF MEASURE	FLUID CONTENT (ml)
Coffee, Tea (hot or iced)	1 cup	240 ml
Fruit Juice	1/2 cup	120 ml
V-8 or Tomato Juice	6 oz (one can)	180 ml
Milk	8 oz (one carton)	240 ml
Soda/Soft Drinks – All	12 oz (1 can)	360 ml
DESSERTS		
Gelatin	1/2 cup	120 ml
Ice Cream/Sherbet (cup)	1/2 cup	120 ml
Popsicle (twin)	3 oz	90 ml
SUPPLEMENTS		
Boost/Ensure/Nepro	8 oz (1 can)	240 ml
Instant Breakfast	8 oz	240 ml
MISCELLANEOUS		
Soup/Broth	6 oz	180 ml
Small Styrofoam cup	8 oz (to the brim)	240 ml
Large Styrofoam cup	32 oz (to the brim)	960 ml
Waxed Cold cup	12 oz (to the brim)	360 ml

WEIGHTS:

Bed should be zeroed with 1 pillow, 1 bottom sheet, 1 draw sheet, 1 top sheet & 1 bedspread.
The diligent equipment also has scales.

ISOLATION:

Note: No visitors should use patient bathrooms.

Cleanse your hands and disinfect stethoscope bell before & after EVERY patient.
Accu-Check Inform Glucose Monitor: Set machine up outside room. Use mini-bulb to obtain blood.
Pulse Oximeter: Can go in Isolation in plastic bag, disinfect probe & cord afterwards
Isolation Meal Trays: Do not need to be bagged if going directly onto meal cart unless soiled with blood/body fluids.
Visitors must follow the instructions on the isolation sign. Put personal items in plastic bag and leave bag closed. When leaving, they call for help to take things out of room; take off all gloves/gowns/masks and put in trash; AND cleanse hands well.

POINT OF CARE TESTING: For all laboratory reference ranges and units of measure, refer to the electronic medical record on date of service.

PAIN MANAGEMENT:

Screen for presence/absence and intensity of pain (minimum every 4 hrs for PCA, epidural or frequent PRN dosing). Assess for pain using UVa Pain Rating scale, other scale appropriate to age/condition or APP (Assume Pain Present) in cognitively impaired patients if treatment or condition would normally be expected to cause pain).
Treat with pharmacologic and/or nonpharmacologic modalities to help patient meet comfort goal.
Reassess any pain intervention as appropriate to treatment and DOCUMENT effectiveness, side-effects and pain score/description on flowsheet.
See Pain scale information on Pages C-2 and D-1 and 2.

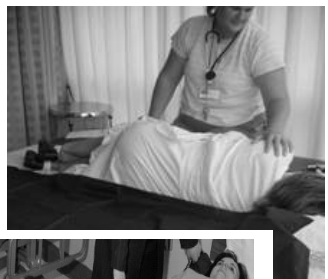
MINIMAL LIFT PROGRAM

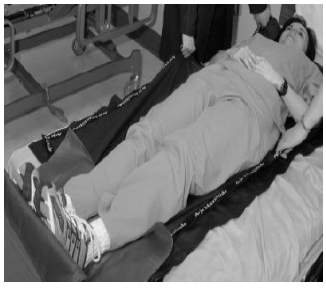
Stedy
Weight Limit: 265 lbs
Patient Mobility: Good for patient that requires minimal assistance
or
Stand by assist
Transfer: Bed to chair, Bed to toilet
Accessories: None

Encore
Weight Limit: 420 lbs
Patient Mobility: good for moderate assist patient that usually require 1-2 people to transfer to chair
Useful for: Stand assist and mobility/ transfer aid
Accessories: Belt with color coded loops for sizing; belts stay with the lift wipe down between patients

Tempo/Tenor
Weight Limit: Tempo < 440 lbs; Tenor < 704 lbs
Patient Mobility: dependent/total lift patient
Accessories: Tempo - light blue disposable slings label with patient name; Tenor – Reusable dark periwinkle sling, wipe down sling between patient use or hand carry to linen room if grossly soiled

HoverMatt
Weight Limit: None
Useful for: transferring from bed to bed/stretcher, particularly in procedure and critical care areas
Sizes: Regular and Bariatric (large)
- **Wipe down between patients; hand carry to Linen Room if grossly soiled**





Maxislides, Blue Transfer Tube, & Orange Extension Tubes
Weight Limit: None
Patient Mobility: Patient unable to completely transfer self to stretcher or table

Uses:
- Maxi Slide – transferring from bed to bed/stretcher, turning patient on side, and boosting up in bed.
- Blue Transfer Tubes – Transferring from Bed to Bed/stretcher/table, can be used to slide portable x-ray cassettes under the patient
- Orange extension Tube – Extending Blue tube or Maxi slide; Pivoting patient from sitting to laying in bed

Sizes: Tubes are one size. Maxislides are Regular (purple) and Extra Large/ Bariatric (Orange)
- Wipe down between patients.
- Each evening, place all Maxislides/Tubes used that day in the mesh bag in the soiled utility room where they will be picked up for cleaning and returned.
- DO NOT place in Linen bags – Equipment will be destroyed by high heat
- Please air dry

General Tips:
- No Minimal Lift Equipment or Supply goes in the Blue Linen Bags or down the Linen Chute!
- General cleaning: Use disinfectant products per hospital procedure
- See Medical Center Human Resources Policy No. 701

PRESSURE ULCER PREVENTION & SUPPORT SURFACE ALGORITHM

Complete Braden Scale for predicting Pressure Ulcer Risk

- Braden > 19
  - Standard Nursing Care
    - Patient > 500 lbs Bari10A Bed
- No skin breakdown **OR** Stage I or II ulcer
  - Use pressure relief strategies and hospital mattress Isoflex
    - Patient > 500 lbs Bari10A Bed with BariMatt Plus
- Braden < 19
  - Patient with Stage III and/or Stage IV pressure ulcers on one turning surface
    - Use pressure relief strategies and hospital mattress Isoflex
      - Patient > 500 lbs Bari10A Bed with BariMatt Plus
  - Patient with Stage III and/or Stage IV pressure ulcers affecting multiple turning surfaces. Patient with burns/recent grafts or flap.
    - Use pressure relief stratagies and Med-Surg Bed
      - Patient > 500 lbs Bari10A Bed with BariMatt Plus

Definitions for Pressure Ulcer Staging

Stage I - Defined area of persistent redness in lightly pigmented skin or in darker skin tones, areas may have red, blue or purple color.

Stage II - Partial thickness skin loss involves the epidermis and/or dermis (abrasion, blister or shallow crater)

Stage III - Full thickness tissue loss involves damage to or necrosis of subcutaneous tissue

Stage IV - Full thickness tissue loss extending down to muscle/bone

Unstageable - Ulcer covered by necrotic tissue

Deep Tissue Injury - Dark purple skin color with or without blister involves full thickness injury

INCONTINENCE ALGORITHM

Assess perineal area
Very moist or constantly moist

- Skin Broken
  - **If Fungal/Yeast Infection**
    (Patchy, red rash with satellite lesions)
    -Obtain order for antifungal cream (Nystatin)
    -Do not use antifungal powder
  - **If Macerated** (Looks whitish, waterlogged) *AND/OR*
    Denuded (Loss of epidermis - top layer of skin, like ruptured blister)
    -Use Sage Perineal Wipes
    -Apply Moisture Barrier on perineal area to protect from stool/urine
    -Evaluate for Foley /Rectal Pouch. Initiate Bowel/Bladder Program.
- Skin Intact
  - -Use Sage Perineal Wipes
    -Avoid plastic backed underpads, diapers
    -use cotton or Dri-Flow underpads

FULL BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

SENSORY PERCEPTION Ability to respond meaningfully to pressure related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli due to diminished level of consciousness or sedation. **OR** Limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** Has a sensory impairment which limits ability to feel discomfort or pain over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** Has some sensory impairment which limits ability to feel discomfort or pain in 1-2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by urine, perspiration, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
MOBILITY Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.
NUTRITION <u>Usual</u> food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 or any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement **OR** Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed/chair, requiring frequent repositioning with maximum assistance. Spasticity, contracture or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

NURSING PROTOCOL FOR INSULIN INFUSION IN ACUTE CARE

Use protocol only when physician's order is in place. NOT FOR USE IN INITIAL TREATMENT OF DKA.

TARGET BLOOD GLUCOSE (BG) RANGE: 125 TO 175 mg/dl
Accu-Chek™ frequency: **Perform Accu-Chek™ every hour.**
Exception: Hypoglycemia (glucose ≤70 mg/dl); test glucose every 15 minutes until >100 mg/dl then resume hourly Accu-Chek™ schedule.

Symbol Key: ↑(increase); ↓(decrease); > (greater than); < (less than); ≥ (greater than or equal to); ≤ (less than or equal to)

Minimal Change in BG BG has changed less than 50 mg/dl in the previous hour	BG has DECREASED BG has decreased 50 mg/dl or more in the previous hour	BG has INCREASED BG has increased 50 mg/dl or more in the previous hour
≤70* STOP INFUSION	≤70* STOP INFUSION	≤70* STOP INFUSION
INITIATE HYPOGLYCEMIA TREATMENT PROTOCOL	**INITIATE HYPOGLYCEMIA TREATMENT PROTOCOL**	**INITIATE HYPOGLYCEMIA TREATMENT PROTOCOL**
71 – 124 ↓ 1 unit / hr	71 – 124 ↓ rate 50%	71 – 124 ↓ by 0.5 unit/hr
125 – 175 no change	125 – 175 ↓ rate 50%	125 – 175 no change
176 – 200 ↑ by 0.5 unit/hr	176 – 200 no change	176 – 200 ↑ by 0.5 unit/hr
201 – 250 ↑ 1 unit/hr	201 – 250 ↑ 0.5 unit/hr	201 – 250 ↑ 1 unit/hr
> 250** ↑ 2 units /hr	> 250** ↑ 1.5 units/hr	> 250** ↑ 2 units/hr

Notify physician if BG is >250 mg/dl for three consecutive readings. Physician may order one-time off-protocol increase in infusion rate. In that case, resume hourly BG tests at the next hour *and* resume infusion adjustments per protocol when the glucose is <250 mg/dl. If glucose remains above 250 mg/dl, notify physician.

Notify physician when insulin infusion rate reaches 15 units/hour.

***Glucose <40 mg/dl** –repeat test on another meter to ensure accuracy, treat hypoglycemia, and **notify physician**. Physician may send sample to lab for verification.

****Glucose >400 mg/dl** – repeat test on another meter to ensure accuracy, treat hyperglycemia, and **notify physician**. Physician may send sample to lab for verification.

NUTRITION – Reduce insulin infusion rate by 50% and notify physician for significant changes in delivery of nutrition (i.e., tube feeding interrupted or discontinued, NPO status, prolonged vomiting).

HYPOGLYCEMIA TREATMENT PROTOCOL

Glucose ≤ 70 mg/dl

- Stop insulin infusion

If patient is conscious and able to eat or drink:

- Give 15 Gm of carbohydrate
- 3 to 4 glucose tablets (preferred treatment if available without delay) *or*
- 4 oz juice or regular soda or 1 cup skim milk

If patient is conscious and on tube feedings

- Give 4 oz apple juice or soda via feeding tube

If patient is unconscious or unable to eat or drink

- Give 25 ml (1/2 amp) of Dextrose 50% slow IV push STAT *or* 1 mg Glucagon IM STAT if no IV access.

Retest BG in 15 minutes

- Repeat treatment every 15 minutes if needed until glucose is >100 mg/dl (then resume schedule for hourly BG tests)
- Notify MD

Restart insulin infusion

- When glucose is ≥ 150 mg/dl
- At 50% previous rate
- Continue hourly BG tests

CONVERSION TO SUBCUTANEOUS INSULIN

1. The physician should evaluate the continued need for insulin infusion:
   a. Every 8 hours
   b. When glucose remains within target range for 3 hours
   c. When patient is tolerating solid food or enteral feeding

2. Stop insulin infusion and begin subcutaneous insulin administration per physician order. *Note:* Subcutaneous intermediate acting or long-acting insulin (e.g., NPH or Glargine) should be given at least 4 hours prior to stopping the infusion. During the transition to subcutaneous insulin, meals require coverage with Regular insulin.

TRANSPORT OF PATIENT DURING INSULIN INFUSION

The physician will decide if infusion can be temporarily stopped for transport, and may order subcutaneous insulin as coverage during the transport. If the infusion cannot be stopped, an insulin infusion-competent nurse must accompany the patient. If staffing does not allow the patient to be accompanied, then consideration is given to delaying the procedure. Take the Insulin Infusion Travel Kit during transport after adding a glucose meter.

RN CHECKLIST – BEFORE BEGINNING ACUTE CARE INSULIN INFUSION PROTOCOL

- ❑ Is there a MIS order for Acute Care Insulin Infusion Protocol with directions to 'titrate infusion rate per protocol'?*
- ❑ Is there a MIS order for Hypoglycemia Treatment Protocol?*
- ❑ If the patient has transferred from an ICU – has ICU Insulin Infusion Protocol been discontinued and Acute Care Insulin Infusion Protocol been ordered?*
- ❑ Have orders for all other insulin and oral diabetes agents been discontinued?*
- ❑ Is there an order for maintenance IV fluids containing dextrose?*
- ❑ Has an Insulin Infusion Flow Sheet been placed on patient's beside chart?
- ❑ Have you documented an Accu-Chek™ result immediately before initiating insulin infusion?

RN CHECKLIST – FOR DKA PROTOCOL:

- ❑ Is there a MIS order for DKA Insulin Infusion Protocol?*
- ❑ Is there a MIS order for Hypoglycemia Treatment Protocol?*
- ❑ Insulin infusion rate in DKA is **NOT** TITRATED AS WITH Acute Care Protocol.
- ❑ Glucose target range for the first 24 hours of DKA treatment is 175 to 200 mg/dl.
- ❑ Obtain Accu-Chek™ results every hour. Call the physician hourly with the Accu-Chek™ result.
- ❑ MD will order initial dose of Regular Insulin IV push (usually 10 to 15 units), and then will order a starting rate for the insulin infusion (usually 5 to 10 units/hour).
- ❑ Maintain the prescribed rate until the MD orders a change in rate. Call the physician when the following occur (for potential orders):
- ❑ Call the physician:
  - If the blood glucose does not decrease by at least 150 mg/dl in the first two hours of treatment (physician may order an increase in insulin rate or in IV fluid rate)
  - When the blood glucose reaches 250 mg/dl (time to change IV fluids to include dextrose)
  - When the blood glucose reaches 175 mg/dl (indicates lower limit of glucose target range for DKA and indicates the time the physician should begin to think about discontinuing DKA protocol)
- ❑ The DKA Protocol is only meant for use for the first 24 hours of DKA treatment. At 24 hours, the physician should begin to think about discontinuing DKA protocol and transition to subcutaneous insulin or to the Acute Care Insulin Infusion Protocol. This transition may occur sooner than 24 hours if hyperglycemia and acidosis are resolved.
- ❑ Additional DKA treatment will include aggressive IV hydration, frequent serum electrolyte checks, electrolyte replacement, and rarely sodium bicarbonate infusion.

**Contact the physician, if necessary, for appropriate orders before beginning insulin infusion.*

PAIN ASSESSMENT SCALES

1. UVa Pain Scale – Combination of Numeric **Pain Rating Scale** 0-10, **Wong-Baker FACES** (recommended for ages 3 years and older), modified **Iowa Pain Thermometer** and **Functional Pain Scale**. See Pages D1 and D2 for the UVa Pain scale and guidelines for use.

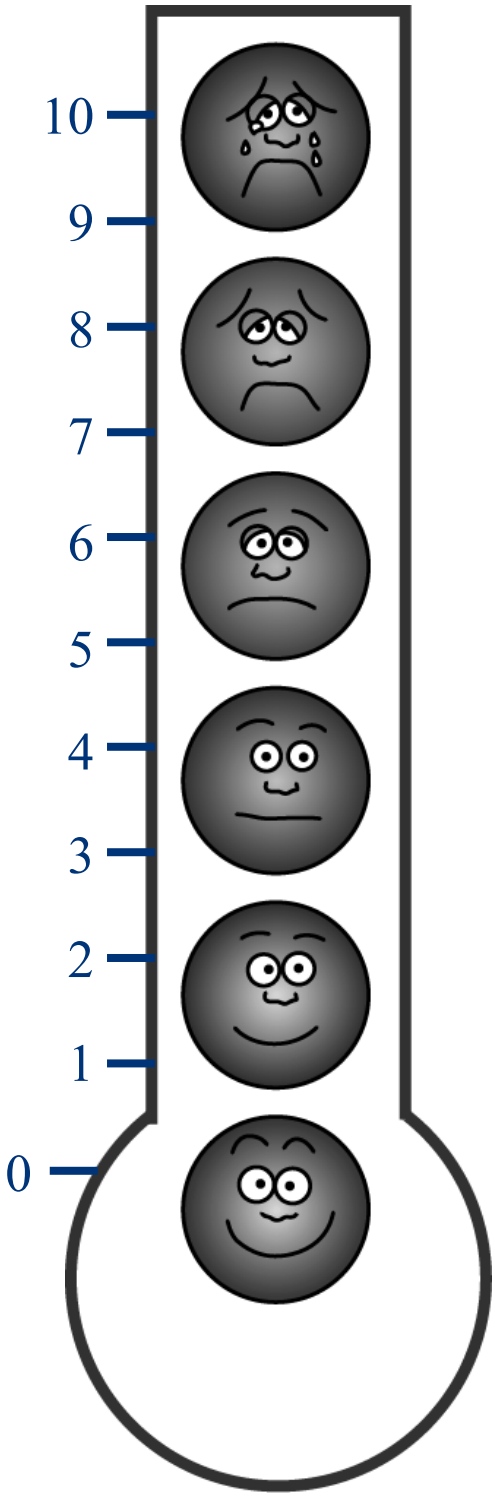
2. **FLACC Scale (recommended for 0-2 years)** (not validated for adults)

Categories	Scoring - 0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaining	Crying steadily, screams or sobs, sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, detradible	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, resulting in a total score between zero and ten.

UVA PAIN RATING SCALE

PAIN RATING



ACTIVITY RATING

Worst possible pain
Unable to do any activities because of pain

Extreme pain
Unable to do most activities because of pain

Severe pain
Unable to do some activities because of pain

Moderate pain
Can do most activities with rest periods

Mild pain
Pain is present but does not limit activity

No pain
Able to do all activities

Faces: Modified from Wong DL: Whaley & Wong's essentials of pediatric nursing, ed 5, pp1215-16, St. Louis, 1997, Mosby. Used with permission.

Thermometer: Used with permission from Keela Herr, University of Iowa.

GUIDELINES FOR THE UVA PAIN SCALE

The UVA Pain Scale is a combination of the three validated scales: The Wong-Baker Face Scale, The Iowa Pain Thermometer, and the Functional Pain or Activity Rating scale (functional descriptors). Combining the three scales with pictures, numbers, and functional words provides up-to-date and most commonly used means to describe the patient's pain.

DURING ASSESSMENT/REASSESSMENT:

1. For patients who can communicate:

- Show the scale to your patients and briefly explain that they can rate their pain using numbers, faces, or words. Tell the patient that you understand anxiety and feeling depressed can also affect your level of pain but you are asking them to rate their pain. Feelings of anxiety and/ or depression should also be addressed.

- Document the pain scale number that corresponds to the faces or the level of the thermometer.

And/Or

- Document the words used in the comment section of the *daily flowsheet* if the patient is visually impaired or cannot identify a number or face.

    - **Wong-Baker FACES Pain Rating Scale**[1]**:** Point to each face using the words to describe the pain intensity. Ask the patient to choose a face that best describes the pain and record the appropriate number.
    - **The Modified Iowa Pain Thermometer (IPT)**[2] Pain rating score 0 to 10 aligns with a pain thermometer to visually help patient to see range of pain rating.
    - **The Functional Pain Scale (FPS)** referred to as ACTIVITY RATING: Ask questions or observe the patient to determine if the pain interferes with function. FPS is especially helpful if the patient has visual or cognitive impairments.

2. For nonverbal patients

- Describe pain behaviors and assume pain present if there is a reason to suspect pain (APP).

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1 From Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: Wong's Essentials of Pediatric Nursing, 6/e, St. Louis, 2001, P. 1301.

2 Other preliminary testing of the IPT with Caucasian and minority older adults including African-Americans and Hispanics, has found it to be reliable and valid and the preferred scale by many subjects. Permission for use granted by Keela Herr, PhD, RN. University of Iowa.