

## 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
<b>DESSERTS</b>		
Gelatin	1/2 cup	120 ml
Ice Cream/Sherbet (cup)	1/2 cup	120 ml
Popsicle (twin)	3 oz	90 ml
<b>SUPPLEMENTS</b>		
Boost/Ensure/Nepro	8 oz (1 can)	240 ml
Instant Breakfast	8 oz	240 ml
<b>MISCELLANEOUS</b>		
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.

### BED ALARM FOR ADVANTA BED (ACUTE CARE):

**Set up** Zero bed scale or verify pt's weight accurate.

**Turn on** Pt in center of bed; press desired mode key until light on & beep heard.

**Turn off** Press & hold ENABLE key & MODE key until all lights & volume off.

### 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



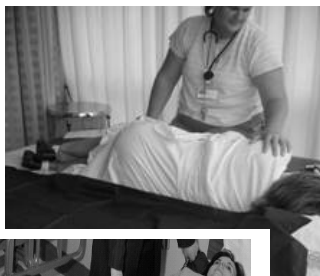
### HoverMatt

**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)

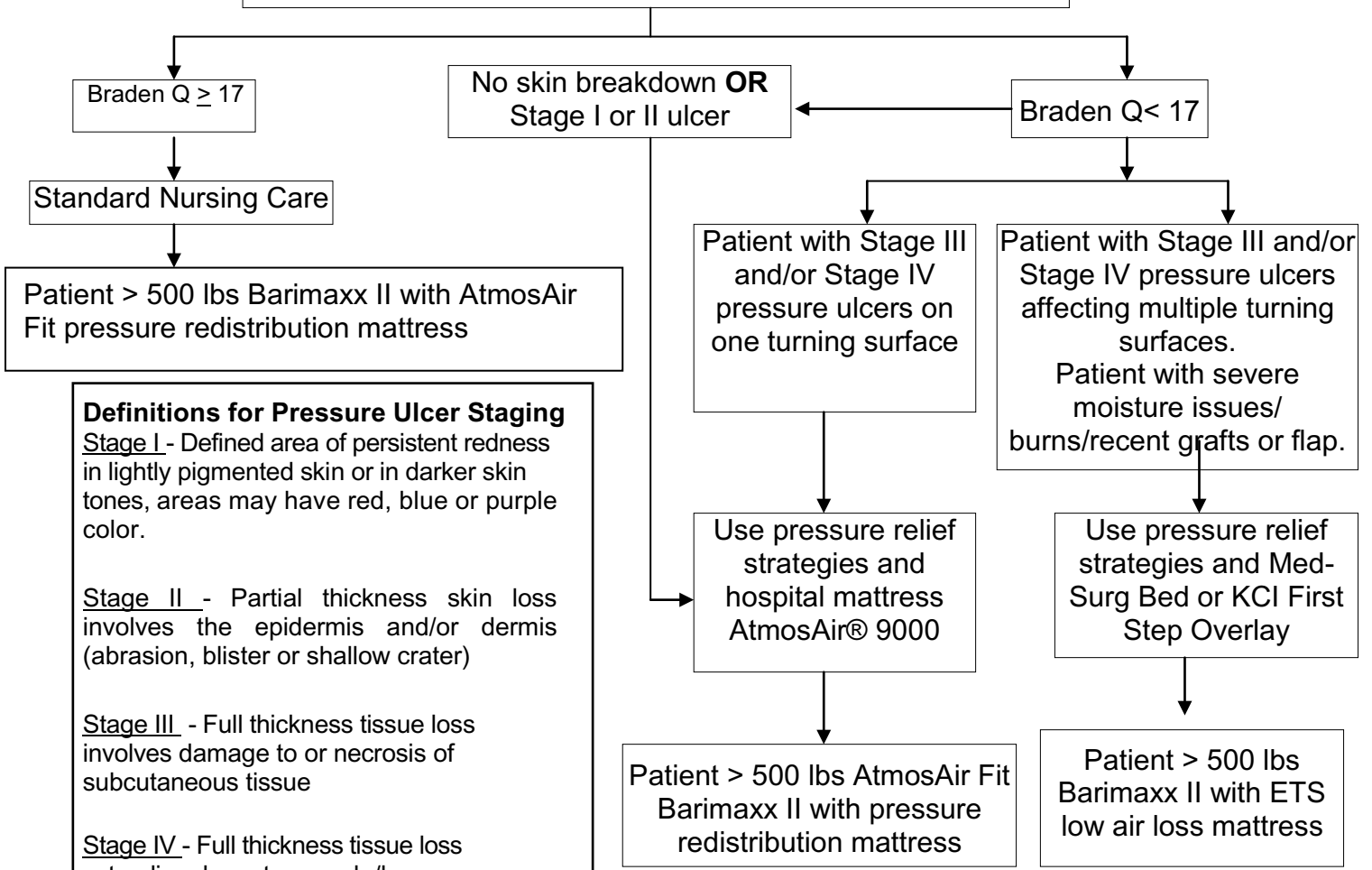
- Wipe down between patients.
- Each evening, place all Maxislides/Tubes used that day in the mesh bag in the soiled utility room where they will be picked up for cleaning and returned.
- DO NOT place in Linen bags - Equipment will be destroyed by high heat

#### 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 Minimal Lift Notebook for details)
- Borrowing: Refer to the Borrowing Grid in the Minimal Lift Notebook
- See Medical Center Policy 261, "Minimal Lift Environment"

# PEDIATRIC PRESSURE ULCER PREVENTION & SUPPORT SURFACE ALGORITHM

Complete Braden Q Scale for predicting Pressure Ulcer Risk



### 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 on  
Braden Scale (subscale 1 or 2)

Skin Broken

Skin Intact

### If Fungal/Yeast Infection

- (Patchy, red rash with satellite lesions)
- Obtain order for antifungal cream (Nystatin)
- Avoid 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/Toileting Program.

- use Sage Perineal Wipes
- use **one** Ultrasorb Pad
- briefs only for ambulatory incontinent patients who get out of bed for OOB transfers to the chair and/or off unit; unfasten brief when in chair

Braden Q Scale					
Intensity and Duration of Pressure					Score
<b>Mobility</b> The ability to change and control body position	<b>1. Completely immobile:</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. Very Limited:</b> Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	<b>3. Slightly Limited:</b> Makes frequent though slight changes in body or extremity position independently.	<b>4. No Limitations:</b> Makes major and frequent changes in position without assistance.	
<b>Activity</b> The degree of physical activity	<b>1. Bedfast:</b> Confined to bed	<b>2. Chairfast:</b> Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted in to chair or wheelchair.	<b>3. Walks Occasionally:</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. All patients too young to ambulate OR walks frequently:</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
<b>Sensory Perception</b> The ability to respond in a <u>developmentally</u> appropriate way to pressure-related discomfort	<b>1. Completely Limited:</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. <b>OR</b> limited ability to feel pain over most of body surface.	<b>2. Very Limited:</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness <b>OR</b> has sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	<b>3. Slightly Limited:</b> Responds to verbal commands, but cannot always communicate discomfort or need to be turned <b>OR</b> has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	<b>4. No Impairment:</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or communicate pain or discomfort.	
Tolerance of the Skin and Supporting Structure					
<b>Moisture</b> Degree to which skin is exposed to moisture	<b>1. Constantly Moist:</b> Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	<b>2. Very Moist:</b> Skin is moist, but not always moist. Linen must be changed at least every 8 hours.	<b>3. Occasionally Moist:</b> Skin is occasionally moist, requiring linen change every 12 hours.	<b>4. Rarely Moist:</b> Skin is usually dry, routine diaper changes, linen only requires changing every 24 hours.	
<b>Friction - Shear</b> <i>Friction:</i> occurs when skin moves against support surfaces <i>Shear:</i> occurs when skin and adjacent bony surface slide across one another	<b>1. Significant Problem:</b> Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction	<b>2. Problem:</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	<b>3. Potential Problem:</b> Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	<b>4. No Apparent Problem:</b> Able to completely lift patient during a position change; 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 at all times.	
<b>Nutrition</b> Usual food intake pattern	<b>1. Very Poor:</b> NPO and/or maintained on clear liquids, or IVs for more than 5 days <b>OR</b> Albumin <2.5 mg/dl <b>OR</b> Never eats a complete meal. Rarely eats more than 1/2 of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	<b>2. Inadequate:</b> Is on liquid diet or tube feedings/TPN which provide inadequate calories and minerals for age <b>OR</b> Albumin <3 mg/dl <b>OR</b> rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	<b>3. Adequate:</b> Is on tube feedings or TPN which provide adequate calories and minerals for age <b>OR</b> eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	<b>4. Excellent:</b> Is on a normal diet providing adequate calories for age. For example: eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
<b>Tissue Perfusion and Oxygenation</b>	<b>1. Extremely Compromised:</b> Hypotensive (MAP <50mmHg; <40 in a newborn) or the patient does not physiologically tolerate position changes	<b>2. Compromised:</b> Normotensive; Oxygen saturation may be <95 %; Hemoglobin maybe < 10 mg/dl; Capillary refill may be > 2 seconds; serum pH is < 7.40.	<b>3. Adequate:</b> Normotensive; Oxygen saturation may be <95 %; Hemoglobin maybe < 10 mg/dl; Capillary refill may be > 2 seconds; serum pH is normal.	<b>4. Excellent:</b> Normotensive; Oxygen saturation >95%; Normal Hgb; Capillary refill < 2 seconds.	
<b>Total:</b> If < 16 At Risk for Skin Breakdown					

Adapted with permission from "Braden Scale for Predicting Pressure Ulcer Risk" ©Braden, B. & Bergstrom, N., 1988.

**METRIC CONVERSION CHARTS**

**Temperature**

C°	F°	C°	F°
34.6	94.3	38.0	100.4
34.8	94.6	38.2	100.7
35.0	95.0	38.4	101.0
35.2	95.4	38.6	101.4
35.4	95.7	38.8	101.8
35.6	96.1	39.0	102.2
35.8	96.4	39.2	102.5
36.0	96.8	39.4	102.9
36.2	97.1	39.6	103.2
36.4	97.5	39.8	103.6
36.6	97.8	40.0	104.0
36.8	98.2	40.2	104.3
37.0	98.6	40.4	104.7
37.2	98.9	40.6	105.1
37.4	99.3	40.8	105.1
37.6	99.6	41.0	105.8
37.8	100.0	41.2	106.1

To convert Celsius to Fahrenheit:  $(9/5 \times ^\circ\text{C}) + 32 = ^\circ\text{F}$   
 To convert Fahrenheit to Celsius:  $(^\circ\text{F} - 32) \times 5/9 = ^\circ\text{C}$

**Height**

cm.	In.
30	11.8
35	13.8
40	15.7
45	17.7
50	19.7
55	21.7
60	23.6
80	27.5
90	35.4
100	39.4
125	49.2
150	59.1
175	68.9

1 ft. = 12 in  
 1 in. = 2.54 cm  
 1 cm = 0.3937 in.

**Weight**

Kg	lb
2.5	5.5
3.0	6.6
4.0	8.8
5.0	11
6.0	13.0
7.0	15.4
8.0	17.6
9.0	19.8
10.0	22.0
11.0	24.2
12.0	26.4
13.0	28.6
14.0	30.8
15.0	33.0
16.0	35.2
17.0	37.4
18.0	39.6
19.0	41.8
20.0	44
25	55
30	66
35	77
40	88
45	99
50	110
55	121
60	132
70	154
80	176
90	198
100	220

1 kg. = 1000gm  
 1 kg. = 2.2 lb  
 1 lb. = 0.45 kg

**PAIN ASSESSMENT SCALES**

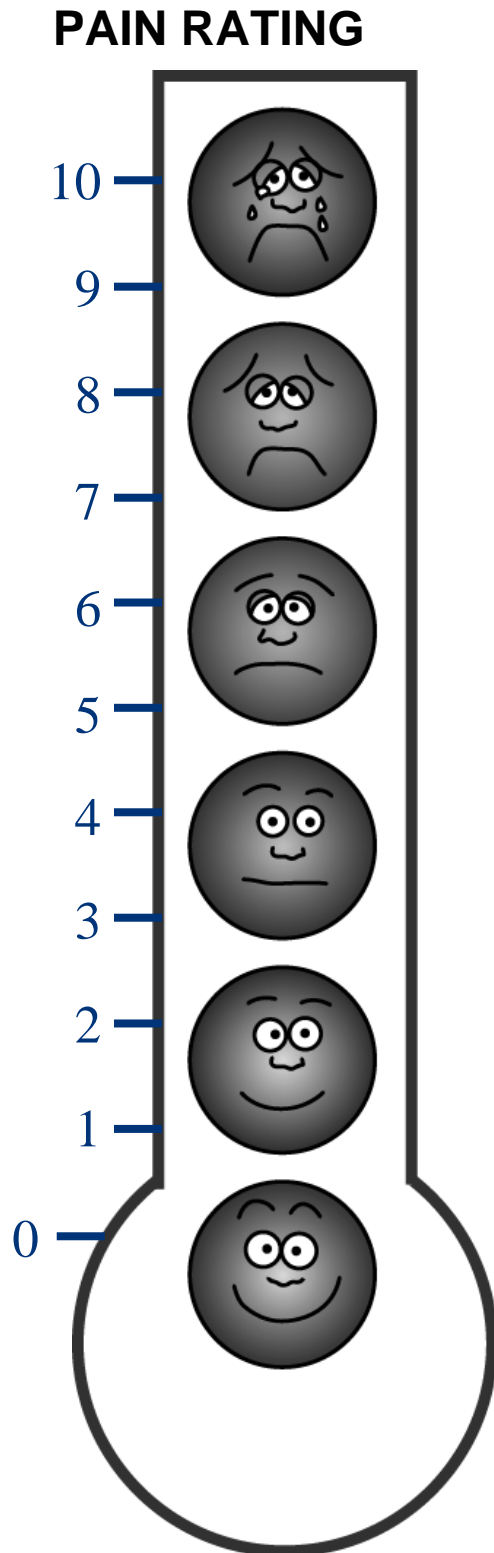
1. UVa Pain Scale – Combination of Numeric **Pain Rating Scale** 0-10, **Wong-Baker FACES** (recommended for ages 3 years and older), modified **Iowa Pain Thermometer** and **Functional Pain Scale**. See Pages D1 and D2 for the UVa Pain scale and guidelines for use.

**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**<sup>1</sup>: 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)**<sup>2</sup> 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.