Ascension

CERTIFICATION OF MEDICAL RECORDS

Patient Name: Grace Schara DOB: 9/22/02

Name of Healthcare Facility: Ascension St Elizabeth Hospital

I certify that the documents attached to this certificate, consisting of 995 pages, are accurate, legible, and complete duplicates of the original medical records of the patient listed above for the following time period:

10/6/21 To 10/13/21

Exclusions:
⊗ None
◯ As follows: _____

I further certify that the original records were: (1) made at or near the time of the occurrence of the matters set forth by, or information transmitted by, a person with knowledge of those matters; (2) kept in the course of the regularly conducted activity; and (3) made by the regularly conducted activity as a regular practice.

I certify under penalty and perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 30th day of January, 2024.

Signature: Corinne Traxler

Printed Name: Corinne Traxler, an employee of Datavant, a contractor with Ascension.

Ascension

FACILITY: STE

PATIENT REGISTRATION and CONSENT

ADMISSION NO.	PT TYPE	REGISTRAR	UNIT (MEDICAL RECORD) NO.	ADMIT DATE	AD TIME	SERVICE/LOCATION	ACCOM
E39547554	IN	JWALLA	E000365038	10/07/21	0012	E.2-C E.2029/1	I

ADMIT TYPE	ADMIT SOURCE	RELIGION / CHURCH	DISCHARGE DISPOSITION	DISCHARGE DATE	DISCH TIME
ER	NHF	CHRISTIAN-NO PARISH 907	E	10/13/21	1927

PATIENT NAME AND ADDRESS
SCHARA,GRACE N
N4833 MISTY MEADOWS DR
SEYMOUR,WI 54165

TELEPHONE	COUNTY	SEX
920-788-0829	OUTAGAMIE	F

OTHER PHONE	DATE OF BIRTH	AGE
920-428-0551	09/22/02	19

PREVIOUS NAME	MAR	VET
	S	N

LAST VISIT	LOCATION	RACE
10/06/21	E.ER	W

PREVIOUS FACILITY	60 DAYS

EMPLOYER NAME AND ADDRESS
STUDENT

TELEPHONE	PATIENT OCCUPATION
920-428-0551	STUDENT

FIRST PERSON TO NOTIFY
SCHARA,SCOTT F
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165

HOME TELEPHONE	WORK TELEPHONE
920-788-0829	920-788-0829

RELATION TO PATIENT: FATHER

ADDITIONAL PERSON TO NOTIFY
SCHARA,CINDY L
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165

HOME TELEPHONE	WORK TELEPHONE
920-428-0551	920-428-0551

RELATION TO PATIENT: MOTHER

REASON FOR VISIT
BREATHING DIFFICULTY - COVID +

COMMENTS

GUARANTOR NAME AND ADDRESS
SCHARA,GRACE N
N4833 MISTY MEADOWS DR
SEYMOUR,WI 54165

TELEPHONE	RELATIONSHIP
920-788-0829	PATIENT

SOCIAL SECURITY NO.
****

EMPLOYER NAME AND ADDRESS
STUDENT

EMPLOYER TELEPHONE	OCCUPATION
	STUDENT

EMERGENCY PHYSICIAN
ESCH DO,ALLY E

ADMITTING PHYSICIAN
BECK MD,DAVID

ATTENDING PHYSICIAN
BECK MD,DAVID

PRIMARY CARE PHYSICIAN
NORDSTROM MD,MARY E

NON MD PROVIDER

ARRIVAL MODE
GC

ACCIDENT/ILLNESS	DATE	TIME
ONSET OF SYMPT	10/06/21	

MANAGED CARE AUTHORIZATION

PRECAUTION - 1

PRECAUTION - 2

PRECAUTION - 3 (for more precautions) *see PCI*

INSURANCE DESCRIPTION - 1
UNITED HEALTHCARE/WMA

GROUP NUMBER	POLICY NUMBER
	7426225372

ADDRESS
PO BOX 5280

CITY / STATE / ZIP
KINGSTON NY 12402

PHONE	FIN CODE
800-504-9660	WMA

GROUP NAME	D.O.B.
MEDICAID FOR SSI	

SUBSCRIBER NAME
SCHARA,GRACE N

SUBSCRIBER POLICY
7426225372

INSURANCE DESCRIPTION - 2

GROUP NUMBER	POLICY NUMBER

ADDRESS

CITY / STATE / ZIP

PHONE	FIN CODE

GROUP NAME	D.O.B.

SUBSCRIBER NAME

SUBSCRIBER POLICY

INSURANCE DESCRIPTION - 3

GROUP NUMBER	POLICY NUMBER

ADDRESS

CITY / STATE / ZIP

PHONE	FIN CODE

GROUP NAME	D.O.B.

SUBSCRIBER NAME

SUBSCRIBER POLICY

CONSENT SIGNED: Y DATE SIGNED: 10/06/21 ANY EXCLUSIONS: N LOC: CLMAD

MR#

Advance Directive: NA Adv Dir Location:
HIPAA Notice Signed: Y Pt Req Info: N

SEE MEDITECH PCI FOR FINAL LAB, ER, AND RAD RESULTS

E39547554 SCHARA,GRACE N
09/22/2002

2SEH0002

PRE-PRINTED ORDERS: TUBE FEEDING - ACUTE (INITIAL)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Medications:

- ■ Pancrelipase (12/38/60) 1 capsule PO daily PRN declog feeding tube
- ■ Sodium Bicarbonate 325 mg PO daily PRN declog feeding tube
- ☐ Initiate Hospital Service medium-dose insulin sliding scale (HSSSIMOD)
- ☐ Initiate Hospital Service hypoglycemia protocol (HSHYPOGLY)

Nursing Assessments/Treatments:

- ■ Bedside Glucose monitoring every 6 hours or every _____ hours as ordered
- ■ Start tube feeding with confirmed FT placement
- ■ Elevate HOB 30 degrees during and for 1/2 hour after feeding
- ■ Height day TF started
- ■ Weight day TF started & every other day
- ■ Strict I&O end of every shift
- ■ Contact LIP for Bowel Program if no BM in 3 days
- ■ If feeding tube displacement is suspected or has occurred, stop the feeding and notify LIP
- ■ Notify LIP for signs/symptoms of tube feeding intolerance and for residual checks per feeding tube management orders
- ■ If patient vomits, alert LIP:
  - a) Stop the tube feeding
  - b) Verify proper tube placement
  - c) Hold the tube feeding for 6 hours
  - d) Restart tube feedings at half the prior rate (but no less than 10 mL/hr) if the patient is not displaying signs of intolerance (nausea, abdominal pain, distension, firmness, ect).
  - e) Check a gastric residual volume (GRV) in 4 hours after restarting the tube feeding
    - i) If the GRV is less than 500 mL advance the tube feeding back to goal rate per original order
    - ii) If the GRV is greater than 500 mL, follow the steps in section C under GRV Management

Tube Feeding Management:

- ■ **FLUSH** tube with 30-60 ml warm tap water
  - CONTINUOUS feeding: every 4 hours
  - INTERMITTENT feeding: before and after feedings
  - MEDICATIONS: pre and post meds with 30 ml water and between meds with 10 ml water
- ■ **OPEN** system management:
  - Fill bags with 8 hour volume of product for continuous feeding
  - Empty each bag - DO NOT add new TF to hanging TF
  - Rinse feeding bag with warm water every 8 hours before adding new TF formula to bag
  - Change bag every 24 hours
  - Open system bag change due at: _____
- ■ **CLOSED** system management:
  - Label container and spike set with patient's name and date/time hung
  - Leave spike set intact for same duration as container for up to 48 hours per spiking
  - Use a new spike set with each new bag
- ■ **GRV CHECKS** for **Nasogastric** and **Gastrostomy tubes.** (NO residual checks for Jejunostomy tubes)
  - A GRV should be checked if there are symptoms of tube feeding intolerance (nausea, abdominal pain, distension, firmness, ect.)
  - Do not perform routine GRVs for patients who are awake and alert and able to communicate, or who do not meet the following criteria: nausea, regurgitation, vomiting, or abdominal bloating, distension or pain

SCANNED

FAXED

10-13-21 1314 Trina Entered

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Shokar / Jean LaRaymekers, RDN, CD

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

TUBE FEEDING - ACUTE (INITIAL)
(Page 2 of 3)

9/21 HSTFACUTE

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0003

PRE-PRINTED ORDERS: TUBE FEEDING - ACUTE (INITIAL)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Tube Feeding Management (cont.):

■ **GRV Management:**

- If the GRV is 500 mL or less and the patient is tolerating tube feeding, continue feeding at prescribed rate
- If the GRV is 500 mL or less **and** the patient has intolerance:
  a) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os.
  b) Reduce the tube feeding to half of the prior rate (but no less than 10 mL/hr)
  c) Recheck a GRV in 4 hours. If the second GRV is greater than 500 mL, ask attending provider about prokinetics and advancing the tube to the Jejunum
  d) When symptoms resolve, advance tube feeding back to goal rate per original order
  e) If the patient develops symptoms of intolerance again
    i) Consult RD for further recommendations
    ii) Notify attending provider
    iii) Follow the protocol under B above until new recommendations/orders are available
- If the GRV is greater than 500 mL:
  a) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os
  b) Hold the tube feeding for 4 hours then recheck another GRV
  c) If the second GRV is less than 500 mL, resume TF at half of the prior rate (but no less than 10 mL/hr) and advance to goal rate as originally ordered. Do not check routine GRVs unless the patient shows signs of intolerance
  d) If the second GRV is greater than 500 mL:
    i) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os
    ii) Continue to hold TF and await further recommendations
      A) Ask about starting prokinetic agent
      B) Ask about placing a Jejunal tube

■ **DECLOG:**

- Crush Pancrelipase (12/38/60) cap & Sodium Bicarbonate 325 mg tab & dissolve in 5 ml warm water
- Instill into occluded FT & wait 5 minutes, then flush with tap water

SCANNED

FAXED

10-13-21
1317
Trinac
Entered

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Snokar Jana Reynebeau, RDN, CD

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

TUBE FEEDING - ACUTE (INITIAL)
(Page 3 of 3)

9/21 HSTFACUTE

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0004

PRE-PRINTED ORDERS: INSULIN THERAPY-SUBCUTANEOUS INJECTION

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Directions: Orders with a check box ☐ must be checked to be instituted. Orders without a check box or with a ■ check box are to be instituted unless specifically lined through.

This order set not intended to be used without an admission order set

Insulin Therapy (Subcutaneously Dosed):

☐ Blood Glucose Monitoring: Before meals and at bedtime or every 6 hours in NPO

Insulin Orders	Breakfast	Lunch	Dinner	Bedtime
☐ Pre-meal Scheduled	Give _____ Units of: ☐ Novolog ☐ _____	Give _____ Units of: ☐ Novolog ☐ _____	Give _____ Units of: ☐ Novolog ☐ _____	
☐ Scheduled	Give _____ Units of: ☐ NPH ☐ Lantus		Give _____ Units of: ☐ NPH	Give _____ Units of: ☐ NPH ☐ Lantus

-Suggested lag times for prandial insulin: Novolog 0-15 minutes before eating; Regular 30 minutes before eating

-For blood glucose < 70 mg/dL:

- If patient can eat or drink, give 4 oz fruit juice/non diet soda, 8oz nonfat milk, or 3-4 glucose tablets
- If patient cannot eat or drink, give D50W 25 mL as IV push
- Check finger capillary glucose every 15 minutes until ≥ 80 mg/dL. Repeat above if < 80 mg/dL

Sliding Scale Insulin (check one box below):

☐ Premeal "correction dose" algorithm for hyperglycemia ☐ Novolog ☐ Regular
Administer in addition to scheduled insulin dose to correct premeal hyperglycemia.
Circle desire algorithm below.

SCANNED

- Use low-dose algorithm for patients requiring < 40 units of scheduled insulin/day
- Use medium-dose algorithm for patients requiring 40-80 units of scheduled insulin/day
- Use high-dose algorithm for patients requiring > 80 units of scheduled insulin/day

FAXED

Premeal "correction dose" Insulin Dose (units)				
Algorithm	Low Dose	Medium Dose	High Dose	Individualized Dose
150-199	1	1	1	_____
200 - 249	2	3	4	_____
250 - 299	3	5	7	_____
300 - 349	4	7	10	_____
>349	5	8	12	_____

10-13-21 1317 Trina E entered

☒ **Sliding scale insulin algorithm** ☒ **Novolog** ☐ **Regular**

Sliding Scale Insulin Dose (units)		
Algorithm	Sliding Scale Dose	Individualized Dose
150-199	3	_____
200 - 249	5	_____
250 - 299	7	_____
300 - 349	9	_____
>349	11	_____

☐ **See Insulin Drip Protocol**

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Shokar/Jana Reynebeau, RPN, CPNP

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

INSULIN THERAPY-SUBCUTANEOUS INJECTION

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2/20 PSOINSSUB

2SEH0005

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/13/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: SHOKAR MD,GAVIN ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003267696 RAD/ABDOMEN FOR TUBE PLACEMENT
TRANSPORTATION? P - PORTABLE
CLINICAL HISTORY? COVID
CAMPUS? SEH
REASON FOR EXAM? FEEDING TUBE PLACEMENT
COMMENTS: WILL CALL WHEN PLACED--HOLLEE 831-8661
Does the patient have an Insulin or other med infusion Pump?
Insulin/med infusion pump must be disconnected prior to exam

ABDOMEN FOR TUBE PLACEMENT

HISTORY: Tube placement. Covid

TECHNIQUE: Portable AP view of the abdomen were performed.

COMPARISON: Portable chest 10/11/2021

FINDINGS: Feeding tube in mid stomach. Mild gaseous distention of stomach. Left arm PICC unchanged. Patchy bilateral mixed interstitial and alveolar infiltrates unchanged. Cardiac size within normal limits and stable.

IMPRESSION: Feeding tube in stomach

Corbin C. Asbury, MD
Radiology Associates of the Fox Valley

RAFVCC

I.2

Electronically Signed By: Corbin Asbury, MD
Signed Date/Time: 10/13/2021 12:06 PM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/13/2021 **
Reported By: ASBURY,CORBIN C MD

CC: BECK MD,DAVID; NORDSTROM MD,MARY E; SHOKAR MD,GAVIN

Edited Date: 10/13/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1333)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/11/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: LEONARD DO,DANIEL P ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003266302 RAD/CHEST PORTABLE
REASON FOR EXAM? covid
COMMENTS:

CHEST PORTABLE

HISTORY: covid

TECHNIQUE: AP portable view of the chest performed.

COMPARISON: 10/8/2021

FINDINGS: Normal heart size. Left PICC in place, terminating in the cavoatrial junction. Extensive pulmonary opacities are visualized bilaterally, concerning for pneumonia or edema.

IMPRESSION: Worsening pulmonary opacities are visualized bilaterally, concerning for pneumonia or edema. Left PICC terminates near the cavoatrial junction.

Douglas Conners, MD
Radiology Associates of the Fox Valley

RAFVMMC

I.2

Electronically Signed By: Douglas Conners, MD
Signed Date/Time: 10/11/2021 5:49 AM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/11/2021 **
Reported By: CONNERS MD,DOUGLAS

CC: BECK MD,DAVID; LEONARD DO,DANIEL P; NORDSTROM MD,MARY E

Edited Date: 10/11/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/08/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: KRALIK MD,JON C ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003265973 RAD/RADIOLOGY EXAM AT NO CHARGE
TRANSPORTATION? P - PORTABLE
CLINICAL HISTORY? COVID
CAMPUS? SEH
REASON FOR EXAM? PICC PLACEMENT
COMMENTS:
EXAM DONE? CHEST PORTABLE

RADIOLOGY EXAM AT NO CHARGE 10/8/2021 2:52 PM

Comparison: Same day.

History: PICC placement.

Findings/impression:
Left upper extremity PICC tip projecting over the high right atrium.
No significant change in the remainder the exam.

Jon C. Kralik, MD
Radiology Associates of the Fox Valley

Office & Patient Scheduling: (920) 967-1000

RAFVSTE
I.2

Electronically Signed By: Jon Kralik, MD
Signed Date/Time: 10/8/2021 2:53 PM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/08/2021 **
Reported By: KRALIK,JON MD

CC: BECK MD,DAVID; CARBERRY MD,GEORGE A; KRALIK MD,JON C;
MARADA MD,RAMANA R; NORDSTROM MD,MARY E

Edited Date: 10/08/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/08/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: MARADA MD,RAMANA R ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003265790 ART/PICC LINE PLACEMENT

DATE OF PROCEDURE: 10/8/2021

CLINICAL INDICATION / HISTORY: Durable venous access requested.

PROCEDURES PERFORMED: Placement of 40 cm double lumen PICC line via left basilic vein access.

PRIMARY OPERATOR: J. Kralik, MD

CONTRAST VOLUME: None

PROCEDURAL REPORT AND IMAGING FINDINGS:
Following a discussion of the risks, benefits, indications, and alternatives to treatment, informed consent was obtained.

The procedure was completed at patient's bedside. The left arm was prepped and draped utilizing all elements of maximum sterile barrier and ultrasound techniques including ABHR. A time-out was performed per hospital protocol to ensure correct patient, site, and procedure to be performed.

With ultrasound, the left arm was evaluated. Permanent record of the image was obtained which demonstrated the basilic vein to be patent. Under direct ultrasound guidance, 1% lidocaine was infiltrated and access was gained easily into the vein utilizing standard micropuncture technique. A guide wire was then advanced into the vein. A vascular sheath was then advanced over a guide wire. Portable chest radiography was used to confirm wire position and measurement. The PICC line was trimmed and then advanced into the central venous system. A final placement film demonstrated the tip of the catheter terminated in the right atrium.

After confirmation of the catheter position, the catheter was secured in place at the skin entry site. There was no immediate complication.

IMPRESSION:
Placement of a double lumen, 40 cm, power injectable (rated to 5mL/sec) PICC line into the left basilic vein using ultrasound guidance and portable chest radiography.

Jon C. Kralik, MD
Division of Vascular & Interventional Radiology

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/08/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: MARADA MD,RAMANA R ACCT# E39547554
Status: DIS IN

EXAM#	TYPE/EXAM	RESULT
003265790	ART/PICC LINE PLACEMENT	

Radiology Associates of the Fox Valley

Office & Patient Scheduling: (920) 967-1000

RAFVSTE
I.int

Electronically Signed By: Jon Kralik, MD
Signed Date/Time: 10/8/2021 3:42 PM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/08/2021 **
Reported By: KRALIK,JON MD

CC: BECK MD,DAVID; MARADA MD,RAMANA R; NORDSTROM MD,MARY E

Edited Date: 10/08/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/08/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: BAUM MD,KARL E
ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003265564 RAD/CHEST PORTABLE
REASON FOR EXAM? COVID POSITIVE, HYPOXIA
COMMENTS:

CHEST PORTABLE

COMPARISON: One day prior

HISTORY: Hypoxia, Covid positive

TECHNIQUE: One view.

FINDINGS:
Lungs: Hazy and reticular opacity in the left greater than right lung bases is overall similar to prior.
Pleura: Normal.
Cardiomediastinal silhouette: Normal.
Pulmonary vasculature: Indistinct.
Osseous structures and soft tissues: Unremarkable for patient age.

IMPRESSION: No significant change.

Joshua Jarvis, MD
Radiology Associates of the Fox Valley

RAFVCC

I.2

Electronically Signed By: Joshua Jarvis, MD
Signed Date/Time: 10/8/2021 7:33 AM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/08/2021 **
Reported By: JARVIS,JOSHUA MD

CC: BAUM MD,KARL E; BECK MD,DAVID; NORDSTROM MD,MARY E

Edited Date: 10/08/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/07/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: BECK MD,DAVID ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003265609 RAD/CHEST 1 VIEW
TRANSPORTATION? P - PORTABLE
CLINICAL HISTORY? COVID

CHEST 1 VIEW

COMPARISON: One day prior

HISTORY: Shortness of breath

TECHNIQUE: One view.

FINDINGS:
Lungs: There is increased dense hazy opacity in the left lung.
Decrease in right basilar opacity.
Pleura: Normal.
Cardiomediastinal silhouette: Normal.
Pulmonary vasculature: Indistinct.
Osseous structures and soft tissues: Unremarkable for patient age.

IMPRESSION: Increased dense hazy opacity in the left lung. Decrease in right basilar opacity.

Joshua Jarvis, MD
Radiology Associates of the Fox Valley

RAFVCC

I.2

Electronically Signed By: Joshua Jarvis, MD
Signed Date/Time: 10/7/2021 10:26 PM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/07/2021 **
Reported By: JARVIS,JOSHUA MD

CC: BECK MD,DAVID; NORDSTROM MD,MARY E

Edited Date: 10/07/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/06/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: BARLOW MD,LAUREN K ACCT# E39547554
Status: DIS IN

EXAM# TYPE/EXAM RESULT

003265000 CT/ANGIO CHEST

CT ANGIOGRAM OF THE CHEST WITH IV CONTRAST

HISTORY: Covid infection, positive d-dimer.

COMPARISON: None available.

TECHNIQUE: CT angiogram of the chest was performed during intravenous administration of nonionic IV contrast without complication. 3-D axial and coronal oblique MIP renderings of the chest vasculature also generated. Automated exposure control was utilized.

FINDINGS: Extensive motion artifact severely limits evaluation.

CHEST WALL AND VISUALIZED NECK: Grossly normal
PLEURA AND PLEURAL SPACE: No significant pleural effusion
TRACHEOBRONCHIAL TREE: Grossly normal
PULMONARY ARTERIES: Extensive motion artifact severely limits evaluation. No definitive pulmonary embolism is seen.
MEDIASTINUM: Mild cardiac prominence.
LUNGS: Extensive infiltrates with consolidation in the posterior lower lungs. Had she infiltrates in the remainder of both lungs. This is likely related to pneumonia.
UPPER ABDOMEN: Normal.
BONES: Normal.

IMPRESSION:
1. Extensive motion artifact significantly limits evaluation. No gross pulmonary embolism is seen.
2. Extensive infiltrates with areas of consolidation in both lungs likely related to pneumonia.
3. Mild cardiac prominence.

Keith Knepel, M.D.
Radiology Associates of the Fox Valley
RAFV CC
I.2

DEPARTMENT OF RADIOLOGY

	D.O.B	AGE	SEX	EXAM DATE
SCHARA,GRACE N	09/22/2002	19	F	10/06/21

LOC: E.2029 1
Pt Ph#: 920-788-0829
MR#: E000365038
Ordered By: BARLOW MD,LAUREN K ACCT# E39547554
Status: DIS IN

EXAM#	TYPE/EXAM	RESULT
003265000	CT/ANGIO CHEST	

Electronically Signed By: Keith Knepel, MD
Signed Date/Time: 10/6/2021 4:28 PM

** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/06/2021 **
Reported By: KNEPEL,KEITH A MD

CC: BARLOW MD,LAUREN K; ESCH DO,ALLY E; NORDSTROM MD,MARY E

Edited Date: 10/06/21 by PROVIDER
Printed Date/Time: 03/04/2022 (1334)

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: MARADA MD,RAMANA R REPORT NO: 1008-0328

DATE OF SERVICE: 10/08/2021

ICU CONSULTATION NOTE

CONSULT REQUESTED BY: Karl Baum, MD

REASON FOR CONSULTATION: The patient with COVID pneumonitis with acute hypoxic respiratory failure requiring noninvasive ventilation.

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: A 19-year-old patient with past medical history of Down syndrome, conductive hearing loss and obstructive sleep apnea, was brought to the hospital by her family secondary to shortness of breath. Apparently, she is a high functioning Down syndrome individual. She resides at home with her family. Apparently, whole family was not vaccinated for COVID-19. On 09/25/2021, family went to Christian concert at Oshkosh where 3000 people congregated indoor and majority of the attendees were not masked. Dad thinks that she probably caught the virus from there. On 09/28/2021, the patient started experiencing running nose. Subsequently, she developed fever with loss of appetite. She was sleeping more. She tested positive for COVID-19 infection with home testing kit. She was hypoxic at the time of admission. She was admitted on 10/07/2021 with the diagnosis of acute hypoxic respiratory failure secondary to COVID-19 pneumonia.

Apparently, they followed the frontline doctors misinformation campaign and placed her on ivermectin and multiple other vitamins. As her oxygen saturations continued to drop down, she needed high flow cannula oxygen, which she did not tolerate. She was started on BiPAP. At the time of admission, her D-dimer was significantly elevated. CT scan did not show any evidence of blood clot but indicated extensive consolidation in bilateral lungs.

PAST MEDICAL HISTORY AND SURGICAL HISTORY:
1. Down syndrome.
2. Conductive hearing loss.
3. Sleep apnea, on CPAP at home.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

CURRENT MEDICATIONS: Heparin, dexamethasone, clotrimazole, clindamycin, Zofran, Mucinex, albuterol. Clotrimazole and clindamycin are topical agents.

SOCIAL HISTORY: No tobacco or alcohol or substance use.

FAMILY HISTORY: Grandmother has a history of CAD. Her brother has depression. Maternal grandfather had a history of diabetes and bone cancer.

REVIEW OF SYSTEMS: Unable to obtain as the patient is on BiPAP and secondary to

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

her mental status.

PHYSICAL EXAMINATION:
GENERAL: The patient is lethargic, but arousable. She is on Precedex drip. No obvious respiratory distress present.
VITAL SIGNS: Temperature 36.3 degrees centigrade. T-max was 40.1. Heart rate 64 per minute, blood pressure is 108/72, oxygen saturation is 91% with BiPAP of 15/10 with FiO2 of 100%.
HEENT: Face is consistent with Down syndrome. Pupils are reacting to light equally on both sides. Sclerae are anicteric. Conjunctivae are pink. Oral mucosa is dry.
NECK: Supple. Trachea is in the midline.
CARDIOVASCULAR: S1, S2 heard. There are no murmurs.
CHEST: Coarse respirations. Respirations are decreased at both lung bases.
ABDOMEN: Soft, nontender. Bowel sounds present.
EXTREMITIES: There is no cyanosis, no clubbing, no edema.
NEUROLOGIC: The patient is lethargic mostly because of Precedex. Precedex was started as the patient was agitated last night. There are no obvious focal neurological deficits.
MUSCULOSKELETAL: There is no cyanosis or clubbing. There is no edema.

IMAGING STUDIES:
1. CT scan of the chest done on 10/06/2021 showed extensive infiltrates with consolidation in the posterior lower lungs. There is mild cardiac prominence noticed.
2. Chest x-ray done today (10/08/2021) showed hazy and reticular opacities in both lungs, left more than right.

LABORATORY VALUES: ABG: pH 7.39, pCO2 of 32, pO2 of 69 and bicarbonate is 19.

CHEMISTRY: Sodium 142, potassium 4.4, chloride 115, bicarbonate 19 with anion gap of 8.3. BUN is 20 and creatinine is 0.95. Glucose is 151. Bilirubin is 0.3, ALT 18, AST 50. C-reactive protein is 4.5.

CBC: White cell count is 5500, hemoglobin is 12.9 and platelet count is 181,000. Neutrophils are 75% and lymphocytes are 11%.

D-dimer is 2243. INR is 1.17.

ASSESSMENT:
1. Acute respiratory failure.
2. Acute respiratory failure secondary to COVID-19 pneumonia.
3. Complete trisomy 21, high functioning Down syndrome.
4. Obstructive sleep apnea.

PLAN:
1. I will adjust the BiPAP settings. The patient is requiring 100% of oxygen

to keep saturations close to 90%. At this point, she is unable to prone.
2. She developed bradycardia with Precedex and Precedex was discontinued. The patient is lethargic still, but responding to verbal commands.
3. Dr. Zeimet is managing the COVID infection issues. She is not a candidate for remdesivir, convalescent plasma or baricitinib or monoclonal antibodies. She is on dexamethasone. She received a couple of doses so far. Dr. Zeimet believes that tocilizumab is going to be effective for her, but her dad apparently wants to do research on it before he agrees.
4. I discussed with dad about prognosis as well as the plans. He made a conference call with his wife and unfortunately their understanding about CPAP ____ ventilation we are using and the oxygen supplementation are different. They think that her home CPAP machine is good enough and they think that nasal cannula oxygen is better than what we are giving now. We tried to explain to best of my ability, but they have their own concepts.
5. Got a PICC line placed. She is requiring Levophed and dopamine. Dopamine is started as her heart rate is staying low even after discontinuing Precedex.
6. DVT prophylaxis, is changed from heparin to Lovenox.
7. GI prophylaxis.

I told the patient's father about the need to intubate if oxygen saturation cannot be maintained above 90% with 100% FiO2 and adjusting the BiPAP. At this point, he did not make a decision.

As she is not able to eat or drink today, we will plan on starting her on some partial parenteral nutrition at least.

CRITICAL CARE TIME: 70 minutes.

JOB ID: 1055015

cc: Ramana Marada MD
Trans: R1
MARRA /escript

Dict: 10/08/21 2125
Tran: 10/08/21 2230

Electronically Signed: RAMANA R MARADA MD 10/26/21 1153

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1007-0140

DATE OF SERVICE: 10/07/2021

REQUESTING PHYSICIAN: Dr. Baum.

This is an infectious diseases consultation requested by Dr. Baum for patient with COVID-19.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old female with Down syndrome who was basically admitted with COVID-19. The patient's father is at the bedside, who provides the history. Apparently, they went to Christian concert on 09/25/2021. The patient started having a runny nose around 09/27/2021 or 09/28/2021 and then started having a fever, diminished appetite, doing more fatigue and weakness. They started monitoring her oxygen saturation, eventually got her tested on 10/01/2021 and then from there, they followed the frontline doctors, missed the information campaign and placed her on some ivermectin and as the vitamins and all that stuff, but her oxygen saturation continued to drop down and eventually they brought her in and she was satting around 86%, was placed on some oxygen and then BiPAP for a short time, but now is on Vapotherm with a flow rate of 20. In any case, I am being asked to render input on next steps. The patient's father feels that she is doing a lot better now. She is not vaccinated and he does not go into details on why that is.

PAST MEDICAL HISTORY: Significant for Trisomy 21, hearing loss, obstructive sleep apnea. He has a history of hidradenitis. Obstructive sleep apnea. Seborrhea dermatitis.

PAST SURGICAL HISTORY: Includes an I and D of a pilonidal cyst.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

CURRENT MEDICATIONS: Include heparin, dexamethasone, clotrimazole, clindamycin, Zofran, Mucinex, albuterol and Tylenol. "the clotrimazole and clindamycin are topical agents."

SOCIAL HISTORY: No tobacco, alcohol or substances.

FAMILY HISTORY: Apparently, mother has COVID-19 as well.

REVIEW OF SYSTEMS: Unable to obtain from the patient, otherwise as above from the father.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature afebrile, heart rate 89-97, respirations 18 to 25, O2 saturation 97% to 99%, currently on a 20 liters of Vapotherm, blood pressure 96-99/50-58.
GENERAL: The patient is awake. She is alert. She is in no distress. She

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appears pleasant. She does have the Down syndrome facies. Extraocular muscles appear full and intact. No scleral icterus or injection noted.
HEENT: No conjunctival petechiae. Mucous membranes are slightly tacky.
NECK: Supple. Nares patent. Vapotherm cannula is in place.
HEART: Appeared regular rate and rhythm.
LUNGS: Appear fairly clear to auscultation bilaterally. No wheezing or rhonchi appreciated.
ABDOMEN: Positive bowel sounds, soft, nontender.
SKIN: No rash, no splinters noted.

LABORATORY DATA: Sodium 141, potassium 4.1, chloride 100, bicarbonate 18, BUN 23, creatinine 1.4, glucose 152, total protein 7.9, albumin 3.8, total bilirubin 0.3, alkaline phosphatase 49, AST 54, ALT 26. WBC is 3.5, H and H 14.8 and 44.7, platelet count 149, neutrophils 54.7, lymphocytes 31.6, monocytes 7.4. Procalcitonin 0.22. From a COVID perspective, went to a concert on 09/25/2021, signs and symptoms started on 09/27/2021 or 09/28/2021, tested positive on 10/01/2021, placed her around day 10 of symptoms. Her CT angiogram showed extensive motion artifact, no gross PE seen. Extensive infiltrates in the areas of consolidation in both lungs, likely related to pneumoniae mild cardiac prominence.

ASSESSMENT:
1. COVID-19.
2. Hypoxia.
3. Down syndrome.

RECOMMENDATIONS:
1. This patient was exposed to SARS-CoV-2 virus presumably from going to a Christian concert on 09/25/2021. Symptoms started a few days later around 09/27/2021 or 09/28/2021 and she tested positive on 10/01/2021, placed her around day 10 or 11 of symptom onset. The patient's family was following the misinformation of the frontline physicians with their vitamin cocktails and ivermectin, but clearly that did not really help her. She continued to decompensate and subsequently was brought in. She was initially on BiPAP for a short time, but then was placed on Vapotherm. She is on a flow rate of 20 and it looks like she has perked up a little bit.
2. I discussed with the father that typically COVID last anywhere from 10 to 14 days that she is in the middle of that. There are three distinct phases, the viral followed by lung phase followed by the complication recovery phase. She is in the lung phase morphing into the complication and/or recovery phase.
3. We discussed several different treatment modalities that we have for COVID with regards to remdesivir. She does not really qualify for this, but he informed me that he did not want to be on this drug anyways. So, this drug will not be utilized.
4. The patient does not qualify for use of convalescent plasma or the monoclonal antibody or Regeneron and these will not be utilized.
5. I think her anti-COVID treatment of choice is dexamethasone 6 mg daily and

we would plan to continue that for up to 10 doses while she requires supplemental oxygen therapy.
6. We briefly discussed the possible use of tocilizumab. Currently, the patient does not meet criteria for. She is on Vapotherm, flow rate of 20 and things seem to have calmed down and she is improving, so at this time, she does not require this. She is going to her own research on this drug whether she wanted to use or not and things were to worsen and we will just kind of reassess things from there. At this time, she does not meet criteria for tocilizumab.
7. I stressed the importance of proning, continue with supplemental oxygen and time and we will have to kind of see how things proceed as we move forward here.
8. Unfortunately, I think the patient probably would not be here if she has been fully vaccinated.

We will plan to follow with you.

Thank you for allowing me to participate in the care of your patient, please call if there are any questions.

JOB ID: 1053286

cc: Karl Baum MD
Trans: R1
ZEIA /escript

Dict: 10/07/21 1153
Tran: 10/07/21 1220

Electronically Signed: ANTHONY P ZEIMET DO 10/07/21 1643

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
PHYSICIAN NOTE

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct No: E39547554
Report No: 1006-0184

EMERGENCY DEPARTMENT RECORD
Physician Documentation
FINAL
Ascension NE Wisconsin St. Elizabeth Hospital
Name: Grace Schara
Age: 19 yrs
Sex: Female
DOB: 09/22/2002
MRN: E000365038
Arrival Date: 10/06/2021
Time: 14:07
Account#: E39547554
Bed A1
Private MD:
ED Physician Barlow, Lauren
Disposition:
10/06
17:55 Critical Care:. lkb
17:57 Chart complete. lkb

Disposition Summary:
10/06/21 17:57
Hospitalization Ordered
Notes: Hospitalization Status: Inpatient Admission
lkb
Provider: Cherian, Arun lkb
Condition: Fair lkb
Problem: new lkb
Symptoms: are unchanged lkb
Bed/Room Type: Inpatient lkb
Location: Oncology: 2-C(10/06/21 23:11) jrt
Room Assignment: 2029(10/06/21 23:11) jrt
Diagnosis
- Confirmed 2019 novel coronavirus (COVID-19) lkb
- Acute respiratory distress requiring non-invasive ventilation secondary to COVID lkb
Forms:
- SBAR: Handoff Communication Form lkb
HPI:
14:41 This 19 yrs old White Female presents to ER via EMS with complaints of Breathing Difficulty - (COVID +). lkb
14:41 The patient has shortness of breath at rest. Severity of symptoms: At their worst the symptoms were moderate in the emergency department the symptoms are unchanged. Unable to obtain HPI due to patient distress. 19-year-old female with Down syndrome, on CPAP nightly, who is brought in by father from urgent care with Covid symptoms since lkb

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9/27/2021, she is now on day 10 of symptoms, found to be hypoxic at urgent care as well as with an elevated D-dimer. Father states that patient tested positive for Covid, he patient did have a telehealth visit with an outside physician was placed on a cocktail of supplements and medications for Covid including ivermectin NAC. Despite taking these treatments, father has noted her to be hypoxic as low as 88%. He is also been giving her nebulizer solution of saline as well as possibly hydrogen peroxide but it is unsure. Patient did have an elevated D-dimer greater than 5000 urgent care thus was sent to the ED. No history of smoking, no history of asthma. Patient is not vaccinated against Covid. Patient is overall been improving as far as her fever is concerned, no longer having fevers, she does have a persistent dry and productive cough.

OB/GYN:
15:55 LMP N/A - jll

Historical:
- Allergies: SULFA (SULFONAMIDES);
- PMHx: down syndrome;
- PSHx: None;
- Immunization history-: Covid Vaccine: None/never.
- Admission Screen:: Does the patient have active C-Diff? (No) Does the patient have a history of MRSA? (No) Does the patient have active Influenza? (No) Does the patient require dialysis? (No) Has the patient been actively treated with chemo or radiation in the last 60 days? (No).
- Source of Medication List:: family.
- Social history:: Smoking status: Never Smoker Vaping/E-Cigarette Use: Reports never vaping.
- Unable to obtain history due to: patient distress.

ROS:
14:47 Unable to obtain ROS due to patient distress. lkb

Exam:
14:47 Constitutional: This is a well developed, well nourished patient who lkb is awake, alert, and in no acute distress, ill-appearing nontoxic Head/Face: normocephalic, atraumatic Eyes: no scleral icterus, no periorbital edema Neck: trachea midline, supple, no nuchal rigidity Chest/axilla: no chest wall tenderness rash or crepitus Cardiovascular: Tachycardic, regular rhythm Respiratory: Poor inspiratory effort, grossly clear lungs without rales or wheezes appreciated, no increased work of breathing or accessory muscle use, currently on supplemental oxygen via nasal cannula Abdomen/GI: soft, nttp, nd, no guarding Back: no CVAT b/l MS/ Extremity: no LE edema

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or calf tenderness b/l, 2+ radial pulses and equal Neuro: alert and awake, moving all extremities spontaneously, following commands Psych: awake and alert, normal mood and behavior

Vital Signs:

14:15 Pulse 110; Resp 20; Pulse Ox 87% on R/A;	jll
14:16 BP 110 / 51; Pulse Ox 97% on 3 lpm NC; Weight 84 kg;	jll
16:12 BP 105 / 53; Pulse 102; Resp 22; Pulse Ox 90% on 3 lpm NC;	dek
17:07 BP 82 / 40; Pulse 87 MON; Resp 16; Pulse Ox 92% on 4 lpm NC;	kr4
17:15 BP 96 / 55; Pulse 88; Resp 16; Pulse Ox 93% 4 lpm ;	kr4
18:39 BP 104 / 57; Pulse 70; Resp 20; Pulse Ox 99% on 80% BiPAP;	ss
20:26 BP 102 / 52 LA Sitting (auto/reg); Pulse 72 MON; Resp 20 S; Pulse Ox 98% on BiPAP;	jk4
22:15 BP 151 / 63 RA Sitting (auto/reg); Pulse 70 MON; Resp 18 S; Pulse Ox 95% on 80% BiPAP; Pain 0/10;	jk4

MDM:

14:17 Patient medically screened.	lkb
16:46 Antibiotic administration: Not indicated. The patient's pulmonary embolism risk score was calculated as follows: the patients heart rate is greater than 100 beats per minute (1.5 Pts) Total Score: 0-2 points. This patient was found to be at low risk for a pulmonary embolism by using the Well's assessment criteria. Covid Vaccine Evaluation for Administration: Patient not eligible to receive the vaccine at this time. Multiple diagnosis were considered in this patient. Data interpreted: Cardiac monitor: Pulse oximetry:. Data reviewed: vital signs, nurses notes, old medical records, radiologic studies. Medication list review: Medication list obtained, updated or reviewed during today's visit. Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home, disposition plan. ED course: Patient is 10 days post symptom onset for Covid, positive D-dimer at clinic as she is low risk for PE by Wells criteria, thus a CT angio was performed, but does not demonstrate PE but does demonstrate pneumonia and focal areas of consolidation. I believe this is secondary to Covid as patient has overall been improving as far as no longer having fever, she does not have an elevated WBC. I would not treat for bacterial pneumonia at this point. Patient is outside the window for monoclonal antibody treatment. I did give her Decadron as well as albuterol. Dad is very adamant that he would like to take patient home did not think is unreasonable, will see if patient is able to maintain her sat with ambulation, otherwise will need home O2. I have a lower suspicion for	lkb

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myocarditis pericarditis dissection pneumothorax ACS.
17:14 ED course: My reassessment, patient dropped her blood pressure to 80/40, currently is requiring 6 L nasal cannula for oxygenation. She has no increased work of breathing at this time. She just received Decadron now. Will give additional liter of fluid, patient may require admission due to her tenuous hemodynamic status. lkb
17:51 ED course: Patient with hypoxia, not improving significantly after albuterol and decadron. Patient currently on oxymask as she keeps removing nasal cannula. Will place patient on bipap now as she is on cpap normally and I think she would benefit from the positive pressure. Patient did drop her BP to 80s systolic but responded nicely to fluids. Will closely monitor and admit patient for hemodynamic monitoring, supplemental oxygen, respiratory monitoring and further evaluation and treatment. lkb

Orders:
Order: Continuous Pulse Oximetry; Ordered: 10/06 14:27; By: jll; For: lkb; Completed: 10/06 14:27; By: jll; Order Method: Verbal - Read back; Sign Off: Barlow, Lauren, MD - 10/06 15:48
Order: IV - Lock 18g AC; Ordered: 10/06 14:27; By: jll; For: lkb; Completed: 10/06 14:27; By: jll; Order Method: Verbal - Read back; Sign Off: Barlow, Lauren, MD - 10/06 15:48
Order: O2 \T\ 2L per NC or adjunct: Titrate to keep SPO2 greater than 92%.; Ordered: 10/06 14:27; By: jll; For: lkb; Completed: 10/06 14:27; By: jll; Order Method: Verbal - Read back; Sign Off: Barlow, Lauren, MD - 10/06 15:48
Order: NS - Sodium Chloride 0.9% * 1000 ml IV at bolus once; Ordered: 10/06 14:34; By: lkb; For: lkb;Administered: 10/06 15:06 By: jll; Rate: bolus; Frequency: once; Order Method: Electronic
Administration: NS - Sodium Chloride 0.9% * 1000 ml IV at bolus in left antecubital via IV Pump Tubing Follow Up: 10/06 18:10
Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml
Order: CT ANGIO CHEST; Ordered: 10/06 14:34; By: lkb; For: lkb; Reviewed: 10/06 16:43; By: lkb; Notes: Bed Name: E12; Order Method: Electronic; CAMPUS? (OECAMPUS): SEH; TRANSPORTATION? (OETRANS): CART; Does the patient have an Insulin or other med infusion Pump? (RADINSPMP1): No; REASON FOR EXAM? (OERFE) limit to 40 characters: covid, pos ddimer, ?PE; ***CREATININE NEEDED*** (RADERCREAT): Yes; CLINICAL HISTORY? (OECH): 84Kg; COMMENTS (OECOM): E12
Test: CT ANGIO CHEST
; ; ; DEPARTMENT OF RADIOLOGY; D.O.B AGE SEX EXAM DATE; SCHARA,GRACE N 09/22/2002 19 F 10/06/21; LOC: E.ER; Pt Ph#: 920-788-0829; MR#: E000365038; Ordered By: BARLOW MD,LAUREN K ACCT# E39547554; Status: REG ER; ; ; EXAM# TYPE/EXAM RESULT; 003265000 CT/ANGIO CHEST; ; CT ANGIOGRAM OF THE CHEST WITH IV CONTRAST; ; HISTORY: Covid infection,

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Report No: 1006-0184

positive d-dimer.; ; COMPARISON: None available.; ; TECHNIQUE: CT angiogram of the chest was performed during intravenous; administration of nonionic IV contrast without complication. 3-D axial; and coronal oblique MIP renderings of the chest vasculature also; generated. Automated exposure control was utilized.; ; FINDINGS: Extensive motion artifact severely limits evaluation.; ; CHEST WALL AND VISUALIZED NECK: Grossly normal; PLEURA AND PLEURAL SPACE: No significant pleural effusion; TRACHEOBRONCHIAL TREE: Grossly normal; PULMONARY ARTERIES: Extensive motion artifact severely limits; evaluation. No definitive pulmonary embolism is seen.; MEDIASTINUM: Mild cardiac prominence.; LUNGS: Extensive infiltrates with consolidation in the posterior lower; lungs. Had she infiltrates in the remainder of both lungs. This is; likely related to pneumonia.; UPPER ABDOMEN: Normal.; BONES: Normal.; ; IMPRESSION:; 1. Extensive motion artifact significantly limits evaluation. No gross; pulmonary embolism is seen.; 2. Extensive infiltrates with areas of consolidation in both lungs; likely related to pneumonia.; 3. Mild cardiac prominence.; ; Keith Knepel, M.D.; Radiology Associates of the Fox Valley; RAFV CC; I.2; ; ; ; ; ; ; PAGE 1 Signed Report (CONTINUED; ; ; DEPARTMENT OF RADIOLOGY; D.O.B AGE SEX EXAM DATE; SCHARA,GRACE N 09/22/2002 19 F 10/06/21; LOC: E.ER; Pt Ph#: 920-788-0829; MR#: E000365038; Ordered By: BARLOW MD,LAUREN K ACCT# E39547554; Status: REG ER; ; ; EXAM# TYPE/EXAM RESULT; 003265000 CT/ANGIO CHEST; ; Electronically Signed By: Keith Knepel, MD; Signed Date/Time: 10/6/2021 4:28 PM; ; ; ** REPORT SIGNED IN OTHER VENDOR SYSTEM 10/06/2021 **; Reported By: KNEPEL,KEITH A MD; ; ; ; ; ;

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
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for Cancellation: Physician Discretion
Order: NS - Sodium Chloride 0.9% * 1000 ml IV at bolus once; Ordered: 10/06 17:10; By: kr4; For: lkb;Administered: 10/06 17:11 By: kr4; Rate: bolus; Frequency: once; Order Method: Verbal - Read back; Sign Off: Barlow, Lauren, MD - 10/06 17:45 Administration: NS - Sodium Chloride 0.9% * 1000 ml IV at bolus in left antecubital via Gravity Tubing Follow Up: 10/06 19:18 Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml
Order: BiPAP (Call RT); Ordered: 10/06 18:10; By: ss; For: lkb; Completed: 10/06 18:10; By: ss; Order Method: Verbal - Read back; Sign Off: Barlow, Lauren, MD - 10/06 18:31

Order Signatures:
Barlow, Lauren, MD, MD, lkb;
Lietzan, Jessica, RN, RN, jll;
Rhino, Katilee, EMT-P, EMT-P, kr4;
Ballerstein, Shelley, RN, RN, ss;
Dispensed Medications:

15:05 Drug: Albuterol HFA Inhaler 4 puffs Route: Inhalation;	jll
18:10 Follow up: Response: No adverse reaction	ss
15:06 Drug: NS - Sodium Chloride 0.9% * 1000 ml Route: IV; Rate: bolus; Site: left antecubital; Delivery: IV Pump Tubing;	jll
18:10 Follow up: Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml	ss
15:09 Drug: Ibuprofen 600 mg Route: PO;	jll
18:10 Follow up: Response: No adverse reaction	ss
17:07 Drug: Decadron 6 mg Route: IVP; Infused Over: 2 mins; Site: left antecubital;	kr4
18:09 Follow up: Response: No adverse reaction	ss
17:11 Drug: NS - Sodium Chloride 0.9% * 1000 ml Route: IV; Rate: bolus; Site: left antecubital; Delivery: Gravity Tubing;	kr4
19:18 Follow up: Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml	ss

The following critical care time is calculated independent of any other billable procedures:
17:55 Critical care time: Bedside Care: 6 minutes, Consultation: 3 minutes, Family Intervention: 8 minutes, Review of labs and imaging and old records: 6 minutes, discussion with other physicians: 11 minutes. lkb
Total time: 34 minutes

Signatures:

Dispatcher MedHost		EDMS
Lietzan, Jessica, RN	RN	jll
Ballerstein, Shelley, RN	RN	ss
Rohm, Jessica, RN	RN	jrt

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
PHYSICIAN NOTE

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct No: E39547554
Report No: 1006-0184

Barlow, Lauren, MD MD lkb
Rhino, Katilee, EMT-P EMT-Pkr4

Corrections: (The following items were deleted from the chart)
16:48 14:41 19-year-old female with Down syndrome who is brought in by father from urgent care with Covid symptoms since 9/27/2021, she is now on day 10 of symptoms, found to be hypoxic at urgent care as well as with an elevated D-dimer. Father states that patient tested positive for Covid, he patient did have a telehealth visit with an outside physician was placed on a cocktail of supplements and medications for Covid including ivermectin NAC. Despite taking these treatments, father has noted her to be hypoxic as low as 88%. He is also been giving her nebulizer solution of saline as well as possibly hydrogen peroxide but it is unsure. Patient did have an elevated D-dimer greater than 5000 urgent care thus was sent to the ED. No history of smoking, no history of asthma. Patient is not vaccinated against Covid. lkb lkb
17:01 17:01 Pulse ox ambulating+NUR ordered. lkb lkb
17:51 14:41 19-year-old female with Down syndrome who is brought in by father from urgent care with Covid symptoms since 9/27/2021, she is now on day 10 of symptoms, found to be hypoxic at urgent care as well as with an elevated D-dimer. Father states that patient tested positive for Covid, he patient did have a telehealth visit with an outside physician was placed on a cocktail of supplements and medications for Covid including ivermectin NAC. Despite taking these treatments, father has noted her to be hypoxic as low as 88%. He is also been giving her nebulizer solution of saline as well as possibly hydrogen peroxide but it is unsure. Patient did have an elevated D-dimer greater than 5000 urgent care thus was sent to the ED. No history of smoking, no history of asthma. Patient is not vaccinated against Covid. Patient is overall been improving as far as her fever is concerned, no longer having fevers, she does have a persistent dry and productive cough. lkb lkb
23:11 17:57 Med-Surg: 3rd Floor lkb jrt
23:11 17:57 lkb jrt

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SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
NURSES NOTE

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct No: E39547554
Report No: 1006-0183

EMERGENCY DEPARTMENT RECORD
Nurse's Notes
FINAL
Ascension NE Wisconsin St. Elizabeth Hospital
Name: Grace Schara
Age: 19 yrs
Sex: Female
DOB: 09/22/2002
MRN: E000365038
Arrival Date: 10/06/2021
Time: 14:07
Account#: E39547554
Bed A1
Private MD:
Diagnosis: Confirmed 2019 novel coronavirus (COVID-19);Acute respiratory distress requiring non-invasive ventilation secondary to COVID

Inbound Details:
Referred by:
Arriving by: EMS
ETA:
Who will see patient? ED Physician
Notes:
Notify referring provider: Do not notify
Presentation:
10/06
14:09 Presenting complaint: EMS states: coming from Ascension Richmond, diagnosed with Covid Friday after starting symptoms on 9/27. Pt is coughing and increasingly short of breath. Covid-19 Screening: 1a. Have you recently tested positive for COVID-19? Yes. 1b. If so, was the test done more than 14 days ago? No, Screening for Covid-19 Positive. Patient placed in droplet and contact isolation. Have you received a COVID 19 Vaccination? No. Covid Vaccine: Unknown. Transition of care: patient was received from another setting of care (ambulatory primary care physician practice): Ascension. Patient immediately brought to treatment area. No wait time necessary. jll
14:09 Acuity: ESI 2 jll
14:09 Method Of Arrival: EMS: GOLD CROSS jll

Triage Assessment:
15:52 Pain: Numeric Pain Scale 0-10 : Pain currently is 0/10, no pain. jll
Columbia Suicide Severity Risk Assessment: 1) In the past month, have you wished you were dead or wished you could go to sleep and not wake up? Patient denies thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. 2) In the past month, have you actually had any thoughts of killing yourself?

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct No: E39547554
Report No: 1006-0183

Patient denies actual thoughts of killing themselves. 6) In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life? Patient denies they have done things, started to do things, or prepared to do things to end their life at some point in their lifetime. Suicide Risk Level: No Risk Identified. Exposure / Travel Screening: Recent exposure to no known communicable diseases.

OB/GYN:
15:55 LMP N/A - jll

Historical:
- Allergies:
1. SULFA (SULFONAMIDES)
- PMHx: down syndrome;
- PSHx: None;
- Immunization history-: Covid Vaccine: None/never.
- Admission Screen:: Does the patient have active C-Diff? (No) Does the patient have a history of MRSA? (No) Does the patient have active Influenza? (No) Does the patient require dialysis? (No) Has the patient been actively treated with chemo or radiation in the last 60 days? (No).
- Source of Medication List:: family.
- Social history:: Smoking status: Never Smoker Vaping/E-Cigarette Use: Reports never vaping.
- Unable to obtain history due to: patient distress.

Screening:
15:53 Covid Vaccine Screen: Patient is eligible to receive the Covid-19 Vaccination. Morse Fall Scale : Recent History of Falling? No (0 points). Secondary diagnosis: No (0 points). Ambulatory Aids: None/Bed Rest/Nurse Assist (0 points). Intravenous Therapy/Heparin/Saline Lock: No (0 points). Gait/Transferring: Normal/Bed Rest/Wheelchair (0 points)/ Mental Status: Oriented to own ability (0 points). Total Score: 0. Risk Level: No Risk. Abuse screen (Does the patient feel they are being/or have been abused, neglected, or exploited?): No. Violence Aggression Assessment Checklist (VAAC): 1. History of Violence (history of being physically aggressive towards a caregiver)? No. 2. Uncooperative (Easily annoyed or angered. Unable to tolerate the presence of others. Will not follow instructions.)? No. 3. Verbal abuse (verbal attacks, abuse name-calling, verbally neutral comments uttered in snarling, aggressive manner)? No. A. Hostile attacking objects (overly loud of noisy (i.e. slams doors, shouts out when talking, etc) or an attack directed at an object and not after an individual (i.e. throwing of an object, banging or smashing windows, furniture): No. B. Threats (A jll

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct No: E39547554
Report No: 1006-0183

verbal outburst more than just a raised voice and where there is deliberate intent to intimidate or threaten another person. A definite intent to physically threatened another person (i.e. raised arm/leg, aggressive stance, fists): No. C. Assaultive/combative (an application of force or attack directed at an individual, i.e. kick, punch, spit, grabbing of clothing, using of a weapon, use of a weapon of opportunity): No. Behaviors exhibited by: Not applicable. Known risk factors: Not applicable. Violence Risk Level: Low. Interventions: Not applicable.

Vital Signs:

14:15 Pulse 110; Resp 20; Pulse Ox 87% on R/A;	jll
14:16 BP 110 / 51; Pulse Ox 97% on 3 lpm NC; Weight 84 kg;	jll
16:12 BP 105 / 53; Pulse 102; Resp 22; Pulse Ox 90% on 3 lpm NC;	dek
17:07 BP 82 / 40; Pulse 87 MON; Resp 16; Pulse Ox 92% on 4 lpm NC;	kr4
17:15 BP 96 / 55; Pulse 88; Resp 16; Pulse Ox 93% 4 lpm ;	kr4
18:39 BP 104 / 57; Pulse 70; Resp 20; Pulse Ox 99% on 80% BiPAP;	ss
20:26 BP 102 / 52 LA Sitting (auto/reg); Pulse 72 MON; Resp 20 S; Pulse Ox 98% on BiPAP;	jk4
22:15 BP 151 / 63 RA Sitting (auto/reg); Pulse 70 MON; Resp 18 S; Pulse Ox 95% on 80% BiPAP; Pain 0/10;	jk4

Vitals:

15:55 Sepsis Screen: Suspicion of Infection: No. Pasero Opioid-induced sedation scale: 1 - Awake and alert.	jll

ED Course:

14:07 Patient arrived in ED.	ekd
14:07 Patient visited by Depner, Elizabeth, CNA	ekd
14:07 Patient moved to Waiting room	ekd
14:07 Patient moved to E12 room	ekd
14:08 Lietzan, Jessica, RN is Primary Nurse.	jll
14:09 Barlow, Lauren, MD is Attending Physician.	lkb
14:15 Triage completed.	jll
14:17 Patient visited by Barlow, Lauren, MD	lkb
14:30 Bed in low position. Call light in reach. Side rails up X2. Adult w/ patient. Continuous Pulse Oximetry on.	jll
14:50 Inserted saline lock: 18 gauge (angio type) in left antecubital area.	jll
15:12 Patient visited by Lietzan, Jessica, RN	jll
15:54 Blood Collection: Blood not collected/ not applicable.	jll
15:55 Arm band placed on Arm band checked for correct identification.	jll
16:07 ANGIO CHEST+CT results returned.	EDMS
16:12 Patient visited by Nelson, Danielle, EST	dek
16:41 ANGIO CHEST+CT results returned.	EDMS
17:07 Patient visited by Rhino, Katilee, EMT-P	kr4
17:16 Patient visited by Rhino, Katilee, EMT-P	kr4

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

Patient Name: SCHARA,GRACE N | Unit Number: E000365038
DOB: 09/22/02 Sex: F | Acct No: E39547554
Date: 10/06/21 | Report No: 1006-0183

17:56 Cherian, Arun, MD is Hospitalizing Provider. lkb
18:11 Bipap settings 12/8 at 100%. ss
18:34 Patient visited by Ballerstein, Shelley, RN ss
18:48 Primary Nurse role handed off by Lietzan, Jessica, RN jk4
18:48 Kneisler, Jennifer, RN is Primary Nurse. jk4
19:14 father does not want to have his daughter stay in the hospital without a parent present. He is willing to commit to not leaving the room while his daughter is in the hospital. Called the lead on 3rd floor and she will contact her manager to see if he can be allowed to stay. Pt does have Down's syndrome and father states she functions at a 12 year level, he also has activated POA. The 3rd floor lead will call our lead with the answer regarding if he can stay with the daughter. ss
19:18 No assistance was given to a provider for a procedure. . ss
20:01 Patient visited by Kneisler, Jennifer, RN jk4
20:27 Patient visited by Kneisler, Jennifer, RN jk4
20:38 Patient visited by Kneisler, Jennifer, RN jk4
22:16 Patient visited by Kneisler, Jennifer, RN jk4
23:11 Bed assignment received: 23:11. jrt
10/07
00:32 Patient moved to A1 room hm1

Administered Medications:
10/06
15:05 Drug: Albuterol HFA Inhaler 4 puffs Route: Inhalation; jll
18:10 Follow up: Response: No adverse reaction ss
15:06 Drug: NS - Sodium Chloride 0.9% * 1000 ml Route: IV; Rate: bolus; Site: left antecubital; Delivery: IV Pump Tubing; jll
18:10 Follow up: Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml ss
15:09 Drug: Ibuprofen 600 mg Route: PO; jll
18:10 Follow up: Response: No adverse reaction ss
17:07 Drug: Decadron 6 mg Route: IVP; Infused Over: 2 mins; Site: left antecubital; kr4
18:09 Follow up: Response: No adverse reaction ss
17:11 Drug: NS - Sodium Chloride 0.9% * 1000 ml Route: IV; Rate: bolus; Site: left antecubital; Delivery: Gravity Tubing; kr4
19:18 Follow up: Response: No adverse reaction; IV Status: Completed infusion; IV Intake: 1000ml ss

Intake:
18:10 IV: 1000ml; Total: 1000ml. ss
19:18 IV: 1000ml; Total: 2000ml. ss

Outcome:
17:57 Decision to Hospitalize by Provider. lkb

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
NURSES NOTE

Patient Name: SCHARA,GRACE N Unit Number: E000365038
DOB: 09/22/02 Sex: F Acct No: E39547554
Date: 10/06/21 Report No: 1006-0183

19:18 Registration completed: Yes ss
19:18 Medication Education: Patient instructed on purpose of all ss
medications given and common side effects of all medications given.
Parent instructed on purpose of all medications given to child and
common side effects of all medications given.
20:27 Discharge Pain Assessment: The patient's pain goal(s) were not met jk4
-patient admitted to the hospital for further pain control.
20:27 Patient and/or family instructed on admit process .
20:27 We like to do follow up calls to see how your are doing once you
leave the emergency department. If you are unavailable can we leave a
message on your answering machine/voice mail? Call back in not
applicable for this patient because patient was admitted to the
inpatient unit.
10/07
00:24 Total face to face (one to one) care was provided to this patient by jk4
hospital staff for 320 minutes
Transition record sent to floor with patient, admitted toTele by
transport accompanied by nurse, family with patient, via stretcher,
with chart, with IV Salinelock in place.
Report called to Brittany,RN
00:43 Patient left the ED. jk4

Signatures:

Dispatcher MedHost		EDMS
Depner, Elizabeth, CNA	CNA	ekd
Lietzan, Jessica, RN	RN	jll
Ballerstein, Shelley, RN	RN	ss
Nelson, Danielle, EST	EST	dek
Rohm, Jessica, RN	RN	jrt
Meyer, Hanna, RN	RN	hm1
Kneisler, Jennifer, RN	RN	jk4
Barlow, Lauren, MD	MD	lkb
Rhino, Katilee, EMT-P	EMT-P	kr4

Corrections: (The following items were deleted from the chart)
10/06
14:18 14:15 BP 110 / 51; Pulse Ox 97% 3 lpm Nasal Cannula; 84 kg; jll jll
17:14 17:07 BP 82 / 40; Pulse 87bpm; MonitorResp 16bpm; Pulse Ox 92% 6 lpm kr4
Nasal Cannula; kr4
18:12 18:11 Bipap settings 10/8 at 100% ss ss

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SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
ORDER SUMMARY

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct Number: E39547554
Report No: 1006-0185

EMERGENCY DEPARTMENT RECORD
Order Summary
FINAL
Name: Grace Schara
MRN: E000365038
19 yrs
/ White
/ Female
Arrival: 10/06/2021
14:07
Chief Complaint: Breathing Difficulty - (COVID +)
Departure Date 10/07/2021
Departure Time 00:43
Orders:
Radiology
Order Name: CT ANGIO CHEST; Last Status: Reviewed; Time: 10/06/21 14:34; By: lkb; For: lkb; Order Method: Electronic; Notes: Bed Name: E12
Test: 1:RPT; Value: DEPARTMENT OF RADIOLOGYD.O.B
AGE SEX EXAM DATESCHARA,GRACE N 09/22/2002 19 F
10/06/21LOC: E.ERPt Ph#: 920-788-0829MR#:
E000365038Ordered By: BARLOW MD,LAUREN K ACCT#
E39547554Status: REG EREXAM# TYPE/EXAM
RESULT003265000 CT/ANGIO CHESTCT ANGIOGRAM OF THE
CHEST WITH IV CONTRASTHISTORY: Covid infection, positive
d-dimer.COMPARISON: None available.TECHNIQUE: CT
angiogram of the chest was performed during
intravenousadministration of nonionic IV contrast without
complication. 3-D axialand coronal oblique MIP renderings of the
chest vasculature alsogenerated. Automated exposure control was
utilized.FINDINGS: Extensive motion artifact severely
limits evaluation.CHEST WALL AND VISUALIZED NECK: Grossly
normalPLEURA AND PLEURAL SPACE: No significant pleural
effusionTRACHEOBRONCHIAL TREE: Grossly normalPULMONARY
ARTERIES: Extensive motion artifact severely limitsevaluation.
No definitive pulmonary embolism is seen.MEDIASTINUM: Mild
cardiac prominence.LUNGS: Extensive infiltrates with
consolidation in the posterior lowerlungs. Had she infiltrates
in the remainder of both lungs. This islikely related to
pneumonia.UPPER ABDOMEN: Normal.BONES:
Normal.IMPRESSION:1. Extensive motion artifact
significantly limits evaluation. No grosspulmonary embolism is
seen.2. Extensive infiltrates with areas of consolidation in
both lungslikely related to pneumonia.3. Mild cardiac
prominence.Keith Knepel, M.D.Radiology Associates of
the Fox ValleyRAFV

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

ASCENSION NE WI ST. ELIZABETH HOSPITAL
EMERGENCY DEPARTMENT
ORDER SUMMARY

Patient Name: SCHARA,GRACE N
DOB: 09/22/02 Sex: F
Date: 10/06/21

Unit Number: E000365038
Acct Number: E39547554
Report No: 1006-0185

CCI.2PAGE 1 Signed Report
(CONTINUEDDEPARTMENT OF RADIOLOGYD.O.B AGE
SEX EXAM DATESCHARA,GRACE N 09/22/2002 19 F 10/06/21LOC:
E.ERPt Ph#: 920-788-0829MR#: E000365038Ordered By:
BARLOW MD,LAUREN K ACCT# E39547554Status: REG
EREXAM# TYPE/EXAM RESULT003265000 CT/ANGIO
CHESTElectronically Signed By: Keith Knepel, MDSigned
Date/Time: 10/6/2021 4:28 PM** REPORT SIGNED IN OTHER
VENDOR SYSTEM 10/06/2021 **Reported By: KNEPEL,KEITH A
MD\E\.b
r\E\\E\.b
r\E\CC: BARLOW MD,LAUREN K; ESCH DO,ALLY E; NORDSTROM
MD,MARY EEdited Date: 10/06/21 by PROVIDERPrinted
Date/Time: 10/06/2021 (1641)PAGE 2 Signed Report; Status: F
Medications
Order Name: Sodium Chloride 0.9% *; Last Status: Administered; Time:
10/06/21 14:34; By: lkb; For: lkb; Order Method: Electronic
Order Name: Albuterol HFA; Last Status: Administered; Time: 10/06/21
14:34; By: lkb; For: lkb; Order Method: Electronic
Order Name: Ibuprofen; Last Status: Administered; Time: 10/06/21
14:35; By: lkb; For: lkb; Order Method: Electronic
Order Name: Decadron; Last Status: Administered; Time: 10/06/21
16:45; By: lkb; For: lkb; Order Method: Electronic
Order Name: Sodium Chloride 0.9% *; Last Status: Administered; Time:
10/06/21 17:10; By: kr4; For: lkb; Order Method: Verbal - Read
back; Sign Off: Barlow, Lauren, MD - 10/06 17:45
****

SCHARA,GRACE N
MRN: E000365038
DOB: 09/22/02

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: SHOKAR MD,GAVIN REPORT NO: 1012-0302

DATE OF ADMISSION: 10/07/2021

DATE OF SERVICE: 10/12/2021

After this morning's assessment, the patient's oxygenation saturations have deteriorated requiring increasing BiPAP settings 100% FiO2, yet still her oxygenation was in the low 80s. Respiratory therapy adjusted the settings of 20/15, which did improve her oxygenation to the high 80s to low 90s. Initially, discussed with Cindy, the patient's mother in regard to goals of care in regard to worst case scenario if she was requiring intubation and she deferred me to her husband, Scott. I had called Scott and had a family conference with him and his children in regard to worst case scenario if the BiPAP at max settings was ineffective for. Initially we discussed positional changes such as proning and affect as well as multiple other questions were answered to the best of my ability. We went over scenarios in regard to intubation versus leaving her on BiPAP in the situation of hypoxia versus comfort care. We spent over 60 minutes during this conference to answer all questions that were posed and counseled as best as possible in regard to the unfortunate situation. Family will convene and decide on what to do hopefully before the evening. They did initially want to decide by tomorrow morning; however, I did implore the importance of deciding as early as possible given her deterioration throughout the day. We are hoping that she does improve gradually on BiPAP and is able to wean down some from the use of max settings that were placed this a.m.; however, we do need a direct answer in regards if she needs intubation, if we should intubate as well as on resuscitation. I did discuss with them in regard to cardiac arrest in the context of respiratory arrest or respiratory distress and the futility of CPR compressions, defibrillation if we are not going to intubate and in someone who has underlying lung disease and ongoing hypoxia. It seems that all parties understood what was discussed. Again, they will reconvene with an answer shortly.

JOB ID: 1058117
cc:
Trans: R1
SHOGA /escript

Dict: 10/12/21 1646
Tran: 10/12/21 1657

Electronically Signed: GAVIN SHOKAR MD 10/17/21 2307

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BECK MD,DAVID REPORT NO: 1007-0034

DATE OF ADMISSION: 10/07/2021

DATE OF SERVICE: 10/06/2021

REASON FOR ADMISSION: Acute hypoxic respiratory failure.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old female with past medical history of complete trisomy 21 syndrome, conductive hearing loss and obstructive sleep apnea, who was brought into the hospital by her family secondary to shortness of breath. The patient is a high functioning Down syndrome individual. She resides at home with her family. The history is gathered from her dad who is at the bedside. The father states that the whole family is not vaccinated for COVID-19. On Saturday 09/25/2021, the whole family went to Christian concert in Oshkosh. There were about 3000 people indoors and majority of the attendees were not masked. The dad thinks she probably caught the virus from there. A couple of days after that, Tuesday, 09/28/2021, the patient started experiencing runny nose and the family thought it might be a sinus infection type of phenomena. Gradually, she started developing fever, decreased appetite level. Also, she was sleeping more. Subsequently, her family bought home testing COVID kit and tested the patient, she turn out to be positive this past Friday. Since then, they have been monitoring her oxygen level. The family looked up the protocol of the front line physicians cocktail and the patient has been receiving those treatments since including: ivermectin, vitamins, supplements and nebulizer treatment. The dad states that they thought she was improving and she was turning corner this past Tuesday morning. He states that when he was going to work Tuesday, he checked her oxygen sat and it was 97% and they were happy. They thought she probably beat the virus. But unfortunately, she started becoming lethargic and her oxygen started to dip down. She was satting in the upper 80s Tuesday evening and Wenesday subsequently, the family was concerned and took her to urgent clinic. There her D-dimer was significantly elevated. Subsequently, she was recommended to come into the Emergency Department for CT and further evaluation. Her CT scan does not indicate any blood clot type of phenomena, but it indicates extensive consolidation in bilateral lungs. she was placed on BiPAP in emergency room and her breathing has appeared to get better. The dad states the patient had one episode of watery diarrhea over the weekend. She did not experience any nausea or vomiting.

PAST MEDICAL AND SURGICAL HISTORY
1. High functioning Down syndrome.
2. Hidradenitis.
3. Conductive hearing loss.
4. Seborrheic dermatitis.
5. I and D of pilonidal cyst.
6. Sleep apnea, on CPAP at home.

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

MEDICATIONS: Awaiting pharmacy verification of meds.

ALLERGIES: NO KNOWN DRUG ALLERGY.

SOCIAL HISTORY: The patient resides at home with family.

HABITS: She does not use alcohol, tobacco or illicit drug.

FAMILY MEDICAL HISTORY: Her maternal grandmother had a history of CAD. Her brother has depression. Her maternal grandfather had history of diabetes mellitus and bone cancer.

REVIEW OF SYSTEMS: Unable to be obtained secondary to the patient's mental status.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 99/58, pulse is 59, respiratory rate is 18, O2 sat is 99% on BiPAP.
GENERAL: Sleepy, but arousable to verbal stimuli.
HEENT: Normocephalic, atraumatic. EOMI, PERRLA.
NECK: Supple.
CARDIOVASCULAR: S1, S2, regular rate.
CHEST: Coarse to auscultation throughout.
ABDOMEN: Soft, nontender, distended. Normoactive bowel sounds in all four quadrants.
EXTREMITIES: No cyanosis, no clubbing, no edema.
NEUROLOGIC: Arousable to verbal stimuli.
SKIN: No diffuse rash noted.
MUSCULOSKELETAL: No joint tenderness noted.

LABORATORY DATA: Noted.

IMAGING STUDY: I independently viewed her chest CT and reviewed radiology report, that appears to be extensive consolidation in bilateral lungs.

IMPRESSION AND PLAN:
1. Acute hypoxic respiratory failure. This appears to be secondary to viral COVID-19 pneumonia. The patient will be admitted to COVID unit with support on BiPAP. We will get ABG on her. I educated the dad in regard to this disease process, pathophysiology as well as treatment modalities that is available through Ascension system. The patient will be placed on IV Decadron, albuterol inhaler, cough medicine, support on BiPAP, proning. I explained to dad that we are not going to offer ivermectin, supplements and vitamins cocktails and other treatment cocktail that has been utilized by frontline physicians. He understands that. We will consult Dr. Zeimet for further expertise.
2. Obstructive sleep apnea. She is on home CPAP, now on BiPAP, doing okay.
3. Thrombocytopenia secondary to viral illness, mild. Monitor.

4. Leukopenia secondary to viral illness. This will be monitored as well.
5. Mildly elevated AST secondary to viral illness. This will be monitored.
6. Acute kidney injury secondary to decreased p.o. intake. We will hydrate, refrain from nephrotoxin. Monitor.
7. Deep venous thrombosis prophylaxis, sequential compression device and heparin.

CODE STATUS: Full code.

JOB ID: 1052781
cc:
Trans: R1
BECD /escript

Dict: 10/07/21 0333
Tran: 10/07/21 0417

Electronically Signed: DAVID BECK MD 10/07/21 1845

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: SHOKAR MD,GAVIN REPORT NO: 1019-0265

DATE OF SERVICE: 10/13/2021

ADDENDUM:

Addendum to job#1013-0156

CRITICAL CARE TIME SPENT: 40 minutes in direct care with the patient minimum as well as 30-45 minutes in discussion with family and another 15 minutes in chart review.

JOB ID: 1064368
cc:
Trans: R1
SHOGA /escript

Dict: 10/19/21 1728
Tran: 10/19/21 1745

Electronically Signed: GAVIN SHOKAR MD 10/21/21 1857

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: SHOKAR MD,GAVIN REPORT NO: 1013-0156

DATE OF SERVICE: 10/13/2021

CHIEF COMPLAINT: Shortness of breath.

SUBJECTIVE: The patient was doing well on same settings of BiPAP this a.m. of 20/15 at 100% FiO2. She was unable to wean to 90% as she does desaturates to about 80s. She had an episode where she got agitated after being assisted to stool and her Precedex was increased to help control agitation as she is starting to try to pull out a PICC and remove the mask. She required restraints by the time of interview with the goal to remove the restraints as soon as possible. She has been able to prone for an hour here and there overnight. This a.m. seems that we have been having less success proning her for more than 20 to 30 minutes as she returns back over onto her side, this is per her nursing report. We will continue to encourage and assess if proning is a viable option for her.

I had a discussion with the family over the phone for roughly half an hour to an hour in regards to code status once again as well as feeding options they have. They had deliberated yesterday after our conversation and decided for a DNI status. We did discuss in regards to CPR resuscitation and the futility of doing CPR in the situation in regards to DNI and they agreed in regards to not pursuing a resuscitation via CPR or defibrillation in the event of respiratory arrest leading to a cardiac arrest. In all regard, they want to continue full management without intubation. We will continue and wish to continue with BiPAP therapy as long as possible. If there is a deterioration and hypoxia without reversibility for prolonged amount of time, we may consider at that time switching to comfort care after a discussion has been completed with family to see if that is the right time. In the meantime and hopefully, we will continue care and with the goal of improvement.

The patient was seen and examined at bedside today. She again was in restraints as above, relatively nonverbal as she was a bit more sedated with Precedex as she was yesterday. Her sister was bedside. All questions were answered.

OBJECTIVE:
VITAL SIGNS: Temperature 101.4, pulse rate 93, respiratory rate 41, blood pressure 127/82, oxygen saturation 82% on 100% FiO2 per charting; however, she was 88% to 92% in room on assessment.

LABORATORY DATA: WBC of 14, neutrophil percentage 95%, lymphocyte percentage 5%. Sodium 140, potassium 4.2, chloride 108, BUN 16, creatinine 0.67, AST 34, ALT 22. LDH 909. CRP of 10.4, albumin of 2.7. D-dimer significant elevation to 23,657.

INS AND OUTS: Positive fluid balance of 1565.

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1013-0156

ASSESSMENT:
1. Acute respiratory failure with hypoxia requiring BiPAP level support.
2. Acute COVID-19 infection with pneumonia.
3. Malnutrition due to BiPAP requirement.
4. Obstructive sleep apnea.
5. Down syndrome, high functioning.
6. Agitation.

PLAN:
1. Continue BiPAP at 20 over 15, FiO2 of 100% with goals to wean as she tolerates. Infectious diseases on board. On dexamethasone.
2. Tested positive on 10/01/2021. Currently on day 16.
3. Requiring Precedex increased rate to 1.4 due to significant agitation this a.m. with goals to wean back down.
4. Labs revealing increased inflammatory response with an elevated CRP, D-dimer as well as she is having a fever this morning of 101.
5. Discussed with family in regards to malnutrition and agreed to a small-bore feeding tube. I discussed with dietary as well in regards to nutrition and recommended Jevity 1.2 at goal rate of 65 mL an hour.
6. Goal of activity is to have her in a chair watching television. If she is lightly sedated as related by family. At this time, she is more agitated and on a higher dose of Precedex and relatively bedbound, although we are working towards this goal if and when she recovers.
7. We will continue encouraging proning.
8. Code status was reviewed with family and she is a DNR/DNI.

DISPOSITION: Remain inpatient.

JOB ID: 1058839
cc:
Trans: R1
SHOGA /escript

Dict: 10/13/21 1257
Tran: 10/13/21 1330

Electronically Signed: GAVIN SHOKAR MD 10/17/21 2307

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: GANDEV MD,GEORGE N REPORT NO: 1013-0143

DATE OF SERVICE: 10/13/2021

SUBJECTIVE: The patient is a 19-year-old female with acute hypoxic respiratory failure related to COVID-19 pneumonia. On background of Down syndrome. Obstructive sleep apnea. No evidence of cardiac dysfunction. She had an echo done a long time ago, but right now, her brain natriuretic peptide is low, so there is probably no need to repeat the echocardiogram. However, the patient tested positive for COVID-19 on 09/28/2021. She was treated with dexamethasone. Unfortunately, her condition continued to deteriorate and she became BiPAP dependent, FiO2 of 100%, and in the last 24 hours, clearly more agitated and confused and unable to maintain her oxygen saturation above 90%. The hospitalist, Dr. Shokar, had extensive conversation with the family. After long consideration, family decided to opt for DNR/DNI status and focus on the comfort and noninvasive management for the patient. Also, apparently, they agreed to a feeding tube and the patient will be receiving some nutrition finally. Also, the patient requires dexmedetomidine to keep comfortable. That will be continued apparently. Overall, at this point, pulmonary does not have much to offer.

I had extensive conversation with the patient's nurse at the bedside and the hospitalist attending, Dr. Shokar.

OBJECTIVE:
VITAL SIGNS: Blood pressure 105/58, heart rate 68, respiratory rate 48, oxygen saturation 82% on 100% FiO2.
GENERAL: She is mildly agitated and very tachypneic.
HEENT: Head atraumatic, normocephalic. Oral mucosa moist.
NECK: Supple, no JVD.
CHEST: Symmetric, bilateral vesicular breath sounds with bibasilar crackles.
HEART: S1, S2, normally heard.
ABDOMEN: Soft, bowel sounds present.
LOWER EXTREMITIES: No edema or cyanosis.

ASSESSMENT AND PLAN:
1. Acute hypoxemic respiratory failure related to COVID-19 pneumonia. She is pretty much BiPAP dependent, FiO2 100%, unable to increase oxygen saturation above 88. After a long discussion, family opted for DNR and DNI status. We will continue dexmedetomidine and BiPAP for comfort mainly. Obviously, we will accept that we will not be able to keep the oxygen saturation above the goal of 88%.
2. Trisomy 21.
3. Obstructive sleep apnea. Continue BiPAP.

Considering the poor prognosis, it looks like the course of action that family has chosen will be most appropriate for the patient. We will focus on the comfort. We will continue supportive care, BiPAP and supplemental oxygen. We will

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

initiate nutrition. Although pulmonary does not have much to offer in this case, we will continue to follow along with the primary care team.

JOB ID: 1058817
cc:
Trans: R1
GANG /escript

Dict: 10/13/21 1241
Tran: 10/13/21 1255

Electronically Signed: GEORGE N GANDEV MD 10/13/21 2033

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1013-0127

DATE OF SERVICE: 10/13/2021

This is an infectious diseases followup progress note for a patient with COVID-19 dated 10/13/2021.

SUBJECTIVE: The patient seen this a.m. She continues to be BiPAP dependent. She is on maximum BiPAP measures right now. She does desat down to 81%. At this juncture, it looks like she may need to get intubated.

OBJECTIVE:
VITAL SIGNS: The patient is afebrile, heart rate is anywhere from 87 to 116, respiratory rate is 24 to 48, blood pressure anywhere from 107 to 121/58 to 79. The patient is satting anywhere from 83% to 92% on BiPAP currently.
GENERAL: She does not appear to be in any distress. She appears comfortable. We are using some sedation on her as well.

She is on dexamethasone, she has received seven doses today.

LABORATORY DATA: Her white count is 14 today, H and H 12.7 and 38.3 and platelet count is 257. Her BMP shows sodium 140, potassium 4.2, chloride 108, bicarbonate 23, BUN 16, creatinine 0.67, and glucose is 101. AST and ALT are 34 and 22 respectively. CRP is up to 10.4 today. LDH is 909. D-dimer is 23657, which is clearly up as well.

Blood culture from 10/07/2021 have been no growth x2. Chest x-ray completed a couple of days ago showed worsening pulmonary opacities.

From a COVID perspective, symptoms started on 09/27/2021 or 09/28/2021, tested positive on 10/01/2021, placed her around day #16 of symptomatology.

ASSESSMENT:
1. COVID-19.
2. Hypoxic respiratory failure.
3. Down syndrome.

RECOMMENDATIONS:
1. Overall, the patient continues to remain BiPAP dependent, but it appears that she is slowly losing the battle with the BiPAP. Her oxygen saturations in the 80s. She likely may need to be intubated unfortunately.
2. From a COVID perspective, symptoms started on 09/27/2021 or 09/28/2021 and she tested positive on 10/01/2021, placed her around day #16 since symptom onset. She is currently entering the final phase of COVID.
3. She remains on dexamethasone, she received seven doses and we will plan to continue that at this time.
4. This patient was offered tocilizumab that her father declined the use of that agent and did not want to use remdesivir either. At this time, this

patient is not a candidate for any of the approved or experimental treatments for COVID that would include remdesivir, tocilizumab, baricitinib, convalescent plasma or Regeneron and these are not going to be utilized. The only treatment will be using on her is dexamethasone.
5. I would recommend continuation with supportive measures and it looks like she may need to be intubated. We will kind of see how things go. I would not be surprised if she does get intubated.
6. At this time, there is not really much in the way of any indication that she had a secondary bacterial infection. At this time, there is no antibiotics were necessary.
7. Please note her white count is elevated. I suspect it is from steroid demargination and of course, she is going to the inflammatory process and even further though we did not really have a good baseline. Her CRP is markedly up to 10.4 from 2.9 just a few days ago and we never checked any LDH when she came in, but her D-dimer is markedly elevated. She will likely need some kind of imaging to rule out clot in the near future. At this time, she is too unstable to do that. I would just continue as is for the time being.
8. Continue supportive measures, proning if able and time and will start to take things one step at a time.

We will plan to follow with you.

Thank you for allowing me to participate in the care of your patient. Please call if there are any questions.

Discussed with Dr. Gandev.

ADDNEUDM: Pt spiked a fever, will draw blood cx and ask for CBC and PCT in am. No need for antibiotics at this time. -APZ

JOB ID: 1058641
cc:
Trans: R1
ZEIA /escript

Dict: 10/13/21 1046
Tran: 10/13/21 1215

Electronically Signed: ANTHONY P ZEIMET DO 10/13/21 1432

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: GANDEV MD,GEORGE N REPORT NO: 1012-0227

DATE OF SERVICE: 10/12/2021

SUBJECTIVE: The patient is a 19-year-old female with acute hypoxic respiratory failure related to COVID-19 pneumonia. She tested positive on 09/28/2021. She was treated with dexamethasone. She has obstructive sleep apnea and on CPAP at home. Did not change much in the last 24 hours. However, yesterday she had a brief period of time where we were able to decrease FiO2 on BiPAP and I felt very encouraged. However, this morning again we had to increase the FiO2 to 85 percent. In spite of being on continuous BiPAP, she remains comfortable. Her p.o. intake is extremely limited. I had a conversation with the hospitalist attending, Dr. Shokar. Apparently, according to him, the family did not agree with tube feeding or TPN. I spoke to both the mother and the father on the phone. They understand the patient condition and the limited options to provide cure. They would like to be called if patient condition deterioreates and they will need to think again in case the patient needs intubation.
I spoke
extensively to the nurse at the bedside. I encouraged them to try Vapotherm again. Hopefully, the patient will be able to tolerate. Fortunately, on the exam, there are no signs of skin break or altered mental status. She does not have increased amount of respiratory secretions and she is able to communicate and protect her airway.

OBJECTIVE:
VITAL SIGNS: Blood pressure 103/68, respiratory rate 42, heart rate 66, oxygen saturation 92% on FiO2 85 BiPAP. Intake 2889, output 1225.
GENERAL: Comfortable, no distress.
HEENT: Head atraumatic, normocephalic. Oral mucosa moist.
NECK: Supple, no JVD.
CHEST: Symmetric, bilateral vesicular breath sounds with bibasilar crackles.
HEART: S1, S2, normally heard.
ABDOMEN: Soft, bowel sounds present.
LOWER EXTREMITIES: No cyanosis.

ASSESSMENT AND PLAN:
1. Acute hypoxemic respiratory failure related to COVID-19 pneumonia. Symptoms onset on 09/27/2021. She tested positive on 10/01/2021. Currently on dexamethasone. ID input appreciated.
2. Trisomy 21.
3. Obstructive sleep apnea. Continue BiPAP.

From here, we can see the patient's condition progressing in two possible ways. One, she gets better and able to tolerate Vapotherm, which will increase her level of comfort and provide ability for p.o. intake or she can deteriorate and then she will go on mechanical ventilation. She is in the chronic phase of COVID-19. The chest x-ray shows some fibrosis. If we are to see any improvement here, it will be extremely slow. This was communicated to the family. I

completely understand that the family will face is a very difficult situation and we will continue to provide support. We will continue anticoagulation with enoxaparin. Lasix is not helpful, but we still need to avoid fluid overload if possible.

Pulmonary will continue to follow the patient.

JOB ID: 1057568
cc:
Trans: R1
GANG /escript

Dict: 10/12/21 1109
Tran: 10/12/21 1418

Electronically Signed: GEORGE N GANDEV MD 10/12/21 1552

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: SHOKAR MD,GAVIN REPORT NO: 1012-0152

DATE OF SERVICE: 10/12/2021

CHIEF COMPLAINT: Shortness of breath.

SUBJECTIVE: The patient seen and examined while she was lying in bed. She had a BiPAP mask on. She was comfortable and calm, somewhat cooperative, although not really verbal at this time. She is currently on Precedex at 0.6 as well as variable FiO2 use of BiPAP, currently at 85%, 15/12. No concerns overnight. She was able to prone.

OBJECTIVE:
VITAL SIGNS: Temperature 99.9, pulse rate 64, respiratory rate varying between 31 and 48 on BiPAP, oxygen saturation 92%, FiO2 of 85.
GENERAL: No acute distress, alert.
HEENT: BiPAP in place. PERRLA.
CARDIOVASCULAR: RRR.
PULMONARY: Clear to auscultation bilaterally with some crackles in the right lower lobe.
ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds.
EXTREMITIES: No edema.

LABORATORY DATA: WBC 10.2, hemoglobin 12.8, platelets 252. BMP relatively unremarkable apart from a chloride of 109. CK of 282. Albumin of 2.7. Procalcitonin from 10/10/2021 of 0.24. D-dimer from 10/08/2021 of 2243. Blood gas from 10/11/2021 revealing a normal pH, pCO2 and HCO3 with a pO2 of 64.

IMAGING: Chest x-ray from 10/11/2021 revealing worsening pulmonary opacities, bilateral, concerning for pneumonia or edema, PICC in place.

I's AND O's: Weight 178. Positive 1.6 liters.

ASSESSMENT:
1. Acute respiratory failure with hypoxia requiring BiPAP level support.
2. Acute COVID-19 infection with pneumonia.
3. Malnutrition due to BiPAP requirement.
4. Obstructive sleep apnea.
5. Down syndrome, high functioning.

PLAN:
1. Currently requiring BiPAP, roughly the same as yesterday. Tested positive on 10/01/2021, currently around day #15. Infectious disease is on board.
2. On dexamethasone.
3. Requiring Precedex at 0.6. She is hyperventilating, possibly from anxiety, which is going to impair her oxygenation; however, her last ABG revealed a normal pCO2 and do not expect that the elevated RR/hyperventilation is impairing her oxygenation at this time unless it significantly increases; however, we

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

should continue the Precedex.
4. Encourage proning.
5. We will discuss with dietary in regards to nutritional status and recommendations.
6. PT, OT.

DISPOSITION: Remain inpatient.

JOB ID: 1057481
cc:
Trans: R1
SHOGA /escript

Dict: 10/12/21 1018
Tran: 10/12/21 1202

Electronically Signed: GAVIN SHOKAR MD 10/17/21 2304

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1012-0150

DATE OF SERVICE: 10/12/2021

This is an infectious diseases followup progress note for a patient with COVID-19 dated 10/12/2021.

SUBJECTIVE: The patient seen this a.m. The patient remains on the BiPAP. They tried to wean down her FiO2, but then her oxygen requirements start to drop down and she is satting in the mid 80s currently. No other acute issues overnight.

OBJECTIVE:
VITAL SIGNS: T-max 99.9, heart rate anywhere from 64-66, respiratory rate 35-48, respiratory rate 95-103/57-68, satting around 86-92%, currently on BiPAP with FiO2 of 85%.
GENERAL: The patient appears comfortable. She is in no overt distress apparently.

He is on dexamethasone, day #6.

LABORATORY DATA: Her white count is 10.2. Her BMP shows sodium 141, potassium 4.2, chloride 109, bicarbonate 22, BUN 13, creatinine 0.67, glucose 119, AST and ALT are 34 and 23 respectively.

Blood culture from the 7th are no growth x2 at just over 96 hours.

From a COVID perspective, symptoms started on 09/27th or 09/28, tested positive on 10/01/2021, placed her around day #15 of symptomatology.

ASSESSMENT:
1. COVID-19.
2. Hypoxic respiratory failure.
3. Down syndrome.

RECOMMENDATIONS:
1. Overall, the patient continues to be on BiPAP dependency. She is satting in the mid 80s currently. Likely will need further adjustment in her FiO2 requirements.
2. From a COVID perspective, symptoms started on 09/27 or 09/28, eighth tested positive on 10/01/2021, placed around day 15. She is clearly in the final complicated phase of COVID. She currently remains on dexamethasone, remain anti-COVID treatment of choice and we will plan to continue that. She is on day #6 and will do that for up to 10 doses.
3. The patient was offered tocilizumab. Father declined to use this treatment modality and therefore, she is outside the window for clinical utility and this treatment modality will not be utilized.
4. The patient is not a candidate for use of remdesivir, convalescent plasma or Regeneron/monoclonal antibodies and these are not going to be utilized either.

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MRN: E000365038
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5. At this juncture, her main treatment for COVID will be supportive measures and dexamethasone and time and we will just have to kind of see how things proceed moving forward here.
6. I would really recommend trying to prone this patient, though I know that is going to be difficult with the BiPAP machine that may provide her some benefit to help her get through her COVID.
7. At this juncture, I would just continue supportive measures and care. At this juncture, there is no indication she is developing a secondary bacterial infection. We will kind of monitor closely and see how things proceed as we move forward here. At this time, no antibiotics are necessary.
8. Continue all supportive care measures at this time.

Thank you for allowing me to participate in the care of your patient, please call with any questions.

JOB ID: 1057489
cc:
Trans: R1
ZEIA /escript

Dict: 10/12/21 1018
Tran: 10/12/21 1159

Electronically Signed: ANTHONY P ZEIMET DO 10/12/21 1601

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1011-0152

DATE OF SERVICE: 10/11/2021

TIME OF SERVICE: 11:30 a.m.

CHIEF COMPLAINT: Follow up acute COVID illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female admitted to the hospital on 10/07/2021. She has a history of trisomy 21 Down syndrome. Her power of attorney for healthcare is her mother and father. Mother, Cindy is number one for the POA and if consent is needed her mother, Cindy is the person to contact. The patient remains on high-flow oxygen. She is on low dose Precedex 2 mcg drip at this point and we are trying to titrate that off. She was calm when I went to see her today. She was awake and able to answer questions. Overall, she states that she is feeling better. Cough improving. No sputum production. No abdominal pain, no chest pain or tightness. She is tolerating the BiPAP. She does not like the Vapotherm because it is too loud. No other complaints today.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature is 99.8, pulse 80, respiratory rate 32, blood pressure is 106/58, pulse ox 90% on BiPAP with pressures of 12/5 and FiO2 of 90%.
GENERAL: The patient was awake and alert. She was cooperative. She was in no acute distress.
HEENT: Pupils are round and reactive to light. Mucous members are moist.
LUNGS: Clear to auscultation anteriorly. Respiratory effort was normal.
CARDIOVASCULAR: Regular rate and rhythm. No rub or gallop.
ABDOMEN: Soft, nontender, nondistended, positive bowel sounds.
EXTREMITIES: No clubbing or cyanosis.

IMPORTANT LABORATORY DATA AND X-RAYS: No labs drawn today.

ASSESSMENT AND PLAN:
1. Acute COVID-19 illness with acute COVID-19 pneumonia. She has acute respiratory failure with hypoxia. Remains on high flow oxygen. Currently on BiPAP. She did not tolerate the Vapotherm very well. When the Vapotherm is maxed out it is very loud and she did not like how loud it was. Her current BiPAP settings are pressures of 15/12 with an FiO2 of 90%. We will continue to try to titrate that down if possible. She was able to prone yesterday and she is going to do that again today. She is currently on dexamethasone 6 mg IV daily. Not a candidate for tocilizumab or remdesivir.
2. Malnutrition. It is difficult for her to stay off the BiPAP long enough to eat a meal. We have protein calorie shakes that she is trying to drink. Continue efforts to try to get her to eat and drink more. Nutrition therapy will be seeing her today. May need to start other nutritional support. The patient's mother and father have not agreed to placing an NG tube. I did talk to them and I told them that I felt if she needs nutritional support enteral

nutrition would be better than TPN. There is a risk of infection with TPN and with enteral nutrition we are using her gut to absorb the protein and calories. 3. Obstructive sleep apnea, she uses CPAP at home, but currently she is on BiPAP.

JOB ID: 1056560
cc:
Trans: R1
BAUK /escript

Dict: 10/11/21 1234
Tran: 10/11/21 1444

Electronically Signed: KARL E BAUM MD 10/11/21 2017

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1011-0127

DATE OF SERVICE: 10/11/2021

This is an infectious diseases followup progress note for a patient with COVID-19 dated 10/11/2021.

SUBJECTIVE: The patient seen this a.m. The patient no really acute issues overnight or new issues per se. She remains on BiPAP and this is variable over use of the high flow oxygen. The patient's father was escorted out of the building yesterday due to some issues. Of course, she has been very condescending to us healthcare professionals. In any case, the patient remains on BiPAP. Dr. Leonard has not overly encouraged that we are going to be able to provide this patient from getting intubated. Hopefully, we can do just that, however.

OBJECTIVE:
VITAL SIGNS: T-max is 99.4 at 0800 and prior to that had 100.1 at 12:00 noon on 10/10/2021, heart rate anywhere from 70-92, respiratory rate is 28-37, and blood pressure anywhere from 94-105/55-69 and the patient is satting anywhere 91-96%, currently on BiPAP with FiO2 of 90%.
GENERAL: The patient seems comfortable. She is in no overt distress currently.

She is on dexamethasone, she received five doses so far.

LABORATORY DATA: Last white count was 10.2, H and H is 12.7 and 38.6. BMP shows sodium 140, potassium 3.8, chloride 108, bicarbonate 23, BUN 16, creatinine 0.74, glucose 116.

Blood culture from the 7th are no growth x2 at just over 72 hours. A chest x-ray was done this morning showed worsening pulmonary opacities are visualized bilaterally concerning for pneumonia or edema.

From a COVID perspective, signs and symptoms started around 09/27/2021 or 09/28/2021, tested positive on 10/01/2021, placed her on day 14 of symptomatology.

ASSESSMENT:
1. COVID-19.
2. Hypoxic respiratory failure.
3. Down syndrome.

RECOMMENDATIONS:
1. Overall, the patient remains in respiratory failure. She is on BiPAP at this juncture. Dr. Leonard is following closely and worked, hoping to prevent her becoming intubated. Time will tell what will happen here.
From a COVID perspective, symptoms started on 09/27/2021 or 09/28/2021, tested positive on 10/01/2021, placed around day 14. She is currently in the final

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
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COVID phase.
2. This patient is outside the window for use of tocilizumab. Her father did not ever get back with me on Friday to consider use of this drug and now we are more than 72 hours from when she was overtly decompensated. At this time, the likelihood that this providing any benefit is pretty low.
3. She remains on dexamethasone, she received 5 doses so far and I will plan to continue that for 10 doses while she requires supplemental oxygen therapy.
4. She is outside the window for the clinical utility for remdesivir, convalescent plasma or the Regeneron, the monoclonal antibody and these will not be utilized.
5. I would continue supportive measures, try to prone and time and we will kind of have to see how things go and get her weaned off the respiratory support. I think it is going to be a long drawn out process, however.
6. I was asked if this patient requires any antimicrobial therapy. We do not really have any evidence that she is decompensating from something besides COVID and furthermore with a normal white count and a normal procalcitonin, would argue there is no bacterial process ongoing here and at this time, she does not require any antimicrobial therapy. Continue supportive measures and time. We will kind of see how things proceed as we move forward here.

Thank you for allowing me to participate in the care of your patient, please call with any questions.

JOB ID: 1056501
cc:
Trans: R1
ZEIA /escript

Dict: 10/11/21 1201
Tran: 10/11/21 1401

Electronically Signed: ANTHONY P ZEIMET DO 10/11/21 1653

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: GANDEV MD,GEORGE N REPORT NO: 1011-0086

DATE OF SERVICE: 10/11/2021

SUBJECTIVE: I examined the patient and I spoke to Dr. Leonard who was at the pulmonologist seeing the patient yesterday. I gathered valuable information from my conversation with Dr. Leonard. The patient is 19 years old with acute hypoxic respiratory failure related to COVID-19 pneumonia. She tested positive on 09/28/2021. Was treated with dexamethasone. Also, patient has previous history of Down syndrome and obstructive sleep apnea, on CPAP at home. Overnight, she was comfortable on BiPAP. She denied any complaints. Slightly tachypneic, but does not use accessory muscles. Able to complete sentences.

OBJECTIVE:
VITAL SIGNS: Temperature 99.4, heart rate 70, respiratory rate 37, blood pressure 105/69, oxygen saturation 96%. She is on 0.2 mg of Precedex. She is on BiPAP with IPAP of 15, EPAP of 12. Her tidal volumes of 449. FiO2 90% and oxygen saturation 94%, respiratory rate 33.
GENERAL: Comfortable, no distress.
HEENT: Head atraumatic, normocephalic. Oral mucosa moist.
NECK: Supple, no JVD.
CHEST: Symmetric, bilateral vesicular breath sounds with basal crackles.
HEART: S1, S2, normally heard.
ABDOMEN: Soft, bowel sounds present.
EXTREMITIES: No cyanosis.

ASSESSMENT AND PLAN:
1. Acute hypoxemic respiratory failure related to COVID-19 pneumonia.
2. Trisomy 21.
3. Obstructive sleep apnea.

I am concerned that the patient requires continuous BiPAP, but so far, I do not see any issues like skin breaks or altered mental status. She is able to cough and communicate freely. She is also on FiO2 90% and oxygen saturation 94%. Appears comfortable. At this point, we can continue BiPAP, monitoring closely for impending deterioration. She is hemodynamically stable. Comfortable on low dose of dexmedetomidine. We will continue the same. We will continue anticoagulation with enoxaparin and furosemide. Following electrolytes and urine output and fluid balance.

Pulmonary will continue to follow the patient.

JOB ID: 1056358
cc:
Trans: R1
GANG /escript

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1011-0086

Dict: 10/11/21 1056
Tran: 10/11/21 1248

Electronically Signed: GEORGE N GANDEV MD 10/12/21 0919

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: LEONARD DO,DANIEL P REPORT NO: 1010-0056

DATE OF SERVICE: 10/10/2021

ICU PROGRESS NOTE

SUBJECTIVE: The patient remains on BiPAP. There were no significant overnight events. Recall patient did have her father in the room with her previously and given her Down syndrome and young age, he was initially allowed to stay in the patient's room for the first several days, but sounds like there was some chronic concern by nursing staff about abusive behavior and he was asked to leave this morning. Despite now being on her own in the room with only nursing staff and myself, patient was quite calm and actually more conversant than she was at this time yesterday. She verbalizes being uncomfortable and she is on her side, does better when she is lying supine. She is requesting to sleep.

OBJECTIVE:
VITAL SIGNS: Temperature 97.7, pulse 60, respirations 36, blood pressure 112/59, pulse ox 95% on 15 and 12 of PEEP at 100% FiO2.
GENERAL: The patient is morbidly obese, on BiPAP, calm, in no acute distress.
HEAD: Atraumatic, normocephalic. The patient does have facies compatible trisomy 21.
EYES: Extraocular muscles are intact.
MOUTH: Somewhat dry mucosa.
NECK: Trachea is midline. No crepitus.
CARDIOVASCULAR: S1, S2.
LUNGS: There are some medium coarse crackles at the bases bilaterally. Bilateral air entry is good. Chest wall expansion is normal.
ABDOMEN: Soft. Bowel sounds present.
SKIN: Warm, dry.
EXTREMITIES: No cyanosis.

DATA: The blood gas was drawn a little bit later this morning showing a pH of 7.44, pCO2 of 35, pO2 of 52.

White count 7.9, hemoglobin 12.7, hematocrit 38.3, platelets 232. Sodium 142, potassium 4, chloride 110, bicarbonate 21, BUN 14, creatinine 0.72, glucose 123. C-reactive protein is down to 2.9. Procalcitonin is 0.24. Patient is 1139 mL positive fluid balance thus far today.

ASSESSMENT:
1. Acute hypoxemic respiratory failure secondary to #2.
2. COVID-19 pneumonia.
3. Trisomy 21.
4. Obstructive sleep apnea.

PLAN: Given the positive fluid balance and the crackles, I am going to give the patient a one-time dose of Lasix via IV. I am also going to be a little bit

more generous with PEEP. We will try taking this up to 14. I have asked that we try proning the patient as tolerated, though she may have some difficulty with this given her limitations at baseline. I do not think this is off the table necessarily, as patient has been very calm and otherwise cooperative this morning. My hope is to avoid intubation, but I am losing hope on this.

CRITICAL CARE TIME: 30 minutes.

JOB ID: 1055652
cc:
Trans: R1
LEODA /escript

Dict: 10/10/21 1022
Tran: 10/10/21 1206

Electronically Signed: DANIEL P LEONARD DO 10/12/21 0819

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1010-0040

DATE OF SERVICE: 10/10/2021

TIME OF SERVICE: 9:00 a.m.

CHIEF COMPLAINT: Follow up acute COVID illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female who was admitted to the hospital on 10/07/2021. She remains on high-flow oxygen. She was lying on her back in bed when I went in to see her. She appeared comfortable. She answered questions appropriately. She does have an intermittent cough, not bringing up any sputum. No nausea or vomiting. Appetite is not the greatest, but she has been trying to eat. No abdominal pain, no diarrhea, no fever.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 97.7, pulse 63, respiratory rate 38, blood pressure 104/50, pulse ox 93% on BiPAP with pressures of 15/12 and an FiO2 of 95%.
GENERAL: The patient was awake and alert. She was cooperative. She was in no acute distress.
LUNGS: Clear to auscultation anteriorly. Respiratory effort was normal.
CARDIAC: Regular rate and rhythm. Distant heart sounds. No audible murmur. No lower extremity edema.
ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds in all four quadrants. No hepatosplenomegaly.
EXTREMITIES: No clubbing or cyanosis.

IMPORTANT LABORATORY DATA AND X-RAYS: White count 7.9, hemoglobin 12.7, platelets were 232. Differential showed 81% neutrophils, 12% lymphocytes. Sodium 142, potassium 4.0, bicarbonate 21, creatinine 0.72. AST was 37, ALT 22. C-reactive protein was 2.9, down from 4.5 two days ago. Procalcitonin 0.24.

ASSESSMENT AND PLAN:
1. Acute COVID-19 illness with acute COVID-19 pneumonia. She has acute respiratory failure with hypoxia. Remains on high-flow oxygen with BiPAP. Currently, her BiPAP settings are 15/12 with an FiO2 of 95%. We are going to try and titrate down on her FiO2 today if possible. I have spoken with the nursing staff. We are going to try and see if she will prone today. We are also going to try Vapotherm when she is eating or drinking. If she cannot tolerate that, we may need to consider enteral nutrition or TPN. At this point, I do not see any evidence of a bacterial pneumonia superimposed on top of her viral pneumonia. White count is normal. She has been having some low-grade fevers, but her fever curve is actually continuing to trend down and her procalcitonin remains normal. She does have an intermittent cough, but no sputum production. We are continuing dexamethasone 6 mg IV daily. At this point, she is not a candidate for tocilizumab or remdesivir.
2. Nutrition. We are going to try her on Vapotherm today to see if she can eat and drink and maintain her oxygen saturation. If we cannot maintain saturations

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

when she is off the BiPAP, we may need to consider enteral nutrition or starting her on TPN.
3. Obstructive sleep apnea. She does use CPAP at home, but currently we are using BiPAP.

JOB ID: 1055612
cc:
Trans: R1
BAUK /escript

Dict: 10/10/21 0925
Tran: 10/10/21 1039

Electronically Signed: KARL E BAUM MD 10/10/21 1600

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1009-0198

DATE OF SERVICE: 10/09/2021

TIME OF SERVICE: 1:30 p.m.

CHIEF COMPLAINT: Follow up acute COVID-19 illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female who was admitted to the hospital on 10/07/2021. She remains on high-flow oxygen. She is on BiPAP with an FiO2 of 100% and pressures of 15/12. Precedex is on at 2, and she is on a low dose drip of norepinephrine to maintain her blood pressure. IV fluids running at 100 mL an hour. She was mildly somnolent, but easily arousable. She responded to yes and no questions. She is not having any pain. She does have an intermittent cough, but not bringing up any sputum. No fevers or chills. No nausea or vomiting. She has to come off the BiPAP for short periods of time to try to eat or drink something. She did not like Vapotherm because it was too loud for her to keep that on for any prolonged period of time, but it sounds like her saturations were okay when she was on it, so we are going to try that when she is eating or drinking.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 99.9, pulse is 71, respiratory rate 30, blood pressure 94/51, pulse ox 93% on BiPAP.
GENERAL: The patient was mildly somnolent, but easily arousable.
RESPIRATORY: Lungs were clear to auscultation anteriorly. She was mildly tachypneic.
CARDIOVASCULAR: Distant heart sounds, regular rhythm. No rub or gallop. No lower extremity edema.
ABDOMEN: Soft, nontender, nondistended, positive bowel sounds in all four quadrants. No hepatosplenomegaly.
EXTREMITIES: No clubbing or cyanosis.

IMPORTANT LABORATORY DATA AND X-RAYS: White count was 7.2, hemoglobin 13.1, platelets were 214. Basic metabolic panel: Sodium 142, potassium 4.2, creatinine 0.77, glucose 123, AST 48, ALT 21, alkaline phosphatase 33. D-dimer 2243.

ASSESSMENT AND PLAN:
1. Acute COVID-19 illness with acute COVID-19 pneumonia. The patient has acute respiratory failure with hypoxia. She remains on high-flow oxygen with BiPAP and pressures of 15/12, FiO2 of 100%. Precedex drip has been tapered down to the point that now she is arousable. We will try to taper that down some more if possible. I talked to her father today about proning. They are going to try that. We also talked about trying to increase activity slightly. I would like her to be rotating in bed from side to side including periods of proning. We will try to use an albuterol inhaler. I told her father we do not want to use nebulizers in light of the fact that we will be aerosolizing the virus. She did

not have any wheezing on exam. Her father asked me about antibiotics for possible bacterial pneumonia. I told him at this point, we do not have any conclusive evidence that she has a bacterial pneumonia superimposed on top of her viral pneumonia. I think that her respiratory failure is secondary to COVID pneumonia, which is a viral pneumonia or pneumonitis. Her white count is normal. She is having low-grade fevers, which are likely related to the COVID illness. Her procalcitonin has been normal. She has no sputum production with her cough. I am going to repeat labs tomorrow. For now, continue dexamethasone 6 mg IV daily. She is not a candidate for tocilizumab or remdesivir at this point.
2. Nutrition. She is able to eat and drink at this point. We will try to have her on Vapotherm and see if she can eat and drink while she is on the Vapotherm and maintain her oxygen saturations. If we take her off BiPAP, she desaturates quickly without any additional oxygen support.
3. Obstructive sleep apnea. We are using BiPAP in the hospital. She does have CPAP at home.
4. POA. The patient's power of attorney for healthcare has been activated. Her mother is the number one agent listed on the POA, her father is number two.

JOB ID: 1055374
cc:
Trans: R1
BAUK /escript

Dict: 10/09/21 1435
Tran: 10/09/21 1458

Electronically Signed: KARL E BAUM MD 10/10/21 1600

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: LEONARD DO,DANIEL P REPORT NO: 1009-0109

DATE OF SERVICE: 10/09/2021

ICU PROGRESS NOTE

SUBJECTIVE: The patient remains on BiPAP with settings of 15/10 100% FiO2. She will desaturate fairly rapidly if the mask is removed for her to take a drink. Apparently, she was a little more alert this morning and was requesting some oral intake. It does not sound like she has had anything solid to eat for almost 48 hours now, however. She has had a dry cough and has not been bringing up any phlegm. It appears that she was febrile about this time yesterday, but has remained afebrile since that time. The patient is on nasal BiPAP mask, is largely noncommunicative. The patient's father is at bedside. The patient cannot provide a meaningful review of systems at this time.

OBJECTIVE:
VITAL SIGNS: Temperature 99.9, pulse 63, respirations 34, blood pressure 96/53, pulse ox 91% and that is on 100% FiO2 on BiPAP.
GENERAL: The patient is calm, in no acute distress, currently on BiPAP. She is requesting to be pulled up in bed. She is morbidly obese.
HEENT: Head atraumatic. Patient has typical feces, associated with trisomy 21. Eyes: Anicteric sclerae. Mouth: Somewhat dry mucosa.
NECK: Trachea is midline. There is no tenderness, no masses appreciated. No crepitus is palpable.
CARDIOVASCULAR: S1, S2.
LUNGS: Diminished air entry at the bases bilaterally. I do not appreciate any crackles, wheezes or rhonchi at this time.
ABDOMEN: Soft. Bowel sounds are present. There is no rigidity.
SKIN: Warm and dry. No ulcerations or wounds.
EXTREMITIES: There is no clubbing, no cyanosis.
LYMPHATICS: There is no significant pitting edema at this time.

DATA: Blood gas from this morning shows pH of 7.43, pCO2 of 32, pO2 of 64 and that is on 100% FiO2 on BiPAP with settings of 15/10. White count is 7.2, hemoglobin 13.1, hematocrit 39.2, platelets 214. There is a left shift with 81% neutrophils, none of which are immature cell forms, although no bands, no myelocytes, no metamyelocytes. Sodium 142, potassium 4.2, chloride 113, bicarbonate 19, BUN 16, creatinine 0.77, glucose 123.

I's and O's, patient is 867 mL positive since midnight.

IMPRESSION:
1. Acute hypoxemic respiratory failure secondary to #2.
2. COVID-19 pneumonia.
3. Trisomy 21.
4. Obstructive sleep apnea.

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1009-0109

PLAN: I have asked dietary service to come by. Would like to start feedings and given that the patient is on a homeopathic dose of Levophed at this time 0.02 mcg per kilogram per minute, I think we should be able to wean this off. We would like to start tube feeds versus TPN given that hemodynamic stability seems to have improved. When I entered the room, the patient was saturating between 82-88%. Some of this seemed to be due to poor signal, but after good signal was assured, the patient again was hanging out right around 87-88%. I have increased the positive end expiratory pressure from 10-12. She is tolerating this well at present. Would like to try proning patient though clearly there are some behavioral issues here that may limit this. Patient's father at bedside is agreed to assist in trying to keep the patient calm and make all of this less traumatic on her, but I still have a feeling that we may be limited in our ability to prone the patient unless of course, she becomes intubated and sedated. My hope would be that we are able to avoid all this. The patient is currently getting dexamethasone, has had a total of three doses in thus far. I did note the patient does have Lovenox on board. We will add on some Pepcid for GI prophylaxis. A total of 90 minutes was spent in critical care time this morning including answering all of patient's father's questions at the bedside. Prognosis is guarded.

JOB ID: 1055193
cc:
Trans: R1
LEODA /escript

Dict: 10/09/21 1009
Tran: 10/09/21 1034

Electronically Signed: DANIEL P LEONARD DO 10/09/21 1045

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1009-0051

DATE OF SERVICE: 10/09/2021

This is an infectious diseases followup progress note for a patient with COVID-19, dated 10/09/2021.

SUBJECTIVE: The patient seen briefly. The patient is on the BiPAP. Currently, dad has been talking with the nurses and staff and wanting prove that she still requires BiPAP when they take it off. She rapidly did drop down to the mid 80s. She has also had some drop in her heart rate as well. The dad never got back in touch with me yesterday to see if he wanted to use the tocilizumab or not. At this time, this patient is outside the window for clinical utility.

OBJECTIVE:
VITAL SIGNS: She has had a T-max of 102.9 at around 8:00 a.m. on 10/08/2021 and she had 102.4 on 10/09/2021. She has been afebrile since her temperature currently is 99, heart rate is anywhere from 70-78, respiratory rate is anywhere from 33-40, blood pressure anywhere from 105-130/55-62, satting around 94-95%, currently on BiPAP with FiO2 of 100%.

The patient is on dexamethasone. She received two doses, received her third dose today.

LABORATORY DATA: Her white count is pending. Last white count was 5.5. Last creatinine was 0.95, is currently pending for today. Blood cultures from the 10/07/2021 are no growth x2 at just over 24 hours.

From a COVID perspective, symptoms started on 09/27/2021 or 09/28 tested positive on 10/01/2021, placed around day 12 of symptomatology.

ASSESSMENT:
1. COVID-19.
2. Hypoxia, respiratory failure.
3. Down syndrome.

RECOMMENDATIONS:
1. Overall, the patient remains in respiratory failure. She is BiPAP dependent at this time.
2. The patient's from a COVID perspective, symptoms started either September 27th or 28th, tested positive on 10/01/2021, placed around day 12, currently of symptomatology, is clearly in the final phase of COVID.
3. Yesterday when I saw this patient and spoke with her dad, I explained to him that we had a very limited window to consider use of tocilizumab and he was going to do additional research on this though he had almost 24 hours, prior to do research on it as well as I talked to him about it. At this time, this patient is now outside the window for clinical utility of this drug and this drug will not be utilized.

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

4. The patient is not a candidate for use of remdesivir, which the dad did not want to utilize either and she is not a candidate for convalescent plasma or Regeneron or baricitinib and these are not going to be utilized.
5. Her only anti-COVID treatment of choice will remain dexamethasone 6 mg daily and we will plan to continue that as we move forward.
6. We will continue respiratory support and would have to kind of see how things go. I highly stressed proning on this patient and we will just have to take things one step at a time. Overall, prognosis is quite guarded at this juncture.
7. There is no indication that this patient has secondary bacterial infection at this time. We will just have to kind of follow and monitor things and see how things go as we move forward here.

Thank you for allowing me to participate in the care of this patient. Please call if there are any questions.

JOB ID: 1055084
cc:
Trans: R1
ZEIA /escript

Dict: 10/09/21 0646
Tran: 10/09/21 0724

Electronically Signed: ANTHONY P ZEIMET DO 10/09/21 0829

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: ZEIMET DO,ANTHONY P REPORT NO: 1008-0147

DATE OF SERVICE: 10/08/2021

This is an infectious diseases followup progress note for a patient with COVID-19 dated 10/08/2021.

SUBJECTIVE: The patient seen briefly this a.m. I attempted to talk to the patient's father who was very antagonistic towards me. Yesterday, I had asked him to consider possible use of tocilizumab on this patient and he was going to do some research on it. He apparently did not do much research on it and I again gave him the low-down on the use of this treatment modality. The patient does meet criteria, but we are running out of window of opportunity for use and success for use. He is going to do some further research and then kind of see what happens, but he is kind of leaning towards that he does not want to use it. He apparently, per nursing staff, is looking at trying to get a home BiPAP, so he can take his daughter home.

OBJECTIVE:
VITAL SIGNS: The patient is febrile, had 104.2 at 0200 on 10/08/2021, temperature currently is 102.4. Heart rate is anywhere from 68 to 72, respiratory rate 33-34, blood pressure anywhere from 84-93/50-53, satting around 92-95%, currently on BiPAP with FiO2 of 100%, was on Vapotherm flow rate of 40.
GENERAL: She appears comfortable, no distress, but is sedated currently.

CBC is currently pending for today as well as a BMP. CRP is also pending, but has not been done. Blood culture from the 7th are no growth x2 at just under 24 hours. A chest x-ray was completed and showed that there is no significant change. Hazy and reticular opacity in left greater than right lung, overall similar to prior.

From a COVID perspective, symptoms started on 09/27/2021 or 09/28/2021, tested positive on 10/01/2021. She is on about day 11 of symptomatology.

ASSESSMENT:
1. COVID-19.
2. Hypoxia.
3. Down syndrome.

RECOMMENDATIONS:
1. Overall, the patient remains with COVID and in some respiratory failure. This has escalated since I saw the patient yesterday. She was on Vapotherm, flow rate of 20, but it looked like she was going to require higher values and shortly after that had went up to 40 and now is on the BiPAP machine. She is febrile and her blood values are currently pending for today, but I suspect she is in some kind of cytokine storm process with regard to her COVID.
2. The patient's dad is quite antagonistic with me. He believes in the frontline doctor stuff and does not really believe or trust us here in the

healthcare setting, which I think is going to be the detriment to his daughter to be honest. He was very antagonistic to me when he picked up the phone to talk with me, and when I asked him a simple question if he had done his research on the drug because I think his daughter would probably benefit from it, he kind of said he did a little bit, but did not really do it fully. In any case, I have talked to him about the tocilizumab again. Our timing to use this is very short. It is within a 24-hour window of the decompensation and this patient is in the middle of that now. I think she might benefit from tocilizumab. If so, we will need to screen her for HIV, hepatitis C and TB. He will let the nurse know if he wants to use it and they will page me to let me know.
3. The patient is not a candidate for the use of remdesivir, convalescent plasma or baricitinib or the monoclonal antibodies. These are not going to be utilized.
4. We will plan to continue her on dexamethasone. She received two doses so far. We will kind of have to see how things proceed as we move forward here.
5. Continue supportive measures and care. I will plan to follow with you.

Thank you for allowing me to participate in the patient's care. Please call if there are any questions.

JOB ID: 1054475
cc:
Trans: R1
ZEIA /escript

Dict: 10/08/21 1143
Tran: 10/08/21 1348

Electronically Signed: ANTHONY P ZEIMET DO 10/08/21 1511

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1008-0115

DATE OF SERVICE: 10/08/2021

TIME OF SERVICE: 9:30 a.m.

CHIEF COMPLAINT: Follow up acute COVID illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female admitted to the hospital on 10/07/2021. She has a history of trisomy 21 Down syndrome. She has clinically worsened overnight. Her oxygen requirement has gone up. She was placed on BiPAP. Initially pressures were 12/88, but Dr. Marada saw the patient today and the pressures are now 15/10 and she is on an FiO2 of 100%. She had to be started on a Precedex drip due to anxiety and struggling against the BiPAP. Her father had questions today about getting BiPAP at home. He has not decided if he would agree to intubation. I discussed that with him today and I told him we need to discuss and he needs to make a decision in case things would worsen suddenly. He told me he could not make a decision yet.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 102.4, pulse 68, respiratory rate 34, blood pressure 84/52, pulse ox 95% on BiPAP with an FiO2 of 100%.
GENERAL: The patient was sedated. She is currently on a Precedex drip.
LUNGS: Clear to auscultation anteriorly. Respiratory effort appeared normal.
CARDIOVASCULAR: Distant heart sounds, regular rhythm. No rub or gallop.
ABDOMEN: Soft, nontender, nondistended, positive bowel sounds in all four quadrants. No hepatosplenomegaly.
EXTREMITIES: No clubbing or cyanosis.

IMPORTANT LABORATORY DATA AND X-RAYS: Labs from today have not come back yet. Chest x-ray done this morning shows no significant change.

ASSESSMENT AND PLAN:
1. Acute COVID-19 illness with acute COVID-19 pneumonia. The patient has acute respiratory failure with hypoxia. Unfortunately, her oxygen requirements have continued to go up. She is now on BiPAP with pressures of 15/10. She has to be sedated with Precedex drip to keep her calm and sedated. She is on an FiO2 of 100%. She is saturating in the mid 90s currently. She was in between 94% and 95% when I was in to see her. I spoke to her father today. I told him frankly that this is a very worrisome situation and that things may and if they do continue to worsen, the only thing we have left that would potentially help her would be intubation. She is currently on dexamethasone. Dr. Zeimet is following. Dr. Zeimet has discussed tocilizumab with the patient's father and he was initially against that, but wanted to do some more research.
2. Nutrition. She was eating and drinking coming into the hospital and she was able to eat yesterday. I do think that nutrition will become a bigger issue and we may need to start her on TPN if she continues to require max BiPAP and possibly intubation. PICC line is going to be placed today.

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

3. Obstructive sleep apnea. The patient was using a CPAP at home. Currently, we are using BiPAP.

JOB ID: 1054319
cc:
Trans: R1
BAUK /escript

Dict: 10/08/21 1026
Tran: 10/08/21 1226

Electronically Signed: KARL E BAUM MD 10/10/21 1600

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1007-0094

DATE OF SERVICE: 10/07/2021

CHIEF COMPLAINT: Follow up acute COVID illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female admitted to the hospital early this morning. She has a history of complete trisomy 21 syndrome, conductive hearing loss and obstructive sleep apnea. She does use CPAP at home. Her father was in the room with her and he is going to be staying in the hospital. Overall, she is feeling better. No cough, no fever or chills. She has been on BiPAP overnight, FiO2 of 70%. No chest pain, no abdominal pain, no nausea, vomiting or diarrhea.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 97.4, pulse 59, respiratory rate 18, blood pressure 99/58, pulse ox 97% on BiPAP.
GENERAL: The patient is awake, alert. She is cooperative, follows all of my commands. She is in no acute distress.
LUNGS: Clear to auscultation anteriorly. Respiratory effort is normal.
CARDIOVASCULAR: Regular rate and rhythm. No rub or gallop.
ABDOMEN: Soft, nontender, nondistended, positive bowel sounds in all four quadrants. No hepatosplenomegaly.
EXTREMITIES: No clubbing or cyanosis. No edema.

IMPORTANT LABORATORY DATA AND X-RAYS: Magnesium 2.0. BTNP was 56. Procalcitonin is pending.

ASSESSMENT AND PLAN:
1. Acute COVID-19 illness with acute COVID-19 pneumonia. She had a CT angiogram of the lungs done last night, which showed no evidence of pulmonary embolism, although there was a lot of motion artifact. There were extensive infiltrates with areas of consolidation in both lungs, likely related to pneumonia. She is on IV dexamethasone. Dr. Zeimet has been consulted. His input and assistance will be much appreciated. I have ordered a diet for her. Continue supplemental oxygen. I am hoping we can transition to Vapotherm today, so that she can eat and drink.
2. Acute respiratory failure with hypoxia. Continue supplemental oxygen.
3. Complete trisomy 21 high functioning Down syndrome.
4. Obstructive sleep apnea. I told the patient we will use BiPAP overnight. Hopefully, her oxygenation will improve and if it does and she is doing well, we could use her CPAP machine from home, but for now BiPAP and Vapotherm will be used.

JOB ID: 1052877
cc:
Trans: R1

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1007-0094

BAUK /escript

Dict: 10/07/21 0817
Tran: 10/07/21 0954

Electronically Signed: KARL E BAUM MD 10/10/21 1600

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: BAUM MD,KARL E REPORT NO: 1007-0094

DATE OF SERVICE: 10/07/2021

CHIEF COMPLAINT: Follow up acute COVID illness.

HISTORY OF PRESENT ILLNESS: A 19-year-old female admitted to the hospital early this morning. She has a history of complete trisomy 21 syndrome, conductive hearing loss and obstructive sleep apnea. She does use CPAP at home. Her father was in the room with her and he is going to be staying in the hospital. Overall, she is feeling better. No cough, no fever or chills. She has been on BiPAP overnight, FiO2 of 70%. No chest pain, no abdominal pain, no nausea, vomiting or diarrhea.

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JOB ID: 1052877
cc:
Trans: R1

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
PROGRESS/STAFFING NOTE

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1007-0094

BAUK /escript

Dict: 10/07/21 0817
Tran: 10/07/21 0954

Electronically Signed: KARL E BAUM MD 10/10/21 1600

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 ADM IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
DISCHARGE SUMMARY

PATIENT NAME: SCHARA,GRACE N ADMIT DATE: 10/07/21
PROVIDER: SHOKAR MD,GAVIN REPORT NO: 1018-0016

DATE OF DISCHARGE: 10/13/2021

DEATH SUMMARY

TIME OF DEATH: 07:27 p.m.

PRIMARY DIAGNOSES:
1. Acute respiratory failure with hypoxia.
2. Acute COVID-19 infection with pneumonia.

SECONDARY DIAGNOSES:
1. Malnutrition.
2. Obstructive sleep apnea.
3. High functioning Down syndrome.
4. Agitation.

HOSPITAL COURSE: A 19-year-old female who presented to the hospital on 10/07/2021 for shortness of breath associated with COVID-19. She was managing outpatient for several days unfortunately deteriorated requiring hospital admission and oxygenation. She received dexamethasone unfortunately deteriorated requiring BiPAP level support. Her BiPAP requirements continued to escalate and pressures were adjusted on multiple occasions. She had a significant amount of agitation requiring a Precedex drip. Unfortunately, since she started developing malnutrition as she had not eaten well and given the high BiPAP requirements, a nasogastric small-bore tube was placed to assist with that. There were multiple discussions with family in regards to her plan of care and considerations for goals of care and worst case scenario. She was transitioned to a DNR/DNI. Unfortunately, on 10/13/2021, she developed sudden and significant hypotension and bradycardia after being on high levels of BiPAP pressures for few days. She deteriorated and passed away at 7:27 p.m. Throughout hospitalization, Infectious Disease and pulmonary/critical care were involved with her care.

JOB ID: 1062313
cc:
Trans: R1
SHOGA /escript

Dict: 10/17/21 2239
Tran: 10/18/21 0528

Electronically Signed: GAVIN SHOKAR MD 10/18/21 1722

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

SCHARA,GRACE N
MRN: E000365038
ACCT: E39547554 DIS IN E.2029-1
DOB: 09/22/02
DEPT: E.DICT

Affinity Health System *LIVE* PCI (PCI: OE Database OSH)

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

Age/Sex: 19 F **Attending:** BECK MD,DAVID
Location: E.2-C **Admitted:** 10/07/21 at 0012
Room/Bed: E.2029-1 **Status:** DIS INx

	Date	Time	By	Nurse Type	Category
Occurred:	10/07/21	0857	LC #CHANG,LA	RN3	
Recorded:	10/07/21	0858	LC #CHANG,LA	RN3	CASE MGMT/SOCIAL SERVICES

Abnormal? N **Confidential?** N

Initial Status Review
Order: Inpatient Date: 10/7/2021 Time: 0057

Payer: UHC WMA

MCG: PG-RF Respiratory Failure GRG

MCG criteria met: New (acute) need for mechanical invasive or noninvasive (eg, bilevel positive airway pressure (BPAP), volume-assured pressure support (VAPS), or volume control) ventilation

Additional supporting information: Acute hypoxic respiratory failure secondary to viral COVID-19 pneumonia, on BiPAP, FiO2 70. IV dexamethasone. ID consult.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	10/07/21	1155	GMH HINTZ,GINA M	SS	
Recorded:	10/07/21	1156	GMH HINTZ,GINA M	SS	CASE MGMT/SOCIAL SERVICES

Abnormal? N **Confidential?** N

Admission Status:
Inpatient: Date 10/7/21 Time 0057
Observation: Date Time
SDC: Date Time

Milliman Guideline: See UR note

Living Situation: With Spouse/Family
Other: with parents

Equipment:

Durable Power of Attorney:

Guardian: Yes
Voluntary Behavioral Health Admission: No
Involuntary 72 hour Mental Health Hold: No
Self Pay: No

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By	Nurse Type	(Continued)
Occurred:	10/07/21	1155	GMH HINTZ,GINA M	SS	**Category**
Recorded:	10/07/21	1156	GMH HINTZ,GINA M	SS	CASE MGMT/SOCIAL SERVICES

Discharge Needs: Case management following

Contact Information:

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/09/21	1442	SMB BREU,SANDI M	RN3	**Category**
Recorded:	10/09/21	1506	SMB BREU,SANDI M	RN3	CASE MGMT/SOCIAL SERVICES

Abnormal? N **Confidential?** N

Case Management: rec'd from manager of case management, Tara Crawford, pt's Advanced Directives document that Rachel, Fremont 2 Mgr had rec'd from pt's Dad, Scott Schara. Writer placed Advanced Directives on pt chart w/note for Medical Records to scan into system. Noted on pt chart Statement of INCAP completed by 2 MD's 10/8/2021 activating pt's Advanced Directives, per same document, #1 HCPOA is Cindy Schara, #2 HCPOA is Scott Schara, #3 HCPOA is Jessica Vander Heiden, #4 HCPOA is Levi Rocke. Noted on Advanced Directives "My agent's authority is effective immediately upon my signing this document, as permitted in WI statutes section 155.05(2). No determination of Incapacity is required", document signed on 9/23/2020 & is considered valid document. Carrie, HUC had checked on 10/8/2021 for Guardianship document in Meditech, Athena & EPIC w/no such document located. Rachel, RN Mgr assisted in getting Advanced Directives document from pt's father on 10/8/2021 as document was not present in Meditech, Athena or EPIC. Rachel had also forwarded to Tara Crawford documents pt's Dad sent to her un-signed (w/email from Hooper Law Office of Appleton stating Dad should have signed version) of "Supported Decision-Making Agreement" listing parents Cindy & Scott Schara as "Supporters", this un-signed document is attached to case management record as reference Dad should have signed copy per Law office. Rachel had also rec'd from pt's Dad "Authorization for Release of Grace Schara's PHI" document that was placed on pt chart which was sent from Hooper Law Office to pt's Dad. Case Management will continue to follow & assist in dc plan as pt gets closer to dc date.

Note Type	Description
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

Age/Sex: 19 F **Attending:** BECK MD,DAVID
Location: E.2-C **Admitted:** 10/07/21 at 0012
Room/Bed: E.2029-1 **Status:** DIS INx

	Date	Time	By		Nurse Type	
Occurred:	10/07/21	0054	BC	CHRISTENSON,BRITTANY	RN	**Category**
Recorded:	10/07/21	0055	BC	CHRISTENSON,BRITTANY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Patient admitted with diagnosis of COVID
at time of 0050 to room 2029 from ED via BED
accompanied by ED STAFF/FATHER.
Report received from ED RN. Patient ID band on/applied.

Patient currently resides at HOME.
Transported to Facility by PERSONAL VEHICLE.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/07/21	0346	BC	CHRISTENSON,BRITTANY	RN	**Category**
Recorded:	10/07/21	0351	BC	CHRISTENSON,BRITTANY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PTS FATHER GOT UPSET WITH US COMING IN TO DO VITALS Q4HRS. WANTS PT TO HAVE
MORE TIME TO SLEEP.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/08/21	0110	LK	KEMPS,LAUREN	RN	**Category**
Recorded:	10/08/21	0129	LK	KEMPS,LAUREN	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DR. BECK NOTIFIED OF ABG RESULT, VITALS, AND CLINICAL STATUS. ORDER OBTAINED
TO CHANGE TYLENOL FROM PO TO PR AND TO INCREASE IVF TO 100 CC/HR. ORDERS
PLACED.

Note Type	Description
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By	Nurse Type	
Occurred:	10/08/21	1200 AM	MIDDLETON, AMANDA	RN	**Category**
Recorded:	10/08/21	1209 AM	MIDDLETON, AMANDA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT FATHER BEDSIDE. FATHER ASKING RN HOSPITAL STATISTICS/NATION WIDE STATISTICS ON COVID MEDICATONS/OUTCOMES. RN REDIRECTED FATHER TO GEAR ALL MEDICATION QUESTIONS TO MD.

DURING MORNING CARES RN GAVE UPDATE TO FATHER ON PATIENT STATUS. FATHER NEEDED MUCH EDUCATION ON PATIENT STATUS. BIPAP SETTINGS INCREASED, PT NEEDING PRECEDEX TO HELP KEEP CALM. ORAL CARES HAVE BEEN DIFFICULT. PT FATHER WANTED TO "PROVE" THAT PATIENT WAS GETTING BETTER AND DID NOT NEED BIPAP. RN REMOVED BIPAP AND PLACED VAPOTHERM 40L 100% AND PATIENT QUICKLY DESATURATED TO 85%. BIPAP REPLACED. FATHER BECAME FIXATED ON PATIENT ABG THINKING THEY LOOKED BETTER. RN EDUCATED THAT THEY WERE NOT.

FATHER CURRENTLY LOOKING INTO TAKING PATIENT HOME ON A HOME BIPAP MACHINE.

Note Type	**Description**
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/08/21	1220 AM	MIDDLETON, AMANDA	RN	**Category**
Recorded:	10/08/21	1221 AM	MIDDLETON, AMANDA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DR MARADA UPDATED ON PATIENT BRAYCARDIA
DR MARADA OK WITH RATES 49-50'S

Note Type	**Description**
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/08/21	1706 EB	BRAATZ,EMILY	RN	**Category**
Recorded:	10/08/21	1706 EB	BRAATZ,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

WRITER PULLED ATROPINE FOR AMANDA M, RN.

Note Type	**Description**
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	
Occurred:	10/08/21	2355	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/08/21	2357	EF	FISHER,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

UPDATE GIVEN TO DR BECK REGARDING PATIENT STATUS AND ELEVATED BLOOD PRESSURE DUE TO AGITATION. DR BECK ALSO SIGNED POA PAPERWORK TO ACTIVATE POA. NO NEW ORDERS AT THIS TIME. WILL CONTINUE TO MONITOR BLOOD PRESSURE BEFORE ADDING ANTIHYPERTENSIVES DUE TO PREVIOUS LOW BLOOD PRESSURES.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/09/21	0604	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/09/21	0605	EF	FISHER,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

CALL WITH DR BECK TO UPDATE ON PATIENT STATUS. DISCUSSED VITALS AND BIPAP SETTINGS. NOTIFIED OF TACHYPNEA UP TO 40S. DISCUSSED BLOOD PRESSURE AND RESTARTING LEVOPHED AT LOW DOSE. REVIEWED POA PAPER WORK. SEE ORDERS FOR LABS AND ABG.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/09/21	1000	VW	WILLS,VICKI	RN	**Category**
Recorded:	10/09/21	1132	VW	WILLS,VICKI	RN	NURSING NOTES

Abnormal? N **Confidential?** N

dr leonard here and able to speak w father at length. orders noted

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/09/21	2337	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/09/21	2346	EF	FISHER,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PARENT SCOTT IN ROOM WITH PATIENT SINCE ADMISSION. HE HAS REPEATEDLY YELLED AT NURSES ON ALL SHIFTS AND TONIGHT HAS ACCUSED NURSES OF LYING ABOUT SEVERITY OF PATIENT STATUS. WHEN ATTEMPTS WERE MADE TO EDUCATE ON MEDICATIONS AND PATIENT CARE HE STATED "I'M NOT GOING TO TAKE ANY OF YOUR GUFF. YOU'RE HERE TO FOLLOW MY COMMANDS". PARENT SHOWS ONGOING,BLATANT DISRESPECT OF NURSES

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	(Continued)
Occurred:	10/09/21	2337	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/09/21	2346	EF	FISHER,EMILY	RN	NURSING NOTES

SUBVERSION OF MEDICAL CARE.
WHEN ENTERING ROOM TO ASSESS ALARMS FROM SPO2
MONITOR, BLOOD PRESSURE CUFF, AND IV PUMP PARENT ACCUSES NURSES OF NOT KNOWING
HOW TO DO NURSING CARE, RUN EQUIPMENT,AND OF EQUIPMENT BEING FAULTY. PARENT
DEMANDED THAT MONITOR ALARMS AND IV ALARMS BE COMPLETELY TURNED OFF AND SPO2
DEVICE BE REMOVED FROM PATIENT. FURTHER
ATTEMPTED TO PROVIDE EDUCATION AND EXPLANATIONS ABOUT THE ALARMS AND FUNCTION
OF EQUIPMENT IN ROOM. ALL ATTEMPTS TO PROVIDE EDUCATION TO PARENT REFUSED.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	0605	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/10/21	0614	EF	FISHER,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PARENT SCOTT CONTINUES TO BE DIFFICULT WITH STAFF WITH QUESTIONING AND RUDE
STATEMENTS ABOUT CARE. ALSO NOTED TO BE INTERFERING WITH PUMP ALARMS. FREQUENT
COMPLAINTS ABOUT MONITOR AND IV PUMP ALARMS. I HAVE REPEATEDLY ATTEMPTED TO
PROVIDE EDUCATION ON THE REASON FOR THE ALARMS AND THE INTERVENTIONS TAKEN TO
CORRECT ALARMS BUT PARENT IS NOT ACCEPTING OF EDUCATION. PARENT REQUESTS THAT
ALL ALARMS BE TURNED OFF INSIDE OF ROOM. EXPLAINED THAT THIS IS NOT POSSIBLE
AND NOT SAFE DUE TO AMOUNT OF TIME NURSING STAFF SPENDS AT THE BEDSIDE IN THE
ROOM WITH PATIENT. PARENT REQUESTS DR BECK AND UNIT SUPERVISOR COME TO SPEAK
WITH HIM. MESSAGE SENT TO DR BECK AND RACHEL TO NOTIFY OF REQUEST AND UPDATE
ON CONCERNS ABOUT PARENT INTERFERENCE IN CARE. AT THIS TIME NO NEW CONCERNS
ABOUT PATIENT STATUS.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	0614	EF	FISHER,EMILY	RN	**Category**
Recorded:	10/10/21	0617	EF	FISHER,EMILY	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PHONE CALL WITH DR BECK TO UPDATE ON CONCERNS WITH PARENT INTERENCE AND
DISRESPECT AND POOR TREATMENT OF STAFF.
DR BECK STATES HE WILL TALK WITH PARENT TO HEAR CONCERNS.
EXPLAINED TO DR BECK PARENT CONCERNS ABOUT ALARMS BEEPING AND INTERVENTIONS
TAKEN TO FIX THEM.

Note Type	Description
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	0830	AB	BARKHOLTZ,ALISON	RN	**Category**
Recorded:	10/10/21	1040	AB	BARKHOLTZ,ALISON	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PATIENT'S MOTHER AND FATHER UPDATED VIA PHONE (FOR MOTHER) AND IN PERSON (FOR FATHER) ABOUT VISITATION POLICY. PATIENT'S FATHER ESCORTED OUT OF BUILDING CALMLY BY SECURITY. PATIENT'S MOTHER CURRENTLY RECOVERING FROM COVID HERSELF AND PER HER STATEMENT DOES NOT FEEL WELL ENOUGH YET. ENCOURAGED PATIENT'S MOTHER (WHO IS PRIMARY POA) TO STAY HOME AND THAT SIGNS/SYMPTOMS EXPRESSED BY ANYONE COMING TO THE HOSPITAL WOULD NOT BE GRANTED ENTRANCE INTO THE BUILDING TO HELP PREVENT THE SPREAD OF COVID. VIRTUAL VISITION OFFERED, AND PLAN SET UP FOR FACETIME WITH PATIENT'S IPAD WITH FAMILY. ALL OF THE ABOVE RELAYED TO PRIMARY RN KATIE CARING FOR PATIENT.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	0830	KRH	HALE,KATHARINE	RN	**Category**
Recorded:	10/10/21	1423	KRH	HALE,KATHARINE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Dr. LEONARD here to see patient. Update given. NEW ORDERS RECEIVED.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	0845	KRH	HALE,KATHARINE	RN	**Category**
Recorded:	10/10/21	1424	KRH	HALE,KATHARINE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Dr. BAUM here to see patient. Update given. PATIENT'S ACTIVATED POA (HER MOTHER) CALLED PER DR BAUM WITH UPDATE.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	1419	KRH	HALE,KATHARINE	RN	**Category**
Recorded:	10/10/21	1422	KRH	HALE,KATHARINE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

FOCUS WORD- FAMILY UPDATED VIA PHONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	(Continued)
Occurred:	10/10/21	1419	KRH	HALE,KATHARINE	RN	**Category**
Recorded:	10/10/21	1422	KRH	HALE,KATHARINE	RN	NURSING NOTES

D- ATTEMPTED TO CONTACT FAMILY MULTIPLE TIMES VIA FACETIME PER IPAD IN ROOM AND PATIENT'S CELLPHONE. MOM/DAD CALLED WRITER BACK ON WORK PHONE
A- UPDATE GIVEN, INCLUDING RECENT LABS, RECENT VITAL SIGNS, NUTRITION ATTEMPTS, MD NOTES, AND CURRENT PRONE STATUS
R- MULTIPLE QUESTIONS ASKED AND ANSWERED. FATHER SCOTT ASKED TO SPEAK WITH DR. BAUM. WRITER GAVE DR BAUM THE MESSAGE. DR BAUM HAS ALREADY UPDATED THE MOTHER EXTENSIVELY THIS AM. FATHER SCOTT ALSO REQUESTED TO HAVE HOME PHONE NUMBER OF 788-5578 REMOVED FROM CONTACT LIST. WRITER CALLED ADMISSIONS WITH THIS REQUEST. 20 + MINUTES SPENT UPDATING FAMILY. WRITER STRESSED TO PATIENT'S PARENTS THAT ASPIRATING IS A VERY REAL RISK AT THIS TIME AND COULD BE DETRIMENTAL FOR THE PATIENT, AND THEREFORE IT IS WRITER'S OPINION TO PROCEED CAUTIOUSLY WITH NUTRITIONAL INTAKE.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/10/21	1815	KRH	HALE,KATHARINE	RN	**Category**
Recorded:	10/10/21	1835	KRH	HALE,KATHARINE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DAD UPDATED VIA FACEBOOK IN ROOM WITH PATIENT. MOM THEN UPDATED VIA FACETIME IN ROOM WITH PATIENT. DURING THIS TIME, WRITER SWITCHING PATIENT IN BETWEEN BIPAP AND OXYMASK FOR ATTEMPT AT PO INTAKE. PT DRANK 1/2 OF ENSURE CLEAR. MULTIPLE BREAKS NEEDED FOR BIPAP D/T SATS <90%

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/11/21	1503	JB	BAUER,JEANEAN	RN	**Category**
Recorded:	10/11/21	1510	JB	BAUER,JEANEAN	RN	NURSING NOTES

Abnormal? N **Confidential?** N

WOUND CONSULT
PATIENT WAS ADMITTED WITH COVID, ON BI-PAP. CURRENTLY NO PRESSURE INJURY TO NOSE, CHEEK IS RED BUT BLANCHABLE. PATIENT HAS CHRONIC WOUND THAT OCCUR, SCARS PRESENT INNER THIGHS. FIRST OPEN WOUND IS IN THE LEFT GROIN FOLD, APPROXIMATELY 1CM X 1CM. SECOND IS IN THE RIGHT ABDOMINAL FOLD, APPROXIMATELY 1CM X 1CM. WOUND BASES ARE RED/YELLOW. CLOTRIMAZOLE CREAM AND CLINDAMYCIN CREAM ARE ORDERED TO BOTH AREAS. ALSO RECOMMEND INTERDRY AG TO HELP WITH EXCESS MOISTURE IN FOLDS. PLACE IN A SINGLE LAYER WITH 2-3" EXCESS FOR MOISTURE WICKING. CONTINUE TO REPOSITION EVERY 2 HOURS, FLOAT HEELS. PATIENT IS ON AN OFFLOADING WAFFLE MATTRESS. EMMA RN ALSO REPORTS PATIENT HAS SOME REDNESS UNDER THE LEFT BREAST. INTERDRY AG CAN BE PLACED THERE AS WELL IN A

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	(Continued)
Occurred:	10/11/21	1503	JB	BAUER,JEANEAN	RN	**Category**
Recorded:	10/11/21	1510	JB	BAUER,JEANEAN	RN	NURSING NOTES

SINGLE LAYER WITH 2-3" EXCESS. REPLACE INTERDRY AG EVERY 5 DAYS AND IF SOILED.
PATIENT HAS A FOLEY
EMMA RN PRESENT FOR ASSESSMENT

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/11/21	1630	ES	STARK,EMMA	NE	**Category**
Recorded:	10/15/21	1238	ES	STARK,EMMA	NE	NURSING NOTES

Abnormal? N **Confidential?** N

WRITER TALKING WITH PT SISTER AT BEDSIDE, WRITER SAID PT WAS TOLERATING PRONING BETTER TODAY AND THAT ABGs LOOKED SLIGHTLY BETTER. WRITER ALSO TOLD PT SISTER THAT PT IS STILL VERY SICK AND THINGS COULD GET BETTER OR WORSE AT THIS POINT. COMFORT PROVIDED FOR FAMILY AND PT.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/12/21	1014	HJM	MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1014	HJM	MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT'S MOTHER UPDATED BY DR SHOKAR ON POC. QUESTIONS ANSWERED.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/12/21	1356	HJM	MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1402	HJM	MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT TURNED FROM PRONE POSITION TO SUPINE WITH HOB 45 DEGREES. FIO2 INCREASED FROM 95% TO 100%. O2 SAT 78-85% AND NOT RECOVERING. DR SHOKAR INFORMED. STAT ABG, RT TO ADJUST BIPAP SETTINGS IF POSSIBLE AND MD WILL COME ASSESS PT AND TALK WITH FAMILY.

Note Type	**Description**
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By	Nurse Type	
Occurred:	10/12/21	1440	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1442	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT'S MOTHER TO CONFIR WITH PT'S FATHER AND GIVE DECISION ON CODE STATUS AS PT IS CURRENTLY DO NOT INUBATE, BUT A FULL CODE. CLARIFICATION NEEDED PER DR SHOKAR'S CONVERSATION WITH MOTHER.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/12/21	1700	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/12/21	1829	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PARENTS UPDATED BY DR SHOKAR OF PT'S LOW O2 SATURATION T/O THIS AFTERNOON. PARENTS DO NOT WANT INTUBATION AS PREVIOUSLY INDICATED.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	0941	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	0942	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DR SHOKAR PAGED FOR SCOTT, TO RETURN CALL.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1134	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1137	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

SMALL BORE NG TUBE PLACED LEFT NARE WITH PT ON 15L OXIMASK FOR PROCEEDURE, PLACED WITH EASE AND BIPAP REPLACED. O2 DESAT TO 61%, SLOW RECOVERY. CXR CALLED TO CONFIRM PLACEMENT. PT'S SISTER PRESENT FOR COMFORT. PT TOLERATED WELL. RR REMAINS IN THE 40'S.

Note Type	Description
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1358	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1359	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

FEEDING TUBE CONFIRMED IN PLACE, TUBE FEEDING STARTED. ATEMPTED BRIDLE X2, 2 RN'S, UNSUCESSFUL D/T PT SHAKING HEAD. TAPED IN PLACE.

Note Type	**Description**
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1750	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1751	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT O2 SAT 54 WITH PRONING. REVERSED WITH NO RECOVERY IN O2 SAT. PT'S SISTER AT BEDSIDE WHO FACETIMED PT'S FATHER TO UPDATE ON SITUATION. FAMILY PROVIDING COMFORT.

Note Type	**Description**
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1755	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1756	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

PT SISTER AT BEDSIDE AND FATHER ON FACETIME UPDATED ON O2 SAT DROP TO 40'S. 2 DIFFERENT O2 PROBES TESTED AND O2 SAT CONFIRMED. STAT ABG ORDERED BY MD. OFFERING PT COMFORT.

Note Type	**Description**
No Type	NONE

	Date	Time	By	Nurse Type	
Occurred:	10/13/21	1805	HJM MCINNIS,HOLLEE	RN	**Category**
Recorded:	10/13/21	1805	HJM MCINNIS,HOLLEE	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DR SHOKAR AT BEDSIDE SPEAKING TO FAMILY.

Note Type	**Description**
No Type	NONE

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	1927	JC	#CASTRO,JORIZZA	RN	**Category**
Recorded:	10/13/21	2323	JC	#CASTRO,JORIZZA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye. Dr. Watton notified and pronouncement of death order and permission to release the body to the funeral home received.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	1927	SP	PAGELS,SARAH	RN	**Category**
Recorded:	10/13/21	2330	SP	PAGELS,SARAH	RN	NURSING NOTES

Abnormal? N **Confidential?** N

DEATH NOTE:

No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye.
Dr. WATTON notified and pronouncement of death order and permission to release the body to the funeral home received.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	1927	JC	#CASTRO,JORIZZA	RN	**Category**
Recorded:	10/13/21	2331	JC	#CASTRO,JORIZZA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Pt went asystole, No Code order in the computer. Day nurse with me at the bedside, team lead in the unit as well. No Pulse or respiration observed. Sister was on the phone with the family. No CPR done due to No Code status, MD informed by the changes.

Note Type	**Description**
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	10/13/21	2320	JC	#CASTRO,JORIZZA	RN	**Category**
Recorded:	10/14/21	0116	JC	#CASTRO,JORIZZA	RN	NURSING NOTES

Abnormal? N **Confidential?** N

Pt picked up by the funeral home from room 2029. All of pt's belongings given

Patient: SCHARA,GRACE N
Account #: E39547554 **Unit #:** E000365038

	Date	Time	By		Nurse Type	(Continued)
Occurred:	10/13/21	2320	JC	#CASTRO,JORIZZA	RN	**Category**
Recorded:	10/14/21	0116	JC	#CASTRO,JORIZZA	RN	NURSING NOTES

to the pt's mom and sister.

Note Type	**Description**
No Type	NONE

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Name: SCHARA,GRACE N **Age/Sex:** 19/F **Attend Dr:** BECK MD,DAVID
N4833 MISTY MEADOWS DR,SEYMOUR,WI 54165 920-788-0829 **Facility:** Asc NE WI St Elizabeth
Acct#: E39547554 **Unit#:** E000365038 **DOB:** 09/22/02 **Location:** CRITICAL CARE BED TOWE
Reg: 10/07/21 **Disch:** 10/13/21 **Status:** DIS INx

========== *** MICROBIOLOGY *** ==========
========== *** BLOOD CULTURE *** ==========

Source: BLOOD - PERIPHERAL

BLOOD CULTURE REPORT Final 10/13/21
Specimen: 21:B0030749R Collected: 10/07/21 2305

NO GROWTH AT FIVE DAYS.

BLOOD CULTURE REPORT Final 10/13/21
Specimen: 21:B0030750R Collected: 10/07/21 2320

NO GROWTH AT FIVE DAYS.

BLOOD CULTURE REPORT Final 10/19/21
Specimen: 21:B0031396S Collected: 10/13/21 1457

NO GROWTH AT FIVE DAYS.

BLOOD CULTURE REPORT Final 10/19/21
Specimen: 21:B0031397S Collected: 10/13/21 1505

NO GROWTH AT FIVE DAYS.

***** DEPARTMENT OF LABORATORY *****

========== *** HEMATOLOGY *** ==========

<<< HEMOGRAM >>>

Date / Time	OCT 13, 21 0357	OCT 12, 21 0442	OCT 11, 21 0510	OCT 10, 21 0530	Reference	Units
WBC	14.0 H	10.2	10.2	7.9	(3.9-12.5)	x1000
RBC	4.30	4.32	4.32	4.29	(3.79-5.23)	million
HGB	12.7	12.8	12.7	12.7	(11.7-15.7)	g/dL
HCT	38.3	38.5	38.6	38.3	(34.9-46.9)	%
MCV	89.2	89.2	89.4	89.4	(80-100)	fl
MCH	29.6	29.7	29.3	29.6	(26.6-33.8)	pg
MCHC	33.2	33.3	32.8	33.1	(32-36)	g/dL
RDW	14.6 H	15.0 H	15.0 H	15.5 H	(11.5-14.5)	%
PLT	257	252	256	232	(160-475)	x1000
MPV	8.5	8.0	7.9	7.9	(7.4-10.4)	fl

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * HEMATOLOGY *** ==========**

<<< HEMOGRAM >>>

Date	OCT 9, 21	OCT 8, 21			Reference	Units
Time	0630	1229				
WBC	7.2	5.5			(3.9-12.5)	x1000
RBC	4.40	4.33			(3.79-5.23)	million
HGB	13.1	12.9			(11.7-15.7)	g/dL
HCT	39.2	38.7			(34.9-46.9)	%
MCV	89.0	89.4			(80-100)	fl
MCH	29.7	29.7			(26.6-33.8)	pg
MCHC	33.4	33.2			(32-36)	g/dL
RDW	15.2 H	15.2 H			(11.5-14.5)	%
PLT	214	181			(160-475)	x1000
MPV	7.6	7.6			(7.4-10.4)	fl

<<< DIFFERENTIAL >>>

Date	OCT 13, 21	OCT 12, 21	OCT 11, 21	OCT 10, 21	Reference	Units
Time	0357	0442	0510	0530		
% NEUTROPHI			83.6 H	81.2 H	(25.0-80.0)	%
% LYMPH			10.3 L	12.3 L	(25.0-45.0)	%
% MONO			5.9	6.4	(2.0-13.0)	%
% EOSIN			0.0 L	0.0 L	(1.0-5.0)	%
% BASOPHIL			0.2	0.1	(0-1.0)	%
ABS NEUT CT			8.5 H	6.4	(1.8-8.0)	x1000
ABS LYMPH C			1.0 L	1.0 L	(1.2-5.2)	x1000
ABS MONO CT			0.6	0.5		x1000
ABS EOSIN C			0.0	0.0		x1000
ABS BASO CT			0.0	0.0		x1000
% SEG	95.0 H	88.0 H			(25.0-70.0)	%
% LYMPH	5.0 L	9.0 L			(25.0-45.0)	%
% MONO		3.0			(2.0-13.0)	%
ABS NEUT CT	13.3	9.0				x1000
ABS LYMPH C	0.7	0.9				x1000
NUCLEATED R	0	0			(0-0)	/100WBC
TOTAL CELLS	100	100				cells

Date	OCT 9, 21	OCT 8, 21			Reference	Units
Time	0630	1229				
% NEUTROPHI	81.7 H				(25.0-80.0)	%
% LYMPH	11.0 L				(25.0-45.0)	%
% MONO	7.1				(2.0-13.0)	%
% EOSIN	0.0 L				(1.0-5.0)	%
% BASOPHIL	0.2				(0-1.0)	%

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * HEMATOLOGY *** ==========**

<<< DIFFERENTIAL >>>

	Date	OCT 9, 21	OCT 8, 21				
	Time	0630	1229			Reference	Units
	ABS NEUT CT	5.9				(1.8-8.0)	x1000
	ABS LYMPH C	0.8 L				(1.2-5.2)	x1000
	ABS MONO CT	0.5					x1000
	ABS EOSIN C	0.0					x1000
	ABS BASO CT	0.0					x1000
	% SEG		75.0 H			(25.0-70.0)	%
	% BAND		9.0			(0-10.0)	%
	% LYMPH		11.0 L			(25.0-45.0)	%
	% MONO		5.0			(2.0-13.0)	%
	ABS NEUT CT		4.6				x1000
	ABS LYMPH C		0.6				x1000
	NUCLEATED R		0			(0-0)	/100WBC
	TOTAL CELLS		100				cells

< MORPHOLOGY >

	Date	OCT 13, 21	OCT 12, 21	OCT 8, 21		
	Time	0357	0442	1229	Reference	Units
	TOXIC GRAN			1+ H		
	PLT MORPH	NORMAL	NORMAL	NORMAL		

<<< COAGULATION >>>

	Date	OCT 13, 21	OCT 8, 21	OCT 7, 21		
	Time	0357	1229	0622	Reference	Units
	PROTIME			12.9(A) H	(9.4-12.5)	SECONDS

(A) Attention: New Ranges Established 7/20/2020

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * HEMATOLOGY *** ==========**

<<< COAGULATION >>>

Date	OCT 13, 21	OCT 8, 21	OCT 7, 21			
Time	0357	1229	0622		Reference	Units
INR			1.17(B) H		(0.86-1.13)	

(B) See (C), (D)
(C) Attention: New Ranges Established 7/30/2021
(D)

INTERNATIONAL NORMALIZED RATIO

* CONDITION/TREATMENT	INR
- Prophylaxis of Venous Thrombosis, Pulmonary Embolism	2.0-3.0
- Prevention of systemic embolism	2.0-3.0
- Tissue heart values	2.0-3.0
- Acute myocardial infarction (to prevent systemic embolism)	2.0-3.0
- Valvular heart disease	2.0-3.0
- Bileaflet mechanical valve in aortic position	2.0-3.0
- Atrial fibrillation	2.0-3.0
- Mechanical prosthetic valves (high risk)	2.5-3.5
- Prevention of recurrent myocardial infarction	2.5-3.5

D-DIMER/QNT	23657(E) H	2243(E) H			(<500)	FEUng/mL

(E) Attention: New Ranges Established 7/20/2020

========== * CHEMISTRY *** ==========**

<<< ELECTROLYTE & BLOOD GAS >>>

Date	------ OCT 13, 21------		------ OCT 12, 21------			
Time	1350	0357	1522	0442	Reference	Units
ABG SAMPLE			(F)			

(F) RIGHT RADIAL ARTERY

O2 STATUS			100%			
pH (ART)			7.42		(7.35-7.45)	
pCO2 (ART)			36		(35-45)	mmHg
BICARB (ART			23		(22-26)	mmol/L
BASE EX (AR			-0.8		(-3.0-3.0)	
pO2 (ART)			59 L		(83-108)	mmHg
O2 SAT (OXY			87.9 L		(94.0-98.0)	%
SODIUM	138	140		141	(136-145)	mmol/L

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * CHEMISTRY *** ==========**

<<< ELECTROLYTE & BLOOD GAS >>>

Date	OCT 13, 21		OCT 12, 21			
Time	1350	0357	1522	0442	Reference	Units
POTASSIUM	4.1	4.2		4.2	(3.5-5.1)	mmol/L
CHLORIDE	108 H	108 H		109 H	(98-107)	mmol/L
tCO2	19 L	23		22	(22-29)	mmol/L
ANION GAP,	10.8	9.8		10.5	(3-18)	mmol/L

Date	OCT 11, 21		OCT 10, 21			
Time	1000	0510	0815	0530	Reference	Units
ABG SAMPLE	(G)		(H)			
O2 STATUS	90%		100			
pH (ART)	7.43		7.44		(7.35-7.45)	
pCO2 (ART)	37		35		(35-45)	mmHg
BICARB (ART	24		23		(22-26)	mmol/L
BASE EX (AR	0.7		0.0		(-3.0-3.0)	
pO2 (ART)	64 L		52 L		(83-108)	mmHg
O2 SAT (OXY	90.5 L		85.0 L		(94.0-98.0)	%
SODIUM		142		142	(136-145)	mmol/L
POTASSIUM		3.8		4.0	(3.5-5.1)	mmol/L
CHLORIDE		108 H		110 H	(98-107)	mmol/L
tCO2		23		21 L	(22-29)	mmol/L
ANION GAP,		11.8		10.8	(3-18)	mmol/L

(G) RIGHT RADIAL ARTERY
(H) RIGHT RADIAL ARTERY

Date	OCT 9, 21		OCT 8, 21			
Time	0848	0630	1229	1225	Reference	Units
ABG SAMPLE	(I)			LINE DRAW		
O2 STATUS	100%			100%		
pH (ART)	7.43			7.39(J)	(7.35-7.45)	

(I) LEFT RADIAL ARTERY

(J) 10/08/21 1318:
pH (ART) previously reported as: 7.44

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * CHEMISTRY *** ==========**

<<< ELECTROLYTE & BLOOD GAS >>>

Date	------ OCT 9, 21------		------ OCT 8, 21------			
Time	0848	0630	1229	1225	Reference	Units
pCO2 (ART)	32 L			32(K) L	(35-45)	mmHg
BICARB (ART	21 L			19(L) L	(22-26)	mmol/L
BASE EX (AR	-2.3			-4.4(M) L	(-3.0-3.0)	
pO2 (ART)	64 L			69(N) L	(83-108)	mmHg
O2 SAT (OXY	91.4 L			92.2(O) L	(94.0-98.0)	%
SODIUM		142	142		(136-145)	mmol/L
POTASSIUM		4.2	4.4		(3.5-5.1)	mmol/L
CHLORIDE		113 H	115 H		(98-107)	mmol/L
tCO2		19 L	19 L		(22-29)	mmol/L
ANION GAP,		9.8	8.3		(3-18)	mmol/L

(K) 10/08/21 1318:
pCO2 (ART) previously reported as: 26 L mmHg

(L) 10/08/21 1319:
HCO3 (ART) previously reported as: 17 L mmol/L

(M) 10/08/21 1319:
BASE EX (ART) previously reported as: -4.9 L

(N) 10/08/21 1320:
pO2 (ART) previously reported as: 162 H mmHg

(O) 10/08/21 1320:
O2 SAT (OXYHGB) previously reported as: 97.3
%

Date	---------- OCT 7, 21----------				
Time	2315	2305	0632	Reference	Units
ABG SAMPLE	(P)		(Q)		
O2 STATUS	100%		70%		
pH (ART)	7.44		7.36	(7.35-7.45)	

(P) RIGHT RADIAL ARTERY
(Q) RIGHT RADIAL ARTERY

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * CHEMISTRY *** ==========**

<<< ELECTROLYTE & BLOOD GAS >>>

Date	OCT 7, 21					
Time	2315	2305	0632		Reference	Units
pCO2 (ART)	30 L		38		(35-45)	mmHg
BICARB (ART	20 L		21 L		(22-26)	mmol/L
BASE EX (AR	-2.5		-3.8 L		(-3.0-3.0)	
pO2 (ART)	46 L		73 L		(83-108)	mmHg
O2 SAT (OXY	82.3 L		93.3 L		(94.0-98.0)	%
SODIUM		144			(136-145)	mmol/L
POTASSIUM		4.8			(3.5-5.1)	mmol/L
CHLORIDE		114 H			(98-107)	mmol/L
tCO2		20 L			(22-29)	mmol/L
ANION GAP,		10.8			(3-18)	mmol/L

<<< ROUTINE CHEMISTRY >>>

Date	OCT 13, 21					
Time	1648	1350	0357	0357	Reference	Units
GLUCOSE		174 H		101 H	(70-99)	mg/dL
GLUCOSE-WH	151 H				(60-99)	mg/dL
CLIA	(R)					

(R) 52D0397482
Test Performed at:
ASCENSION NE WISCONSIN-ST ELIZABETH CAMPUS
1506 S Oneida St, Appleton WI 54915

UREA NITROG		18		16	(7-26)	mg/dL
CREATININE		0.74		0.67	(0.57-1.11)	mg/dl
CALCIUM TOT		8.2 L		8.5	(8.4-10.5)	mg/dL
GFR CALCULA		> 60(S)		> 60(S)	(>60)	mL/min

(S) Units: mL/min/1.73 sq.m
Assume Caucasian. For Af Amer, multiply GFRe by 1.21

PHOSPHORUS		3.5			(2.3-4.7)	mg/dL
MAGNESIUM		1.7			(1.6-2.6)	mg/dL
BILIRUBIN T				0.5	(0.2-1.2)	mg/dL
ALKPHOS				51	(40-150)	U/L
GOT(AST)				34	(5-34)	U/L
GPT(ALT)				22	(0-55)	U/L
LDH TOTAL			909 H		(125-220)	U/L
PROTEIN TOT				6.1 L	(6.2-8.0)	g/dL
ALBUMIN				2.7 L	(3.5-5.2)	g/dL

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * CHEMISTRY *** ==========**

<<< ROUTINE CHEMISTRY >>>

Date	OCT 12, 21	OCT 11, 21	OCT 10, 21	OCT 9, 21		
Time	0442	0510	0530	0630	Reference	Units
GLUCOSE	119 H	116 H	123 H	123 H	(70-99)	mg/dL
UREA NITROG	13	16	14	16	(7-26)	mg/dL
CREATININE	0.67	0.74	0.72	0.77	(0.57-1.11)	mg/dl
CALCIUM TOT	8.4	8.4	8.4	8.3 L	(8.4-10.5)	mg/dL
GFR CALCULA	> 60(T)	> 60(T)	> 60(T)	> 60(T)	(>60)	mL/min

(T) Units: mL/min/1.73 sq.m
Assume Caucasian. For Af Amer, multiply GFRe by 1.21

BILIRUBIN T	0.5	0.5	0.4	0.3	(0.2-1.2)	mg/dL
ALKPHOS	41	39 L	37 L	33 L	(40-150)	U/L
GOT(AST)	34	31	37 H	48 H	(5-34)	U/L
GPT(ALT)	23	22	22	21	(0-55)	U/L
CK TOTAL	282 H		181 H		(29-168)	U/L
PROTEIN TOT	6.0 L	6.6	6.4	6.3	(6.2-8.0)	g/dL
ALBUMIN	2.7 L	3.0 L	2.9 L	2.9 L	(3.5-5.2)	g/dL

Date	OCT 8, 21	---------- OCT 7, 21----------				
Time	1229	2305	2305	2305	Reference	Units
GLUCOSE	151 H			138 H	(70-99)	mg/dL
UREA NITROG	20			20	(7-26)	mg/dL
CREATININE	0.95			1.12 H	(0.57-1.11)	mg/dl
CALCIUM TOT	8.2 L			9.2	(8.4-10.5)	mg/dL
GFR CALCULA	> 60(U)			> 60(U)	(>60)	mL/min

(U) Units: mL/min/1.73 sq.m
Assume Caucasian. For Af Amer, multiply GFRe by 1.21

MAGNESIUM		1.9			(1.6-2.6)	mg/dL
BILIRUBIN T	0.3				(0.2-1.2)	mg/dL
ALKPHOS	35 L				(40-150)	U/L
GOT(AST)	50 H				(5-34)	U/L
GPT(ALT)	18				(0-55)	U/L
CK TOTAL	432 H				(29-168)	U/L
BT NATR PEP			24		(<100)	pg/mL
PROTEIN TOT	6.3				(6.2-8.0)	g/dL
ALBUMIN	2.9 L				(3.5-5.2)	g/dL

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

***** DEPARTMENT OF LABORATORY *****

========== * CHEMISTRY *** ==========**

<<< ROUTINE CHEMISTRY >>>

Date	------ OCT 7, 21------					
Time	0622	0622			Reference	Units
MAGNESIUM	2.0				(1.6-2.6)	mg/dL
BT NATR PEP		56			(<100)	pg/mL

========== * EIA/SEROLOGY *** ==========**

<<< SEROLOGY >>>

Date	OCT 13, 21	OCT 10, 21	OCT 8, 21			
Time	0357	0530	1229		Reference	Units
CRP	10.4 H	2.9 H	4.5 H		(<0.5)	mg/dL

Laboratory Summary Report
PCI User: ASDUESTE Lab Database: LAB.O

Patient: SCHARA,GRACE N #E39547554 **(Continued)**

========== *** **REFERRED TESTS** *** ==========

Date	OCT 10, 21	OCT 7, 21				
Time	0530	0622			Reference	Units
PROCALCITON	0.24(V)	0.22(V)			(0-0.24)	ng/mL

(V) Adults and Infants > 48 hours old:
NORMAL RANGE: < 0.5 ng/mL - Sepsis not likely

INTERPRETATION:
DIAGNOSIS OF SYSTEMIC BACTERIAL INFECTION/SEPSIS
PCT (ng/mL)
<0.5 SEPSIS IS NOT LIKELY. Low risk for progression to severe sepsis. NOTE: Concentrations of < 0.5 ng/mL do not exclude localized infections or systemic infection in its initial stages (< 6 hours).
>=0.5 - <2 SEPSIS IS POSSIBLE. Moderate risk for progression to severe sepsis. The patient should be closely monitored both clinically and by re-assessing PCT within 6-24 hours.
>=2 - < 10 SEPSIS IS LIKELY. High risk for progression to severe sepsis.
>= 10 IMPORTANT SYSTEMIC INFLAMMATORY RESPONSE, ALMOST EXCLUSIVELY DUE TO SEVERE BACTERIAL SEPSIS OR SEPTIC SHOCK. High likelihood of severe sepsis or septic shock.

DIFFERENTIAL DIAGNOSIS OF LOWER RESPIRATORY TRACT INFECTIONS
PCT (ng/mL)
<0.1 Indicates absence of bacterial infection. Use of antibiotics strongly discouraged, even in the presence of impaired pulmonary reserve in AECOPD.
>= 0.1 - < 0.25 Bacterial infection unlikely. The use of antibiotics is discouraged.
>= 0.25 - < 0.5 Bacterial infection is possible. Recommended to initiate antimicrobial therapy.
>= 0.5 Suggests the presence of bacterial infection. Antibiotic treatment strongly recommended.

NOTE: In certain situations (the first days after a major trauma, major surgery, severe burns, treatment with OKT3 antibodies, neonates < 48 hours old, fungal infections, malaria, prolonged or severe cardiogenic shock, small cell lung cancer and prolonged severe organ perfusion anomalies), increased procalcitonin can occur without infection. Reassessment 6-24 hours after initial draw is recommended.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

Additional Interventions

9999998 ZZEMPI D MO
- Document 10/06/21 1409 10/06/21 1410
EMPI: 206478
- Create 10/06/21 1410 10/06/21 1410
- Document 10/07/21 0016 10/07/21 0016
EMPI: 206478

1239 CARES: Personalized Care ^ C BID PS
-Shampoo PRN
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 1000 CT 10/07/21 1130 CT

Chlorhexidine (CHG) bath: (Once daily for patients with central line or in ICU)
Foley care: (BID and PRN, separate from bath)
Securement device present:
If CHG bath or foley care REFUSED, RN Notified:

Bath: Complete
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: GROIN
Oral Hygiene:
Peri-care: Yes
Telemetry patches changed:
Linens changed: Yes

Comments:

- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
23001 PAIN: Pain Management ^ C Q4H PS
Tolerable pain level:
-If not having pain, may change intervention to Q4H
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0055 BC 10/07/21 0056 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: Resp Quality: Labored

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0200
Non-pharmacological interventions:

23001 PAIN: Pain Management ^ (continued)
Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense

23001 PAIN: Pain Management ^ (continued)
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION

23001 PAIN: Pain Management ^ (continued)

Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture,	0-Not observed 1-Observed	:	:

23001 PAIN: Pain Management ^ (continued)
equipment or affected area during movement

		Score w/movement	Score at rest:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

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Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		
0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:
CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	
BREATHING PATTERNS		
0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	
ARMS		Score:
0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or	

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 0200 BC 10/07/21 0316 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 0316 BC 10/07/21 0316 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS

23001 PAIN: Pain Management ^ (continued)
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :

23001 PAIN: Pain Management ^ (continued)

1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	

23001 PAIN: Pain Management ^ (continued)

2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/07/21 0400 BC 10/07/21 0442 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments: PT IS SLEEPING,

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)

23001 PAIN: Pain Management ^ (continued)

1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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Score Score

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

		w/movement	at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

23001 PAIN: Pain Management ^ (continued)

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 0441 BC 10/07/21 0441 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score

0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS

0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY

0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY

0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY

0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

23001 PAIN: Pain Management ^ (continued)

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:

0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS

0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION

Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated

0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)

0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

PAIN AD- Assessment in Advance Dementia

Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 0602 BC 10/07/21 0606 BC
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

23001 PAIN: Pain Management ^ (continued)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC?	Y	All patients 8 & up with ability to understand & recognize value of numbers
FACES?		Use for all patients age 4 and up. (Revised)
FLACC?		Use for non-verbal, non-intubated (2 month-18 yrs of age)
FLACC-R?		Use for Children (2mon-18yrs) with Cognitive Impairment
PAIN-AD?		Advanced Dementia - Adult patients with dx of dementia (non-intubated)
APP?		(Assume Pain Present) All patient populations If patient is .
CPOT?		Adult (18 & older) ICU patients (Intubated OR extubated)
CNPI?		Adult patients, ICU & non-ICU (non-intubated and non-verbal)
NIPS?		Newborn (non-intubated), full-term newborn up to 1 yr of age

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

23001 PAIN: Pain Management ^ (continued)

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched	0-Not observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

teeth, tightened lips, jaw drop, distorted expressions)	1-Observed		
Bracing	0-Not observed		
Clutching or holding onto furniture, equipment or affected area during movement	1-Observed	:	:
Restlessness			
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than	Copyright @ Shift F8

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

usual, gagging; breath holding

ARMS Score:

0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :

1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :

1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :

1-Fussy Alert, restless & thrashing Total:

Perceived Location: :

Comfort Measures:

Response: Copyright at Shift F8

- Document 10/07/21 0700 BC 10/07/21 0701 BC

Pain: N Pain Scale: Y Unable to express pain: .

Location:

Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?

Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:

PCA 24hr total amount infused at 2200: PCA pump cleared:

Current Epidural amount infused:

Epidural 24hr total amount infused at 2200:

Additional pain site:

Pain rating: Location:

Description:

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning

23001 PAIN: Pain Management ^ (continued)
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change

23001 PAIN: Pain Management ^ (continued)

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain	0-Not observed 1-Observed	:	:

23001 PAIN: Pain Management ^ (continued)

(e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score :
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 0800 BB 10/07/21 1125 BB
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: 20 Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;

23001 PAIN: Pain Management ^ (continued)

sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation

23001 PAIN: Pain Management ^ (continued)
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw	:

23001 PAIN: Pain Management ^ (continued)

(neg.facial expression-nose, mouth & brow)

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/07/21 0900 BB 10/07/21 1126 BB
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: 20 Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

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CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

23001 PAIN: Pain Management ^ (continued)
==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement Restlessness	0-Not observed 1-Observed	:	:

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Sts	Direction	From Change

23001 PAIN: Pain Management ^ (continued)
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still — 0-Not observed / 1-Observed :
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Score w/movement | Score at rest:

Rubbing (Massaging affected area) — 0-Not observed / 1-Observed : :

Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough]) — 0-Not observed / 1-Observed : :

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles — Restful face, neutral expression
1 - Grimace — Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)
Score :

CRY
0 - No Cry — Quiet, not crying
1 - Whimper — Mild moaning, intermittent
2 - Vigorous Cry — Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)
:

BREATHING PATTERNS
0-Relaxed — Usual pattern for this infant
1-Change in Breathing — Indrawing, irregular, faster than usual, gagging; breath holding
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ARMS
0-Relaxed/Restrained — No muscular rigidity; occasional random movements of arms
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion
Score: :

23001 PAIN: Pain Management ^ (continued)
LEGS
0-Relaxed/Restrained — No muscular rigidity; occasional random leg movement
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion
:

STATE OF AROUSAL
0-Sleeping/Awake — Quiet, peaceful sleeping or alert random leg movement
1-Fussy — Alert, restless & thrashing
:
Total:

Perceived Location:
Comfort Measures:
Response:
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- Ed Directs 10/07/21 1126 BB 10/07/21 1126 BB 10/07 0029 Q1H => 10/07 0029 Q1H
10/07 0800 Q4H
- Document 10/07/21 1224 BB 10/07/21 1225 BB
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: 20 Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/07/21 1600 BB 10/07/21 1900 BB
Pain: N Pain Scale: Y Unable to express pain: .
Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: 20 Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC?	Y	All patients 8 & up with ability to understand & recognize value of numbers
FACES?		Use for all patients age 4 and up. (Revised)
FLACC?		Use for non-verbal, non-intubated (2 month-18 yrs of age)
FLACC-R?		Use for Children (2mon-18yrs) with Cognitive Impairment
PAIN-AD?		Advanced Dementia - Adult patients with dx of dementia (non-intubated)
APP?		(Assume Pain Present) All patient populations If patient is .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

23001 PAIN: Pain Management ^ (continued)
Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

23001 PAIN: Pain Management ^ (continued)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
2 - Vigorous Cry Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/07/21 2000 SH 10/07/21 2207 SH
Pain: N Pain Scale: N Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Rate: 36 Resp Quality: Shallow

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

23001 PAIN: Pain Management ^ (continued)

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)
FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

23001 PAIN: Pain Management ^ (continued)
COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:
==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score :
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
506 Assessment, shift ^ C SHIFT PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0104 BC 10/07/21 0113 BC
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: Y If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: ALERT AND ORIENTED

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: Y If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: Y If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: Right:
Dorsalis Pedis: Left: Right:
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: HR 60S

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP 80% 12/8. RR 27

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: DENIES ISSUES

506 Assessment, shift ^ (continued)

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: Y If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Clarity:

Comments: DENIES ISSUES. DID NOT OBSERVE AT THIS TIME

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS ARE RED
*If skin not intact, document on appropriate intervention.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Describe:
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: DID NOT OBSERVE GAIT. UP ADLIB WITH DAD IN ROOM

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: CALM AND COOPERATIVE

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/07/21 0800 BB 10/07/21 1124 BB

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: ALERT AND ORIENTED. HX DOWN SYNDROME, FATHER PRESENT TO ASSIST WITH PT PMH AND COMFORT WITH HOSPITAL STAY. APPROVED BY ADMIN PER REPORT. OCCASIONALLY FORGETFUL, BASELINE PER PT FATHER.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: Y If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 1+ Diminshed,weak,thready Right: 1+ Diminshed,weak,thready
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Non-pitting RLE: Non-pitting

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: VSS. HX OF LOW BLOOD PRESSURES, PER PT FATHER. BP 96/50 THIS AM.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y

Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: DRY COUGH OFTEN. C/O PERSISTENT COUGH, PRN GUAFENESIN GIVEN. VAPOTHERM 20L @ 100% CURRENTLY AND MAINTAINING O2 SATS, UNABLE TO WEAN DOWN AT THIS TIME. BIPAP @ HS FOR HX OF OSA.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: DENIES ISSUES

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: SMALL INCONTINENCE/DRIBBLING- NORMAL PER PT. USES PANT LINER @ BASELINE AND CURRENTLY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Describe:
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: N Location:

Comments: AMBULATES WELL, OCCASIONALLY LOSES BALANCE. SBA/GB.
DENIES PAIN CURRENTLY.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments: CALM AND COOPERATIVE. ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/07/21 1600 BB 10/07/21 1830 BB
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Due to:

Comments: ALERT AND ORIENTED. HX DOWN SYNDROME, FATHER PRESENT TO ASSIST WITH COMFORT of HOSPITAL STAY. OCCASIONALLY FORGETFUL.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: Y If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 1+ Diminshed,weak,thready Right: 1+ Diminshed,weak,thready
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:

506 Assessment, shift ^ (continued)
LUE: RUE:

LLE: Non-pitting RLE: Non-pitting

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR/ST 90-130.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: 35L @100% O2 ON VAPOTHERM.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Clarity:

506 Assessment, shift ^ (continued)
Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Describe:
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: N Location:

Comments: AMBULATES WELL, OCCASIONALLY LOSES BALANCE. SBA/GB.
DENIES PAIN CURRENTLY.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: CALM AND COOPERATIVE. ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
17058 INTEG: Braden scale ^ C 14 PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0126 BC 10/07/21 0127 BC
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 3 - NO APPARENT PROBLEMS
Braden Total Score: 19

Is this a decline in condition from last assessment:
- Document 10/07/21 0304 BC 10/07/21 0305 BC
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 3 - NO APPARENT PROBLEMS
Braden Total Score: 19

Is this a decline in condition from last assessment:
- Document 10/07/21 0400 BC 10/07/21 0400 BC
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17058 INTEG: Braden scale ^ (continued)

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 3 - NO APPARENT PROBLEMS
Braden Total Score: 19

Is this a decline in condition from last assessment:
- Document 10/07/21 1400 BB 10/07/21 1701 BB
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 3 - NO APPARENT PROBLEMS
Braden Total Score: 19

Is this a decline in condition from last assessment:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
3130 SAFETY: Fall Morse Scale ^ C 08,20 PS
Assessment to be completed BID & with condition change.
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0800 BB 10/07/21 1125 BB
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

3130 SAFETY: Fall Morse Scale ^ (continued)
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/07/21 2000 SH 10/07/21 2206 SH
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
750 RN Sedation Risk Assessment ^ C 17 PS
Date general anesthesia received:
Length of time under general anesthesia:
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 1700 BB 10/07/21 1910 BB
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
750 RN Sedation Risk Assessment	^ (continued)												
If increase in risk, Respiratory Therapy referral:													
Comments:													
- Ed Status					10/07/21	2224	SH	10/07/21	2224	SH			A => C
2551 Vital Signs (VS)		^ C	SHIFT										PS
- Create					10/07/21	0029	BC	10/07/21	0029	BC			
- Document					10/07/21	0051	BC	10/07/21	0053	BC			
P 59 R 18													
SPO2%: 99 Oxygen (LPM): Oxygen (%):													
FiO2 (%): PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?													
Resp Quality:													
RASS Scale (ICU patients)													
Position:													
BP 99/58 MAP: 75 BP#2: MAP:													
Extremity: Extremity:													
Mode: Mode:													
T 97.4 (degrees F) T (degrees C) Route: Axillary													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)	^ (continued)												
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													
- Document					10/07/21	0800	CT	10/07/21	0842	CT			
P 77 R 25													
SPO2%: 99 Oxygen (LPM): Oxygen (%):													
FiO2 (%): 70 PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?													
Resp Quality:													
RASS Scale (ICU patients)													
Position: Lying													
BP 96/50 MAP: 71 BP#2: MAP:													
Extremity: RIGHT ARM Extremity:													
Mode: Non-invasive BP Monitor Mode:													
T 98.5 (degrees F) T (degrees C) Route: Axillary													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ C SHIFT PS
- Document 10/07/21 1600 CT 10/07/21 1714 CT
P 112 R 24
SPO2%: 90 Oxygen (LPM): 40.0 Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: High Flow/Vapotherm

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 128/69 MAP: 90 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.7 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C

1750 Intake, food, monitor ^ C PC PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 1000 CT 10/07/21 1130 CT
Meal: Breakfast
Diet: GENERAL
% eaten: 100
Level of assist with meals: Set-up

Comments:
- Document 10/07/21 1301 CT 10/07/21 1301 CT
Meal: Lunch
Diet: GENERAL
% eaten: 100
Level of assist with meals: Set-up

Comments: PATIENT EATING YOGURT FROM BREAKFAST, AND DAD WILL CONTINUE TO ORDER MEALS.
- Document 10/07/21 1902 CT 10/07/21 1902 CT
Meal: Dinner
Diet: GENERAL
% eaten: 100
Level of assist with meals: Set-up

Comments:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
31014 Review Plan of Care with pt/family ^ C SHIFT END PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0532 BC 10/07/21 0532 BC
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Document 10/07/21 1400 BB 10/07/21 1702 BB
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/07/21 2207 SH 10/07/21 2210 SH
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: New intervention added
Referrals initiated
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
1607 ADL: Toileting, offer ^ C PRN PS
Last BM:
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
31710 EDUC: Medication education ^ C SHIFT END PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0532 BC 10/07/21 0533 BC
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy:

31710 EDUC: Medication education ^ (continued)

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s): NACL

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/07/21 1400 BB 10/07/21 2027 BB
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Heparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/07/21 2207 SH 10/07/21 2211 SH
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):

31710 EDUC: Medication education ^ (continued)
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Learner Response/Outcome:

Comments:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
2559 Weight ^ C 05 PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0450 DW 10/07/21 0451 DW
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 187 Kg: 84.822
BMI: 41.92 . -

Method:
Comments:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
3160 SAFETY: Patient checks ^ C Q1HWA,Q2HWS PS
Alarm:
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0217 KM 10/07/21 0218 KM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?

3160 SAFETY: Patient checks ^ (continued)
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 0406 KM 10/07/21 0407 KM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 0602 BC 10/07/21 0604 BC
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: Y On phone: Interactions: TV: In therapy: ADL's

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 0659 KM 10/07/21 0700 KM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 0800 CT 10/07/21 0841 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 0900 CT 10/07/21 0920 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 1000 CT 10/07/21 1131 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 1100 CT 10/07/21 1132 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Comments:
- Document 10/07/21 1157 CT 10/07/21 1158 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/07/21 1301 CT 10/07/21 1302 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Chair Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/07/21 1344 CT 10/07/21 1346 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: Y In therapy: ADL's Y
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/07/21 1456 CT 10/07/21 1456 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/07/21 1558 CT 10/07/21 1600 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 1700 CT 10/07/21 1710 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 1800 CT 10/07/21 1840 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Y Restless: Y Crying: Y Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 1841 CT 10/07/21 1841 CT
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Resting: On phone: Interactions: Y TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 2000 KM 10/07/21 2039 KM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: Y TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 2040 KM 10/07/21 2040 KM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/07/21 2207 SH 10/07/21 2209 SH
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Y Agitated: Y Aggressive: Combative: Confusion/Confused:
Impulsive: Y Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Y Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
3150 SAFETY: Elopement Risk Assessment ^ C 16 PS
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 1600 BB 10/07/21 1900 BB
Is patient mobile: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3150 SAFETY: Elopement Risk Assessment ^ (continued)
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment Resident of mental health facility
Known outstanding warrant Federal, State or Local inmate
Legal detention or 72 hour hold History of elopement/wandering
Family/responsible party voices concerns Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3150 SAFETY: Elopement Risk Assessment	^	C	16										PS
- Ed Status					10/07/21	2224	SH	10/07/21	2224	SH			A => C
60601 MU: VTE LIP required documentation Refer to LIP Required Documentation for VTE Quality Objectives (MU & core measures). Change status of intervention to complete once the LIP has completed this documentation.	^	C	06,10,18										PS
- Create					10/07/21	0029	BC	10/07/21	0029	BC			
- Document					10/07/21	0602	BC	10/07/21	0606	BC			
LIP documentation completed: N													
Date LIP documentation completed:													
Per LIP Required documentation for VTE Meaningful Use:													
VTE medication prophylaxis initiated:													
Reason for no VTE medication prophylaxis prescribed:													
VTE mechanical prophylaxis initiated:													
Reason for no VTE mechanical prophylaxis prescribed:													
- Document					10/07/21	1000	BB	10/07/21	1128	BB			
LIP documentation completed: N													
Date LIP documentation completed:													
Per LIP Required documentation for VTE Meaningful Use:													
VTE medication prophylaxis initiated:													
Reason for no VTE medication prophylaxis prescribed:													
VTE mechanical prophylaxis initiated:													
Reason for no VTE mechanical prophylaxis prescribed:													
- Document					10/07/21	1800	BB	10/07/21	2025	BB			
LIP documentation completed: N													
Date LIP documentation completed:													
Per LIP Required documentation for VTE Meaningful Use:													
VTE medication prophylaxis initiated:													
Reason for no VTE medication prophylaxis prescribed:													
VTE mechanical prophylaxis initiated:													
Reason for no VTE mechanical prophylaxis prescribed:													
- Ed Status					10/07/21	2224	SH	10/07/21	2224	SH			A => C
2505 ADL: Activity/mobility Activity Order:	^	C	Q2H										PS
- Create					10/07/21	0029	BC	10/07/21	0029	BC			
- Document					10/07/21	0217	KM	10/07/21	0217	KM			
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Left Patient refused repositioning: N													
HOB elevated: Y Degrees: 20 Heels propped:													
Medical Devices checked and repositioned:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2505 ADL: Activity/mobility (continued)	^												
Dangle: Stand:													
Chair: Chair type:													
Weight shift: Y													
Ambulate: Distance:													
Weight bearing status:													
Assist: *Blue ?													
Staff Assisting: Assistive Devices:													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document					10/07/21	0406	KM	10/07/21	0407	KM			
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Supine Patient refused repositioning: N													
HOB elevated: Y Degrees: 20 Heels propped:													
Medical Devices checked and repositioned: TELE IV TUBING													
Dangle: Stand:													
Chair: Chair type:													
Weight shift: Y													
Ambulate: Distance:													
Weight bearing status:													
Assist: *Blue ?													
Staff Assisting: Assistive Devices:													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments: PT ABLE TO REPOSITION INDEPENDENTLY. UP AD LIB.													
- Document					10/07/21	0600	KM	10/07/21	0657	KM			
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Supine Patient refused repositioning: N													
HOB elevated: Y Degrees: 40 Heels propped:													
Medical Devices checked and repositioned: TELE IV TUBING CPAP/BIPAP SCDS													
Dangle: Yes Stand: Yes													
Chair: Chair type:													
Weight shift: Y													
Ambulate: Yes Distance: BRP													
Weight bearing status: FULL													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 0800 CT 10/07/21 0838 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 40 Heels propped:
Medical Devices checked and repositioned: TELE
IV TUBING
CPAP/BIPAP
SCDS

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 1000 CT 10/07/21 1131 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 40 Heels propped: Yes
Medical Devices checked and repositioned: TELE
IV TUBING
SCDS
Nasal Cannula & O2 Tubing

Dangle: Yes Stand: Yes
Chair: Chair type:
Weight shift: Y

Ambulate: Yes Distance: BRP
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:

2505 ADL: Activity/mobility ^ C Q2H PS
Activity Order:
- Document 10/07/21 1157 CT 10/07/21 1158 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 40 Heels propped: Yes
Medical Devices checked and repositioned: TELE
IV TUBING
SCDS
Nasal Cannula & O2 Tubing

Dangle: Yes Stand: Yes
Chair: Chair type:
Weight shift: Y

Ambulate: Yes Distance: BRP
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 1344 CT 10/07/21 1344 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 40 Heels propped: Yes
Medical Devices checked and repositioned: TELE
SCDS
Nasal Cannula & O2 Tubing

Dangle: Yes Stand: Yes
Chair: Chair type:
Weight shift: Y

Ambulate: Yes Distance: BRP
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 1558 CT 10/07/21 1600 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 40 Heels propped: Yes
Medical Devices checked and repositioned: TELE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

SCDS
Nasal Cannula & O2 Tubing

Dangle: Yes Stand: Yes
Chair: Chair type:
Weight shift: Y

Ambulate: Yes Distance: BRP
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 1800 CT 10/07/21 1840 CT
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 40 Heels propped:
Medical Devices checked and repositioned: TELE
SCDS
Nasal Cannula & O2 Tubing

Dangle: Yes Stand: Yes
Chair: Chair type:
Weight shift: Y

Ambulate: Yes Distance: BRP
Weight bearing status: FULL

Assist: Supervision/Stand-by *Blue ?
Staff Assisting: 1 Assistive Devices: Gait Belt

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/07/21 2000 SH 10/07/21 2202 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 30 Heels propped: No
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

2505 ADL: Activity/mobility ^ (continued)

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT ABLE TO REPOSITION INDEPENDENTLY. THRASHING
NONSTOP FOR THE LAST TWO HOURS
- Document 10/07/21 2207 SH 10/07/21 2208 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: No
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT ABLE TO REPOSITION INDEPENDENTLY
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
33095 MED: Influenza/Pneumococcal vaccine ^ C 06,14,20 PS
INPT: Change status to Complete when the
assessment is complete.
OBS/SDC: Change direction to PRN and
leave active
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0602 BC 10/07/21 0606 BC
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/07/21 1400 BB 10/07/21 1705 BB
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/07/21 2000 SH 10/07/21 2207 SH
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
60675 MU: VTE ongoing assessment VTE - to be documented throughout the hospital stay & upon discharge. measures). Change status of intervention to complete once the LIP has completed this documentation.	^ C	06,10,18	PS										
- Create					10/07/21	0029	BC	10/07/21	0029	BC			
- Document					10/07/21	0602	BC	10/07/21	0606	BC			

*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.

- Document					10/07/21	1000	BB	10/07/21	1128	BB			

*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.

- Document					10/07/21	1800	BB	10/07/21	2026	BB			

*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
60675 MU: VTE ongoing assessment ^ (continued) If no, reason for discontinuing overlap therapy:													

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.

- Ed Status			A => C		10/07/21	2224	SH	10/07/21	2224	SH			
2520 Intake & Output	^ C	SHIFT END	PS										
- Create					10/07/21	0029	BC	10/07/21	0029	BC			
- Document					10/07/21	0600	KM	10/07/21	0658	KM			

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:	Y	TPN:		TF:	
PO:		Lipids:		TF/NG Flush:	
Supplement(s):		Packed RBC:		Cardiac Output flush:	
Parenteral:	97.0	Fresh Frozen Plasma:		Other #1:	
Propofol:		Albumin:		Other #2:	
Cleviprex:		Platelets:			
Chemotherapy:					

Comments:

Total Intake/8hr shift: 97

OUTPUT

Urine:	300	Chest Tube #2:		Autologous Reinfuser:	
# of Unmeasured Voids:	1	Chest Tube #3:		CSF:	
# of Bowel Movements:		Bile Drain:		Ultrafiltrate:	
Stool (liquid):		JP/Hemovac #1:		Other #1:	
Emesis:		JP/Hemovac #2:		Other #2:	
NG Tube:		JP/Hemovac #3:			
Chest Tube #1:		JP/Hemovac #4:			

Comments: LARGE MISSED VOID X1

Total Ouput/8hr shift: 300

- Document					10/07/21	1344	CT	10/07/21	1345	CT			

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:		TPN:		TF:	
PO:	450	Lipids:		TF/NG Flush:	
Supplement(s):		Packed RBC:		Cardiac Output flush:	
Parenteral:	98.0	Fresh Frozen Plasma:		Other #1:	
Propofol:		Albumin:		Other #2:	
Cleviprex:		Platelets:			
Chemotherapy:					

Comments:

Total Intake/8hr shift: 548

OUTPUT

Urine:		Chest Tube #2:		Autologous Reinfuser:	
# of Unmeasured Voids:	1	Chest Tube #3:		CSF:	
# of Bowel Movements:		Bile Drain:		Ultrafiltrate:	
Stool (liquid):		JP/Hemovac #1:		Other #1:	
Emesis:		JP/Hemovac #2:		Other #2:	
NG Tube:		JP/Hemovac #3:			

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

2520 Intake & Output ^ (continued)
Chest Tube #1: JP/Hemovac #4:
Comments: PT OUTPUT UNKNOWN D/T MISSED VOID.
Total Ouput/8hr shift: 0
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
60685 Sepsis Screening Tool ^ C PRN PS
Screening to be completed on:
1. All admitted patients
2. During rapid response
3. With change in condition
4. With transfer to new unit

Notify provider of any positive screening results

Provider determines the diagnosis and subsequent orders
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0133 BC 10/07/21 0135 BC
SEPSIS SCREENING TOOL

1. Is the patient's history suggestive of an infection? Y
**To view possible options to consider, use blue ? on tool bar or shift F8
2. SIRS - Systemic Inflammatory Response Syndrome
SIRS Criteria: Are any two of following signs & symptoms of infection both present AND NEW to the patient? N

Hyperthermia > 38 C (100.4F) or Hypothermia < 36 C (96.8F)?	N	T: 97.4	
Tachycardia > 90 beats per minute?	N	P: 59	
Tachypnea > 20 breaths per minute?	N	R: 18	
PaCO2 < 32mmHG?	N	PaCO2:	Date:
WBC < 4.0 x 1000 or > 12.0 x 1000 or Bands > 10%?	Y	WBC: 3.5	Date: 10/06/21 1212
		Bands:	Date:

3. Signs of Organ Dysfunction (excluding chronic conditions)
Are ANY of the following organ dysfunction criteria present? Y

Acute respiratory failure:			
- NEW non-invasive ventilation (BiPAP)?	Y		
- invasive ventilation?	N		
Urine output < 0.5 ml/kg/hour for > 2 hours?			
Systolic BP decrease > 40 mmHg from baseline?			
Systolic BP < 90 mmHg?	N	BP: 99/58	
MAP < 65 mmHg?	N	MAP: 71	
Bilirubin > 2 mg/dL?	N	Bilirubin: 0.3	Date: 10/06/21 1658
Platelet count < 100 x 1000?	N	Platelets: 149	Date: 10/06/21 1212

60685 Sepsis Screening Tool ^ (continued)

Lactate > 2 mmol/L?	N	Lactate:	Date:
Creatinine:			
- > 2.0 mg/dL?	N	Creatinine: 1.40	Date: 10/06/21 1211
- increase > 0.5 above baseline for CKD?			
Coagulopathy - for patients NOT on warfarin			
- INR > 1.5?	N	INR:	Date:
- aPTT > 60 secs?	N	APTT:	Date:

4. Mortality Screening: qSOFA = Quick Sepsis Organ-Related Failure Assessment
qSOFA score: How many of the following signs & symptoms are present? 1
Altered Mental Status?
Tachypnea > 22/min N qSOFA >= 2 is a positive score and
Systolic BP < 100 mmHg? Y reflects increased mortality risk

5. Screening suggestive of:

Infection	Y	
Sepsis	N	Infection + 2 SIRS Criteria
Severe Sepsis	N	Infection + 2 SIRS Criteria + 1 Organ Dysfunction Criteria
Septic Shock	N	Sepsis characterized by unresponsive hypotension and lactic acidosis (lactate > 2 mmol/L) requiring vasopressor therapy to maintain MAP > 65 mmHg despite adequate fluid resuscitation
Mortality Risk	N	qSOFA >= 2 reflects increased mortality risk

Comments:

RN: notify provider of any positive screening results, concerns or uncertainty
Provider determines the diagnosis and subsequent orders
If provider does not respond and patient deteriorates, call a Rapid Response
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
3127 SAFETY: Fall Risk Intervention- Adult ^ C 08,20 PS
Assessment to be completed BID & with condition change.
- Create 10/07/21 0029 BC 10/07/21 0029 BC
- Document 10/07/21 0128 BC 10/07/21 0128 BC
Fall Risk Interventions

Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y
Hourly rounding	Y	Toileting schedule	Y
Safe Exit Side	Y	Within Arms reach when toileting	Y
Call light within reach	Y	Patient Education/brochure	
Re-orientation	Y	Assistive device(s)	
Risk for Fall Care Plan	Y	Pharmacy review of medications	
Non-skid socks	Y	Bed in low position/wheels locked	Y
Hand off of fall risk status	Y	Free of clutter	Y
Gait Belt	Y	Call Don't Fall Poster	Y
Identify fall risk category or score		Bed close to nurse station	Y
1:1 in diagnostic/treatment areas		Yellow gown	Y
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair	
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3127 SAFETY: Fall Risk Intervention- Adult ^ (continued)
Additional Interventions*
- Document 10/07/21 0800 BB 10/07/21 1125 BB
Fall Risk Interventions

Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y
Hourly rounding	Y	Toileting schedule	Y
Safe Exit Side	Y	Within Arms reach when toileting	Y
Call light within reach	Y	Patient Education/brochure	Y
Re-orientation	Y	Assistive device(s)	
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y
Non-skid socks	Y	Bed in low position/wheels locked	Y
Hand off of fall risk status	Y	Free of clutter	Y
Gait Belt	Y	Call Don't Fall Poster	Y
Identify fall risk category or score	Y	Bed close to nurse station	Y
1:1 in diagnostic/treatment areas		Yellow gown	Y
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair	
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y

Additional Interventions*
- Document 10/07/21 2000 SH 10/07/21 2206 SH
Fall Risk Interventions

Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	
Hourly rounding	Y	Toileting schedule	Y
Safe Exit Side	Y	Within Arms reach when toileting	Y
Call light within reach	Y	Patient Education/brochure	Y
Re-orientation	Y	Assistive device(s)	
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y
Non-skid socks	Y	Bed in low position/wheels locked	Y
Hand off of fall risk status	Y	Free of clutter	Y
Gait Belt	Y	Call Don't Fall Poster	Y
Identify fall risk category or score		Bed close to nurse station	Y
1:1 in diagnostic/treatment areas		Yellow gown	Y
Fall Risk armband on (specific pts only)		Lap belt when in chair/wheelchair	
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y

Additional Interventions*
- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C
17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Create 10/07/21 0030 BC 10/07/21 0030 BC
- Document 10/07/21 0200 BC 10/07/21 0316 BC
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/07/21 0441 BC 10/07/21 0441 BC
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/07/21 0602 BC 10/07/21 0606 BC
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/07/21 0800 BB 10/07/21 1125 BB
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: SL/FLUSHED

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Ed Text 10/07/21 1126 BB 10/07/21 1126 BB
- Ed Directs 10/07/21 1126 BB 10/07/21 1126 BB 10/07 0030 Q2H => 10/07 0030 Q2H
10/07 0800 BID
- Document 10/07/21 2207 SH 10/07/21 2210 SH
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: SL/FLUSHED

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Ed Text 10/07/21 2342 LK 10/07/21 2342 LK
- Ed Directs 10/07/21 2342 LK 10/07/21 2342 LK 10/07 0030 Q2H => 10/07 0030 Q2H
10/07 0800 BID 10/07 0800 BID
10/08 0000 Q2H

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/08/21 0000 LK 10/08/21 0054 LK
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 0200 LK 10/08/21 0216 LK
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 0400 LK 10/08/21 0436 LK
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 0600 LK 10/08/21 0606 LK
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Y Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 0800 AM 10/08/21 0950 AM
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/08/21 1010 AM 10/08/21 1012 AM
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 1211 AM 10/08/21 1219 AM
Peripheral Site: Y Central Line Site: N

Document what applies
Peripheral site location: Left Antecubital IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 1418 AM 10/08/21 1423 AM
Peripheral Site: Y Central Line Site: Y

Document what applies
Peripheral site location: Left Antecubital IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 1615 AM 10/08/21 1636 AM
Peripheral Site: Y Central Line Site: Y

Document what applies
Peripheral site location: Left Antecubital IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued: Y
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: Left Brachial Artery IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 1821 AM 10/08/21 1822 AM
Peripheral Site: N Central Line Site: Y

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: Left Brachial Artery IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: both ports infusing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/08/21 2000 MP 10/08/21 2040 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/08/21 2200 MP 10/08/21 2247 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 0000 MP 10/09/21 0043 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 0200 MP 10/09/21 0210 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 0400 MP 10/09/21 0405 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patient: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patient: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/09/21 0600 MP 10/09/21 0618 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 0811 VW 10/09/21 0821 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 1011 VW 10/09/21 1013 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 1153 VW 10/09/21 1155 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 1411 VW 10/09/21 1434 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/09/21 1611 VW 10/09/21 1625 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 1800 VW 10/09/21 1801 VW
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 2000 MP 10/09/21 2128 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/09/21 2157 MP 10/09/21 2219 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/10/21 0000 MP 10/10/21 0041 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ C Q2H PS
Site Care due:10/12
IV Type: ANGIO
Site Location: LAC
Insertion date:10/7
- Document 10/10/21 0200 MP 10/10/21 0203 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/10/21 0400 MP 10/10/21 0404 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:
- Document 10/10/21 0556 MP 10/10/21 0556 MP
Peripheral Site: N Central Line Site: N

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Peripheral site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Attempts: Type: Size (gauge):
Site Care:
New tubing:
Cap change:
Discontinued:
Tip Intact at Removal?

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17028 IV: Peripheral/Acute Cen Line/Capped ^ (continued)
Comments:

Document what applies
Central line site location: IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: Triple lumen: Quad lumen:
Arterial percutaneous introducer sheath:
Venous percutaneous introducer sheath:
Pulmonary artery catheter:
Internal measurement (cm): Site care: Biopatch changed: New Tubing:
Cap change: Discontinued: Tip sent for culture:

Comments:

- Ed Status	10/10/21	0939	KRH	10/10/21	0939	KRH							A => C
118	PRI: Skin integrity, risk for impaired R/t illness &/or decreased activity			*70693003	D		CONT						PS
- Create	10/07/21	0032	BC	10/07/21	0032	BC							
139	PRI: Self-care deficit R/t: HOSPITALIZATION			*78629008	D		CONT						PS
- Create	10/07/21	0032	BC	10/07/21	0032	BC							
- Ed Text	10/09/21	0957	VW	10/09/21	0957	VW							
216	OUT: Free from complications - Hemodynamic stability - Free from infection - Activity progressing to baseline - Alert - Stable respiratory status - Tolerates diet - Absence of embolic event - Free from injury Target Date: 10/20/21				^ D		22						PS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Change

216 OUT: Free from complications ^ D 22 PS
- Create 10/07/21 0032 BC 10/07/21 0032 BC
- Document 10/07/21 2207 SH 10/07/21 2208 SH
Target Date: 10/10/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, progress to goal
Alert: Met
Stable respiratory status: Not met, progress to goal
Tolerates diet: Not met, progress to goal
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/08/21 2200 MP 10/08/21 2243 MP
Target Date: 10/10/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, progress to goal
Alert: Met
Stable respiratory status: Not met, progress to goal
Tolerates diet: Not met, no prog to goal
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Ed Text 10/09/21 0958 VW 10/09/21 0958 VW
- Document 10/09/21 2151 MP 10/09/21 2151 MP
Target Date: 10/12/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>

216 OUT: Free from complications ^ (continued)
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, progress to goal
Alert: Met
Stable respiratory status: Not met, progress to goal
Tolerates diet: Not met, progress to goal
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/10/21 2200 MP 10/10/21 2205 MP
Target Date: 10/12/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, progress to goal
Alert: Met
Stable respiratory status: Not met, progress to goal
Tolerates diet: Not met, progress to goal
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Target Date: 10/12/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, progress to goal
Alert: Met
Stable respiratory status: Not met, progress to goal
Tolerates diet: Not met, progress to goal

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

216 OUT: Free from complications ^ (continued)
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/12/21 2200 SH 10/12/21 2225 SH
Target Date: 10/14/21

Criteria can be viewed by clicking blue ? on toolbar or pressing shift <F8>
Hemodynamic stability: Not met, progress to goal
Free from infection: Not met, progress to goal
Tolerates activity: Not met, no prog to goal
Alert: Met
Stable respiratory status: Not met, no prog to goal
Tolerates diet: Not met, no prog to goal
Absence of embolic event: Not met, progress to goal
Free from injury: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
217 OUT: Increase strength & function ^ D 22 PS
of ADLs/activity
- decreased level of assist
- increased endurance
Target Date: 10/20/21
- Create 10/07/21 0032 BC 10/07/21 0032 BC
- Document 10/07/21 2207 SH 10/07/21 2208 SH
Target Date: 10/10/21
Decreased level of assist: Met
Increased endurance: Met

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

217 OUT: Increase strength & function ^ (continued)
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/08/21 2200 MP 10/08/21 2244 MP
Target Date: 10/10/21
Decreased level of assist: Not met, progress to goal
Increased endurance: Not met, progress to goal

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Ed Text 10/09/21 1000 VW 10/09/21 1000 VW
- Document 10/09/21 2151 MP 10/09/21 2151 MP
Target Date: 10/10/21
Decreased level of assist: Not met, progress to goal
Increased endurance: Not met, progress to goal

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/10/21 2200 MP 10/10/21 2206 MP
Target Date: 10/13/21
Decreased level of assist: Not met, progress to goal
Increased endurance: Not met, progress to goal

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Target Date: 10/13/21
Decreased level of assist: Not met, progress to goal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

217 OUT: Increase strength & function ^ (continued)
Increased endurance: Not met, progress to goal

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:
- Document 10/12/21 2200 SH 10/12/21 2225 SH
Target Date: 10/14/21
Decreased level of assist: Not met, progress to goal
Increased endurance: Not met, progress to goal

MET/NOT MET/NOT APPLICABLE
Additional criteria: :
Additional criteria: :
Additional criteria: :

**During Hospitalization: If any criteria changes from MET to NOT MET, enter comment.
**ON DISCHARGE: If ALL criteria have been met, change status to complete.
If ALL criteria have not been met, enter comment and leave status active.

Comments:

31705 EDUC: General education ^ D SHIFT END PS
-If multiple EDUC interventions present,
may change general education
intervention directions to PRN
- Create 10/07/21 0032 BC 10/07/21 0032 BC
- Document 10/07/21 0532 BC 10/07/21 0533 BC
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Patient Safety Handbook: Speak up: Role of family: Y Know your medications:
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

31705 EDUC: General education ^ (continued)

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/07/21 1400 BB 10/07/21 1704 BB
Topic: Orient to Unit: (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Code H: Identification bands: Patient Rounding: Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Pain Management: Non-pharmacological: Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Y Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Diet/Nutrition: Diet ordered: Y I&O: Y Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Y Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Y Other: INHALER USAGE

Learners, if other than patient: Family member

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Method: Verbal
Demonstrated
Learner Response/Outcome: Verbalizes understanding
Requires reinforcement

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/07/21 2207 SH 10/07/21 2211 SH
Topic: Orient to Unit: (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Refuses to receive info

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:
Learners, if other than patient:
Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:

31705 EDUC: General education ^ (continued)

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:

- Document 10/08/21 0436 LK 10/08/21 0440 LK

Topic: Orient to Unit: (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

31705 EDUC: General education ^ (continued)

Learner Response/Outcome: Verbalizes understanding

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: Y BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Edit Results 10/08/21 0436 LK 10/08/21 0441 LK
Learners, if other than patient: Family member []
Learner Response/Outcome: Requires reinforcement [Verbalizes understanding]
Continuous pulse oximetry: [Y]

31705 EDUC: General education ^ (continued)
Other: ALARMS ON IV PUMP []
Learners, if other than patient: Family member []
Learner Response/Outcome: Requires reinforcement [Verbalizes understanding]
- Document 10/08/21 1425 AM 10/08/21 1425 AM
Topic: Orient to Unit: N (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles: Bed mobility: Body mechanics: Exercise program: Cane: Crutches: Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Telemetry/monitors: IV pump: PCA/Epidural pumps: Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen: Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2: Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection: Immunosuppressed: Airborne isolation: Contact isolation: Droplet isolation: Latex isolation: Seizure precautions: Suicide prevention: Suicide crisis hotline: Peds security system: Bed alarm: Chair alarm: Door alarm: Floor alarm: Wanderguard: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile: Vanco-resistant enterococcus: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities: Recovery activities: Family waiting area: NPO status: IV therapy: Foley: Drains: DVT prevention: Activity status: Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/08/21 2200 MP 10/08/21 2323 MP
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient:

Method: Verbal

31705 EDUC: General education ^ (continued)

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Activity: Activity restrictions: Bedrest: Y Ambulation: Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Y Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:
Method: Verbal
Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:
Method: Verbal
Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Risk for infection:
Other:

Learners, if other than patient:
Method: Verbal
Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:
Method:
Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 0600 MP 10/09/21 0619 MP
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Y
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Risk for infection:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

31705 EDUC: General education ^ (continued)
Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 1411 VW 10/09/21 1435 VW
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Patient Safety Handbook: Speak up: Y Role of family: Y Know your medications: Y
Code H: Y Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

31705 EDUC: General education ^ (continued)

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 2152 MP 10/09/21 2155 MP
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: Y I&O: Y Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Y Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 0553 MP 10/10/21 0555 MP
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls,

31705 EDUC: General education ^ (continued)
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other:

Learners, if other than patient: Family member

Method: Verbal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Y Contact isolation: Y
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Topic: Orient to Unit: N (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Code H: Identification bands: Patient Rounding: Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales: Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles: Bed mobility: Body mechanics: Exercise program: Cane: Crutches: Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 2200 MP 10/10/21 2211 MP
Topic: Orient to Unit: N (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

31705 EDUC: General education ^ (continued)
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Y Contact isolation: Y
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:

31705 EDUC: General education ^ (continued)
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 0536 MP 10/11/21 0538 MP
Topic: Orient to Unit: (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Y
Code H: Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change

31705 EDUC: General education ^ (continued)
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Y Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Y Supplements: Fluid restriction:

31705 EDUC: General education ^ (continued)
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: Y PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Oxygen: Y
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Y Contact isolation: Y
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 1353 ES 10/11/21 1355 ES
Topic: Orient to Unit: N (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Patient Safety Handbook: Speak up: Y Role of family: Y Know your medications: Y
Code H: Y Identification bands: Y Patient Rounding: Y
Fall prevention: Y Pressure Ulcer prevention: Y
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease: COVID
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Pain Management: Non-pharmacological: Y Pharmacological: Y Pain Scales: Y
Notify staff of pain: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Activity: Activity restrictions: Bedrest: Y Ambulation: Y Reposition: Y
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:Y
Bed mobility: Y Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: Y I&O: Supplements: Fluid restriction: Y
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Y
Telemetry/monitors: Y IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Respiratory: Cough & deep breathe: Y Incentive spirometry: Y Oxygen: Y

31705 EDUC: General education ^ (continued)
Continuous pulse oximetry: Y BiPAP: Y CPAP: End Tidal CO2:
Respiratory treatments: Y Other: INHALER USAGE

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: IV: Purpose/procedure: Y Site care: Y Risk for infection:
Other: ALARMS ON IV PUMP

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Y Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Topic: Orient to Unit: N (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Telemetry/monitors: IV pump: PCA/Epidural pumps: Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen: Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2: Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:

31705 EDUC: General education ^ (continued)

Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection: Immunosuppressed: Airborne isolation: Contact isolation: Droplet isolation: Latex isolation: Seizure precautions: Suicide prevention: Suicide crisis hotline: Peds security system: Bed alarm: Chair alarm: Door alarm: Floor alarm: Wanderguard: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile: Vanco-resistant enterococcus: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities: Recovery activities: Family waiting area: NPO status: IV therapy: Foley: Drains: DVT prevention: Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments: POC UPDATED WITH FATHER VIA PHONE CALL THIS EVENING.

- Document 10/12/21 0513 CGR 10/12/21 0514 CGR

Topic: Orient to Unit: N (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Code H: Identification bands: Patient Rounding: Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales: Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Y Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles: Bed mobility: Body mechanics: Exercise program: Cane: Crutches: Walker: Traction: Other:

Learners, if other than patient:

Method: Demonstrated

Learner Response/Outcome: Requires reinforcement

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Telemetry/monitors: IV pump: PCA/Epidural pumps:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

31705 EDUC: General education ^ (continued)

Comments:
- Document 10/12/21 1400 HJM 10/12/21 1412 HJM

Topic: Orient to Unit: Y (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other: DIET, ACTIVITY, BIPAP-02 WEAN PROCESS, LABS, VS
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications: Code H: Identification bands: Patient Rounding: Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales: Notify staff of pain: Other:

Learners, if other than patient:

Method:

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition: Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles: Bed mobility: Body mechanics: Exercise program: Cane: Crutches: Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Telemetry/monitors: IV pump: PCA/Epidural pumps: Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen: Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2: Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls,
telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)
Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

31705 EDUC: General education ^ (continued)
Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

31705 EDUC: General education ^ (continued)
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

31705 EDUC: General education ^ (continued)
Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/13/21 0600 SH 10/13/21 0630 SH
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction:
Calorie count: TPN/Enteral feedings:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings:
Telemetry/monitors: IV pump: PCA/Epidural pumps:
Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen:
Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2:
Respiratory treatments: Other:

Learners, if other than patient:

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection:
Immunosuppressed: Airborne isolation: Contact isolation:
Droplet isolation: Latex isolation: Seizure precautions:
Suicide prevention: Suicide crisis hotline:
Peds security system: Bed alarm: Chair alarm:
Door alarm: Floor alarm: Wanderguard:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile:
Vanco-resistant enterococcus:
Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

31705 EDUC: General education ^ (continued)

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities:
Recovery activities: Family waiting area: NPO status:
IV therapy: Foley: Drains: DVT prevention:
Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Nicotine Cessation:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Discharge planning/home readiness:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
Topic: Orient to Unit: Y (includes unit routine, call light, bed controls, telephone, TV remote, visiting hours, visitor stay, bringing in food, use of refrigerator)
Other: DIET, ACTIVITY, BIPAP-O2 WEAN PROCESS, LABS, VS, NG, TUBE FEEDING
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

31705 EDUC: General education ^ (continued)

Topic: Patient Safety Handbook: Speak up: Role of family: Know your medications:
Code H: Identification bands: Patient Rounding:
Fall prevention: Pressure Ulcer prevention:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Hand hygiene:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Basic Anatomy & Disease:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pain Management: Non-pharmacological: Pharmacological: Pain Scales:
Notify staff of pain: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Activity: Activity restrictions: Bedrest: Ambulation: Reposition:
Weight-bearing status: Transfer training: Gait training: Ankle pumps/circles:
Bed mobility: Body mechanics: Exercise program: Cane: Crutches:
Walker: Traction: Other:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31705 EDUC: General education ^ (continued)

Learner Response/Outcome:

Topic: Diet/Nutrition: Diet ordered: I&O: Supplements: Fluid restriction: Calorie count: TPN/Enteral feedings: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Equipment: Ace wraps: Elastic stockings: Sequential stockings: Telemetry/monitors: IV pump: PCA/Epidural pumps: Tube feeding pump: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Respiratory: Cough & deep breathe: Incentive spirometry: Oxygen: Continuous pulse oximetry: BiPAP: CPAP: End Tidal CO2: Respiratory treatments: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: IV: Purpose/procedure: Site care: Risk for infection: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Procedures/tests: Glucose monitoring: Catheter insertion: Blood transfusion: Other:

Learners, if other than patient:

31705 EDUC: General education ^ (continued)

Method:

Learner Response/Outcome:

Topic: Safety/Precautions: Signs/symptoms of infection: Catheter related infection: Immunosuppressed: Airborne isolation: Contact isolation: Droplet isolation: Latex isolation: Seizure precautions: Suicide prevention: Suicide crisis hotline: Peds security system: Bed alarm: Chair alarm: Door alarm: Floor alarm: Wanderguard: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Multi-drug resistant organisms: MRSA: C-difficile: Vanco-resistant enterococcus: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Pre-op/Pre-procedure: Procedure: Prep: Intra-op activities: Recovery activities: Family waiting area: NPO status: IV therapy: Foley: Drains: DVT prevention: Activity status: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Topic: Other:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
31705 EDUC: General education	^	(continued)											
Topic: Nicotine Cessation:													
Learners, if other than patient:													
Method:													
Learner Response/Outcome:													
Topic: Discharge planning/home readiness:													
Learners, if other than patient:													
Method:													
Learner Response/Outcome:													
Comments:													
1725 ADL: Activity, bedrest	D	PRN	OE										
Provider order:													
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
2566 ADL: Activity, Proning -Trial 1 hour of awake prone positioning -If tolerated, encourage prone positioning 12-16 hours per day -If patient intubated, has a decline in condition, or cannot prone independently, contact LIP for patient specific proning orders	D	PRN	OE										
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
2535 ADL: Activity, chair	D	PRN	OE										
Provider order: -Up to chair for all meals -Up to chair for all meals													
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
515 Isolation Type:Contact	^ D	SHIFT	OE										
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
- Document					10/07/21	0100	BC	10/07/21	0204	BC			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/07/21	0800	BB	10/07/21	1124	BB			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/07/21	1600	BB	10/07/21	1900	BB			
Isolation precautions: AIR													
Reason for Isolation: COVID													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
515 Isolation Type:Contact	^ D	SHIFT	OE										
- Document					10/07/21	2339	LK	10/07/21	2339	LK			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/08/21	0815	AM	10/08/21	0948	AM			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/08/21	1608	AM	10/08/21	1608	AM			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	0100	MP	10/09/21	0109	MP			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	0811	VW	10/09/21	0817	VW			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	1611	VW	10/09/21	1622	VW			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/10/21	0052	MP	10/10/21	0052	MP			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/10/21	0800	KRH	10/10/21	0936	KRH			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/10/21	1525	MMG	10/10/21	1525	MMG			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/11/21	0027	MP	10/11/21	0027	MP			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/11/21	0728	ES	10/11/21	0728	ES			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/11/21	1514	ES	10/11/21	1514	ES			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/12/21	0006	CGR	10/12/21	0059	CGR			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/12/21	0800	HJM	10/12/21	0856	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/12/21	1528	HJM	10/12/21	1528	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/13/21	0112	BV	10/13/21	0112	BV			
Isolation precautions: CON													
Reason for Isolation: COVID													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
515 Isolation Type:Contact	^	D	SHIFT										OE
- Document					10/13/21	0802	HJM	10/13/21	0807	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/13/21	1600	HJM	10/13/21	1612	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
515 Isolation Type:Airborne	^	D	SHIFT										OE
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
- Document					10/07/21	0100	BC	10/07/21	0205	BC			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/07/21	0800	BB	10/07/21	1124	BB			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/07/21	1600	BB	10/07/21	1900	BB			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/07/21	2339	LK	10/07/21	2339	LK			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Ed Text					10/08/21	0249	LK	10/08/21	0250	LK			
- Document					10/08/21	0815	AM	10/08/21	0948	AM			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/08/21	1608	AM	10/08/21	1608	AM			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	0100	MP	10/09/21	0110	MP			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	0811	VW	10/09/21	0817	VW			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/09/21	1611	VW	10/09/21	1622	VW			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/10/21	0052	MP	10/10/21	0052	MP			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/10/21	0800	KRH	10/10/21	0936	KRH			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/10/21	1525	MMG	10/10/21	1525	MMG			
Isolation precautions: AIR													
Reason for Isolation: COVID													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
515 Isolation Type:Airborne	^	D	SHIFT										OE
- Document					10/11/21	0027	MP	10/11/21	0028	MP			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/11/21	0728	ES	10/11/21	0728	ES			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/11/21	1514	ES	10/11/21	1514	ES			
Isolation precautions: AIR													
Reason for Isolation: COVID													
- Document					10/12/21	0006	CGR	10/12/21	0059	CGR			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/12/21	0800	HJM	10/12/21	0856	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/12/21	1528	HJM	10/12/21	1528	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/13/21	0112	BV	10/13/21	0112	BV			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/13/21	0802	HJM	10/13/21	0807	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
- Document					10/13/21	1600	HJM	10/13/21	1612	HJM			
Isolation precautions: CON													
Reason for Isolation: COVID													
2551 Vital Signs (VS)	^	C	Q4H*										OE
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
- Document					10/07/21	0413	KM	10/07/21	0415	KM			
P 68 R													
SPO2%: 97 Oxygen (LPM): Oxygen (%):													
FiO2 (%): PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?													
Resp Quality:													
RASS Scale (ICU patients)													
Position:													
BP MAP: BP#2: MAP:													
Extremity: Extremity:													
Mode: Mode:													
T (degrees F) T (degrees C) Route:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: COULD NOT OBTAIN FULL SET OF VITALS DUE TO PT
FATHER GETTING UPSET ABOUT TRYING TO WAKE PT UP.
NURSE AND DOCTOR AWARE.

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/07/21 0800 CT 10/07/21 0840 CT
P 77 R 25
SPO2%: 99 Oxygen (LPM): Oxygen (%):
FiO2 (%): 70 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 96/50 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.5 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:

2551 Vital Signs (VS) ^ (continued)

PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/07/21 1200 CT 10/07/21 1229 CT
P 95 R 24
SPO2%: 96 Oxygen (LPM): 20.0 Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: High Flow/Vapotherm

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 100/57 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.6 (degrees F) T (degrees C) Route: Oral

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ (continued)

CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/07/21 1600 CT 10/07/21 1715 CT
P 112 R 24
SPO2%: 90 Oxygen (LPM): 40.0 Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: High Flow/Vapotherm

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 128/69 MAP: 90 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.7 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ (continued)

PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/07/21 2142 MM 10/07/21 2143 MM
P 144 R 47
SPO2%: 97 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Shallow

RASS Scale (ICU patients)

Position: Lying
BP 130/62 MAP: 77 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2551 Vital Signs (VS) ^ (continued)
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C

9015 CV: Telemetry, monitor as ordered ^ C SHIFT END OE
Change patches daily with bath.
RN to document at end of shift.

- Create 10/07/21 0057 DB 10/07/21 0057 DB
- Document 10/07/21 0602 BC 10/07/21 0604 BC

Rhythm Interpretation/Telemetry Tech report: sr 60-70

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:

- Document 10/07/21 1400 BB 10/07/21 1701 BB

Rhythm Interpretation/Telemetry Tech report: SR/ST 96-111

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:

- Document 10/07/21 2212 SH 10/07/21 2212 SH

Rhythm Interpretation/Telemetry Tech report: ST 120-150S

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

9015 CV: Telemetry, monitor as ordered ^ (continued)
Comments:

- Ed Status 10/07/21 2224 SH 10/07/21 2224 SH A => C

11011 RESP: Pulse Oximetry D CONT OE
Provider order:
Oximetry:

Document on vital sign intervention

- Create 10/07/21 0057 DB 10/07/21 0057 DB

11011 RESP: Pulse Oximetry D PER ORDERS OE
Provider order: Maintain SaO2 above 92%
Oximetry: Maintain SaO2 above 92%

Document on vital sign intervention

- Create 10/07/21 0057 DB 10/07/21 0057 DB

11015 RESP: Cough & Deep Breathe ^ D Q2HWA OE

- Create 10/07/21 0057 DB 10/07/21 0057 DB
- Document 10/07/21 0602 BC 10/07/21 0605 BC

Cough & deep breathe: Yes
Comments: FREQ COUGH

- Document 10/07/21 0800 CT 10/07/21 0841 CT

Cough & deep breathe: Yes
Comments: ENCOURAGED

- Document 10/07/21 1000 CT 10/07/21 1132 CT

Cough & deep breathe: Yes
Comments: ENCOURAGED

- Document 10/07/21 1157 CT 10/07/21 1158 CT

Cough & deep breathe: Yes
Comments: WITNESSED

- Document 10/07/21 1344 CT 10/07/21 1346 CT

Cough & deep breathe: Yes
Comments: ENCOURAGED AND COMPLETED

- Document 10/07/21 1558 CT 10/07/21 1601 CT

Cough & deep breathe: Yes
Comments: ENCOURAGED AND COMPLETED

- Document 10/07/21 1800 CT 10/07/21 1841 CT

Cough & deep breathe: Yes
Comments: ENCOURAGED AND COMPLETED

- Document 10/07/21 2000 SH 10/07/21 2207 SH

Cough & deep breathe: Yes
Comments: SPONTANEOUSLY

- Document 10/07/21 2207 SH 10/07/21 2210 SH

Cough & deep breathe: Yes
Comments: SPONTANEOUSLY

- Document 10/08/21 0600 LK 10/08/21 0606 LK

Cough & deep breathe: Yes
Comments: SPONTANEOUSLY

- Document 10/08/21 0815 AM 10/08/21 0950 AM

Cough & deep breathe: Yes
Comments: SPONTANIOUS

Intervention Description	Sts	Direction	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
11015 RESP: Cough & Deep Breathe							^ D Q2HWA		OE
- Document	10/08/21	1010	AM	10/08/21	1011	AM			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/08/21	1211	AM	10/08/21	1219	AM			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/08/21	1418	AM	10/08/21	1422	AM			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/08/21	1615	AM	10/08/21	1633	AM			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/08/21	1817	FD	10/08/21	1818	FD			
Cough & deep breathe:									
Comments: SPONTANIOUS									
- Document	10/08/21	2000	MP	10/08/21	2038	MP			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/08/21	2200	MP	10/08/21	2246	MP			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/09/21	0600	MP	10/09/21	0617	MP			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/09/21	0811	VW	10/09/21	0821	VW			
Cough & deep breathe: Yes									
Comments:									
- Document	10/09/21	1011	VW	10/09/21	1013	VW			
Cough & deep breathe: Yes									
Comments:									
- Document	10/09/21	1153	VW	10/09/21	1155	VW			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/09/21	1411	VW	10/09/21	1434	VW			
Cough & deep breathe: Yes									
Comments:									
- Document	10/09/21	1611	VW	10/09/21	1624	VW			
Cough & deep breathe: Yes									
Comments:									
- Document	10/09/21	1800	VW	10/09/21	1801	VW			
Cough & deep breathe: Yes									
Comments:									
- Document	10/09/21	2000	MP	10/09/21	2128	MP			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/09/21	2157	MP	10/09/21	2219	MP			
Cough & deep breathe: Yes									
Comments: SPONTANIOUS									
- Document	10/10/21	0556	MP	10/10/21	0556	MP			
Cough & deep breathe: Yes									

Intervention Description	Sts	Direction	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
11015 RESP: Cough & Deep Breathe							^ (continued)		
Comments: SPONTANIOUS									
- Document	10/10/21	0800	KRH	10/10/21	0938	KRH			
Cough & deep breathe: Yes									
Comments:									
- Document	10/10/21	1000	KRH	10/10/21	1024	KRH			
Cough & deep breathe: No									
Comments:									
- Document	10/10/21	1230	KRH	10/10/21	1320	KRH			
Cough & deep breathe: Yes									
Comments: OCC COUGING FITS WITH MOVEMENT, RESOLVES									
- Document	10/10/21	1400	KRH	10/10/21	1418	KRH			
Cough & deep breathe: No									
Comments:									
- Document	10/10/21	1606	KRH	10/10/21	1616	KRH			
Cough & deep breathe: No									
Comments:									
- Document	10/10/21	1800	KRH	10/10/21	1809	KRH			
Cough & deep breathe: Yes									
Comments:									
- Document	10/10/21	2000	MP	10/10/21	2048	MP			
Cough & deep breathe: Yes									
Comments: OCC COUGING FITS WITH MOVEMENT, RESOLVES									
- Document	10/10/21	2200	MP	10/10/21	2209	MP			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	0548	MP	10/11/21	0548	MP			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	0800	ES	10/11/21	0842	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1003	ES	10/11/21	1004	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1157	ES	10/11/21	1158	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1353	ES	10/11/21	1354	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1600	ES	10/11/21	1633	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1742	ES	10/11/21	1742	ES			
Cough & deep breathe: Yes									
Comments: SPONTANEOUS									
- Document	10/11/21	1952	CGR	10/11/21	2000	CGR			
Cough & deep breathe: Yes									
Comments:									

Intervention Description	Sts	Direction	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11015 RESP: Cough & Deep Breathe ^ D Q2HWA OE
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Cough & deep breathe:
Comments: SPONTANEOUS
- Document 10/12/21 0513 CGR 10/12/21 0513 CGR
Cough & deep breathe: Yes
Comments:
- Document 10/12/21 0800 HJM 10/12/21 0858 HJM
Cough & deep breathe: Yes
Comments:
- Document 10/12/21 0940 KS 10/12/21 0940 KS
Cough & deep breathe: Yes
Comments:
- Ed Status 10/12/21 1132 HJM 10/12/21 1132 HJM A => H

11012 RESP: Incentive Spirometry ^ D Q1HWA OE
Incentive Spirometry Date/Goal:
- Create 10/07/21 0057 DB 10/07/21 0057 DB
- Document 10/07/21 0602 BC 10/07/21 0605 BC
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping: Y

Comments: ENCOURAGE
- Document 10/07/21 0700 BC 10/07/21 0701 BC
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: BIPAP DEPENDENT
- Document 10/07/21 0701 KM 10/07/21 0701 KM
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: PT RESTING AT THIS TIME
- Document 10/07/21 0800 CT 10/07/21 0841 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: BIPAP IN PLACE
- Document 10/07/21 0900 CT 10/07/21 0921 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

11012 RESP: Incentive Spirometry ^ (continued)
Comments: TOLERATING VAPOTHERM, WILL ENCOURAGE AFTER MEAL
- Document 10/07/21 1000 CT 10/07/21 1131 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1100 CT 10/07/21 1132 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1157 CT 10/07/21 1158 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1301 CT 10/07/21 1302 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1344 CT 10/07/21 1346 CT
Incentive spirometry volume achieved (ml):
Independent: N
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1456 CT 10/07/21 1456 CT
Incentive spirometry volume achieved (ml):
Independent:
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE
- Document 10/07/21 1558 CT 10/07/21 1601 CT
Incentive spirometry volume achieved (ml):
Independent: N
Refused:
Sleeping:

Comments: TOLERATING VAPOTHERM, NOT COMPLETE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/07/21	1700	CT	10/07/21	1711	CT			
Incentive spirometry volume achieved (ml):													
Independent: N													
Refused:													
Sleeping:													
Comments: TOLERATING VAPOTHERM, NOT COMPLETE													
- Document					10/07/21	1800	CT	10/07/21	1841	CT			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													
- Document					10/07/21	1841	CT	10/07/21	1841	CT			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													
- Document					10/07/21	2000	KM	10/07/21	2039	KM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													
- Document					10/07/21	2100	SH	10/07/21	2211	SH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													
- Document					10/07/21	2207	SH	10/07/21	2209	SH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													
- Document					10/07/21	2207	SH	10/07/21	2209	SH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP IN PLACE													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/08/21	0600	LK	10/08/21	0606	LK			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/08/21	0655	LK	10/08/21	0657	LK			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/08/21	0815	AM	10/08/21	0950	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	0900	AM	10/08/21	1000	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1010	AM	10/08/21	1011	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1100	AM	10/08/21	1154	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1211	AM	10/08/21	1219	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/08/21	1310	AM	10/08/21	1311	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1418	AM	10/08/21	1422	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1509	FD	10/08/21	1510	FD			
Incentive spirometry volume achieved (ml):													
Independent: N													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1615	AM	10/08/21	1633	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1711	AM	10/08/21	1711	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1817	FD	10/08/21	1818	FD			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	1841	AM	10/08/21	1842	AM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/08/21	2000	MP	10/08/21	2038	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	2100	MP	10/08/21	2113	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments: BIPAP DEPENDENT													
- Document					10/08/21	2200	MP	10/08/21	2246	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	0600	MP	10/09/21	0617	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused: Y													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	0654	MP	10/09/21	0654	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused: Y													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	0811	VW	10/09/21	0821	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	0911	VW	10/09/21	0938	VW			
Incentive spirometry volume achieved (ml):													
Independent: N													
Refused:													
Sleeping:													
Comments:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/09/21	1011	VW	10/09/21	1013	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1111	VW	10/09/21	1131	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1153	VW	10/09/21	1155	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:											Y		
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1314	VW	10/09/21	1315	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1411	VW	10/09/21	1434	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:											Y		
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1511	VW	10/09/21	1538	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1611	VW	10/09/21	1624	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/09/21	1656	VW	10/09/21	1657	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1800	VW	10/09/21	1801	VW			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	1900	EF	10/09/21	2005	EF			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	2000	MP	10/09/21	2128	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:											Y		
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	2100	MP	10/09/21	2130	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/09/21	2157	MP	10/09/21	2219	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													
- Document					10/10/21	0556	MP	10/10/21	0556	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/10/21	0653	MP	10/10/21	0653	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments: BIPAP DEPENDENT													
- Document					10/10/21	0800	KRH	10/10/21	0938	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/10/21	0900	KRH	10/10/21	0940	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/10/21	1000	KRH	10/10/21	1024	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/10/21	1100	KRH	10/10/21	1124	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/10/21	1230	KRH	10/10/21	1320	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/10/21	1300	KRH	10/10/21	1321	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/10/21	1400	KRH	10/10/21	1418	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT, proned													
- Document					10/10/21	1512	KRH	10/10/21	1513	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT, PRONED													
- Document					10/10/21	1606	KRH	10/10/21	1616	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT, PRONED													
- Document					10/10/21	1700	KRH	10/10/21	1807	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/10/21	1800	KRH	10/10/21	1809	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/10/21	1909	KRH	10/10/21	1909	KRH			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/10/21	2000	MP	10/10/21	2046	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused: Y													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/10/21	2057	MP	10/10/21	2057	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/10/21	2200	MP	10/10/21	2209	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/11/21	0547	MP	10/11/21	0548	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused: Y													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	0652	MP	10/11/21	0652	MP			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping: Y													
Comments:													
- Document					10/11/21	0800	ES	10/11/21	0842	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	0851	ES	10/11/21	0851	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1003	ES	10/11/21	1004	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/11/21	1052	ES	10/11/21	1053	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1157	ES	10/11/21	1158	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1302	ES	10/11/21	1303	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1353	ES	10/11/21	1354	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1500	ES	10/11/21	1512	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1600	ES	10/11/21	1633	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1643	ES	10/11/21	1643	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/11/21	1800	ES	10/11/21	1832	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1906	ES	10/11/21	1907	ES			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	1952	CGR	10/11/21	2000	CGR			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	2119	RS	10/11/21	2119	RS			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/11/21	2138	CGR	10/11/21	2138	CGR			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/12/21	0515	CGR	10/12/21	0515	CGR			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Document					10/12/21	0654	CGR	10/12/21	0654	CGR			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
11012 RESP: Incentive Spirometry	^	D	Q1HWA										OE
Incentive Spirometry Date/Goal:													
- Document					10/12/21	0800	HJM	10/12/21	0858	HJM			
Incentive spirometry volume achieved (ml):													
Independent:													
Refused:													
Sleeping:													
Comments: NOT PERFORMED - BIPAP DEPENDENT													
- Ed Status					10/12/21	0900	HJM	10/12/21	0900	HJM			A => H
2559 Weight	^	C	ON ADMISSION										OE
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
- Ed Status					10/07/21	2224	SH	10/07/21	2224	SH			A => C
4031 SAFETY: Precautions		D	PER ORDERS										OE
Provider order: Follow protocol for Airborne Respiratory Precautions during and after any Aerosol Generating Procedure													
Follow protocol for Airborne Respiratory Precautions during and after any Aerosol Generating Procedure													
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
27390 Notify MD		D	PRN										OE
Provider order:													
Notify LIP:													
-T > 38 or < 36													
-HR > 120 or < 55													
-SBP > 170 or < 100													
-DBP > 120 or < 60													
-MAP < 60													
-RR > 25 or < 12													
-O2 sat < 92													
-UO < 240													
-If oxygen requirements above 6 liters per minute required to maintain goal SpO2													
- Create					10/07/21	0057	DB	10/07/21	0057	DB			
35005 DISCHARGE: Plan/Instructions		D	PRN										OE
Provider order:													
Specify: Patient education COVID+ Discharge Home. If patient positive AND after patient informed of positive diagnosis by provider.													
- Create					10/07/21	0057	DB	10/07/21	0057	DB			

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ D Q2H OE
Placement: **F9 To View Options**
Provider order:
When not ambulating

Remove and inspect skin surfaces twice
daily. Check tubing position & skin
irritation every 2hrs.
Type:

- Create 10/07/21 0057 DB 10/07/21 0057 DB
- Document 10/07/21 0200 BC 10/07/21 0316 BC
Athrombic pump: Y
On: N Refused:
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: PT SLEEPING, UP ADLIB
- Document 10/07/21 0406 KM 10/07/21 0407 KM
Athrombic pump: Y
On: N Refused:
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: PT SLEEPING, UP ADLIB
- Document 10/07/21 0602 BC 10/07/21 0605 BC
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/07/21 0800 CT 10/07/21 0841 CT
Athrombic pump: Y
On: N Refused: Y
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/07/21 1000 CT 10/07/21 1131 CT
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral

9176 CV: Athrombic Pump/SCDs ^ (continued)
Time off:
Time on:

Comments:
- Document 10/07/21 1157 CT 10/07/21 1158 CT
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/07/21 1344 CT 10/07/21 1346 CT
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/07/21 1558 CT 10/07/21 1600 CT
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/07/21 1800 CT 10/07/21 1840 CT
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: PT UP TO BATHROOM, WILL REAPPLY AT BEDTIME
- Document 10/07/21 2000 SH 10/07/21 2206 SH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR SAFETY. PATIENT IS CURRENTLY NON-
COOPERATIVE AND MOVING AROUND

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
9176 CV: Athrombic Pump/SCDs When not ambulating Remove and inspect skin surfaces twice daily. Check tubing position & skin irritation every 2hrs. Type:	^	D	Q2H										OE

- Document 10/07/21 2207 SH 10/07/21 2209 SH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR SAFETY. PATIENT IS CURRENTLY NON-COOPERATIVE AND MOVING AROUND

- Document 10/08/21 0000 LK 10/08/21 0054 LK
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR SAFETY. PATIENT IS CURRENTLY NON-COOPERATIVE AND MOVING AROUND

- Document 10/08/21 0200 LK 10/08/21 0216 LK
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR SAFETY. PATIENT IS CURRENTLY NON-COOPERATIVE AND MOVING AROUND

- Document 10/08/21 0400 LK 10/08/21 0436 LK
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

- Document 10/08/21 0600 LK 10/08/21 0605 LK
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
9176 CV: Athrombic Pump/SCDs (continued)	^												

Time off:
Time on:

Comments:

- Document 10/08/21 0815 AM 10/08/21 0949 AM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

- Document 10/08/21 1010 AM 10/08/21 1011 AM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

- Document 10/08/21 1211 AM 10/08/21 1219 AM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

- Document 10/08/21 1418 AM 10/08/21 1422 AM
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

- Document 10/08/21 1615 AM 10/08/21 1633 AM
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
9176 CV: Athrombic Pump/SCDs When not ambulating Remove and inspect skin surfaces twice daily. Check tubing position & skin irritation every 2hrs. Type:	^	D	Q2H										OE

- Document 10/08/21 1817 FD 10/08/21 1818 FD
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/08/21 2000 MP 10/08/21 2037 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/08/21 2200 MP 10/08/21 2246 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/09/21 0000 MP 10/09/21 0042 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/09/21 0200 MP 10/09/21 0210 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
9176 CV: Athrombic Pump/SCDs (continued)	^												

Comments:
- Document 10/09/21 0400 MP 10/09/21 0405 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/09/21 0600 MP 10/09/21 0617 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/09/21 0811 VW 10/09/21 0821 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 1011 VW 10/09/21 1012 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 1153 VW 10/09/21 1155 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 1411 VW 10/09/21 1434 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 1611 VW 10/09/21 1624 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 1800 VW 10/09/21 1801 VW
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on: 0600

Comments:
- Document 10/09/21 2000 MP 10/09/21 2127 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/09/21 2157 MP 10/09/21 2219 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 0000 MP 10/10/21 0040 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ D Q2H OE
When not ambulating

Remove and inspect skin surfaces twice daily. Check tubing position & skin irritation every 2hrs.
Type:
- Document 10/10/21 0200 MP 10/10/21 0203 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 0400 MP 10/10/21 0404 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 0556 MP 10/10/21 0556 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 0800 KRH 10/10/21 0938 KRH
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 1000 KRH 10/10/21 1024 KRH
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)
Comments:
- Document 10/10/21 1230 KRH 10/10/21 1319 KRH
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Athrombic pump: Y
On: N Refused:
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 1800 KRH 10/10/21 1809 KRH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/10/21 2000 MP 10/10/21 2046 MP
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Edit Results 10/10/21 2000 MP 10/10/21 2212 MP
On: Y [N]
- Document 10/10/21 2200 MP 10/10/21 2208 MP
Athrombic pump: Y

9176 CV: Athrombic Pump/SCDs ^ (continued)
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Edit Results 10/10/21 2200 MP 10/10/21 2211 MP
On: Y [N]
- Document 10/11/21 0000 MP 10/11/21 0013 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 0200 MP 10/11/21 0205 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 0400 MP 10/11/21 0416 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 0550 MP 10/11/21 0550 MP
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 0800 ES 10/11/21 0842 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)
Time off: 0800
Time on: 0805

Comments:
- Document 10/11/21 1003 ES 10/11/21 1004 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 1157 ES 10/11/21 1158 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 1600 ES 10/11/21 1633 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 1800 ES 10/11/21 1832 ES
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:

9176 CV: Athrombic Pump/SCDs ^ D Q2H OE
When not ambulating

Remove and inspect skin surfaces twice daily. Check tubing position & skin irritation every 2hrs.
Type:
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Athrombic pump: Y
On: N Refused: Y
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/12/21 0006 CGR 10/12/21 0101 CGR
Athrombic pump: Y
On: N Refused: Y
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/12/21 0152 CGR 10/12/21 0153 CGR
Athrombic pump: Y
On: N Refused: Y
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)

Comments:
- Document 10/12/21 0551 CGR 10/12/21 0552 CGR
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/12/21 0800 HJM 10/12/21 0858 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off: 0745
Time on: 0800

Comments:
- Document 10/12/21 0940 KS 10/12/21 0940 KS
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments:
- Document 10/12/21 1130 HJM 10/12/21 1130 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off: 1120
Time on: 1130

Comments:
- Document 10/12/21 1400 HJM 10/12/21 1410 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/12/21 1529 HJM 10/12/21 1529 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)

Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/12/21 1800 HJM 10/12/21 1831 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/12/21 2000 BV 10/12/21 2056 BV
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR SAFETY. PATIENT IS CURRENTLY NON-
COOPERATIVE AND MOVING AROUND
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 0000 SH 10/13/21 0024 SH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 0200 SH 10/13/21 0239 SH
Athrombic pump: Y
On: N Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

9176 CV: Athrombic Pump/SCDs ^ (continued)
Comments:
- Document 10/13/21 0401 BV 10/13/21 0401 BV
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 0600 SH 10/13/21 0629 SH
Athrombic pump: Y
On: Y Refused: N
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 0802 HJM 10/13/21 0809 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off: 0750
Time on: 0800

Comments:
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 1405 HJM 10/13/21 1405 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N

9176 CV: Athrombic Pump/SCDs ^ (continued)
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
Athrombic pump: Y
On: Y Refused:
Tubing in proper position: Y Skin irritation noted: N
Specify Type: Knee Lower Extremity: Bilateral
Time off:
Time on:

Comments:
- Document 10/13/21 1805 HJM 10/13/21 1806 HJM
Athrombic pump: Y
On: N Refused:
Tubing in proper position: Skin irritation noted:
Specify Type: Lower Extremity:
Time off:
Time on:

Comments: OFF FOR BREAK
27396 Notify Provider To Consult D PRN OE
- Create 10/07/21 0057 DB 10/07/21 0057 DB
29063 ADM: Part A - Adult Admission Intake ^ D ON ADMISSION AS
- Create 10/07/21 0113 BC 10/07/21 0123 BC
- Document 10/07/21 0113 BC 10/07/21 0123 BC
Adult Admission Intake Assessment

Ht-Ft: 4 In: 8 Cm:
Wt-Lbs: 185 Kg: 84 BMI:

Patient admitted from: Emergency Department
Name of Transfer/Other Facility:
Reason for Visit: COVID

Information obtained from:
Unable to Obtain Info Due To:
Do you want family notified of your admission?
Name of person notified:
Do you want your primary care provider notified of your admission? Y
List name/method of contact: DR NORDSTROM AT ST ELIZABETHS
Primary Support Person(s): SCOTT - DAD

Patient's preferred name:

Do you think of yourself as:
Describe other sexual orientation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)

What is your current gender identity:
Describe other gender identity:

Preferred communication method:
Preferred written language for discussing healthcare: English eng
Preferred verbal language for discussing healthcare: English eng
Is interpretation needed:
Interpreter Services Declined Reason:

Sensory Deficits:	Sensory Devices Needed:	Sensory Devices At Bedside:
Vision Impaired	Glasses	Glasses

Surgical and Hospitalization Hx: NO
[Pertinent &/or within the last year]

Implanted or Applied Medical Device: None

Enrolled in clinical trial: No
Type:
Other:

Enrolled in Palliative Care: N

Advance Directives: NA
Would you like additional information about AD:
Location:

Travel Associated Infectious Disease Screen:
Have you traveled recently: No
Where:

Do you have any of the following symptoms? Cough
Fatigue
Fever
Respiratory Illness
Shortness of Breath
Weakness

General Infectious Disease Screen:
Have you been exposed to someone with a suspected infectious disease within the past 3 weeks: Yes
(i.e. Tuberculosis (TB), Ebola, Influenza, Pertussis, Measles, Mumps, Chicken Pox, etc.)
If Yes, what disease have you recently been exposed to: COVID

Communicable Disease History:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)

CDIFF: N
MRSA: N
MDRO (Multi-Drug Resistant Organism): N
VRE (Vancomycin-Resistant Enterococcus): N
CRE (Carbapenem-Resistant Enterobacteriaceae): N

If BOTH active infection that cannot be contained by dressing AND if Hx of MRSA, VRE or MDRO then initiate Contact Precautions. If patient has a history of or an active infection of CRE then initiate Contact Precautions for every admission

Influenza Vaccine Date (Mo/Yr): N
Tetanus Date:

COVID-19 Vaccine
Vaccine #1 Received: N Date:
Vaccine #2 Received: Date:
Vaccine #3 Received: Date:
Vaccine Booster Received: Date:
Vaccine Manufacturer:

Is pt pregnant? NO Lactating:

Malnutrition Screening Tool [MST]

Have you lost weight recently WITHOUT trying: No

Have you been eating poorly b/c of decreased appetite: No
Malnutrition Screening Tool (MST) Score: 0
Risk: Not at risk
MST of 0-1 = Not at Risk MST of 2 or more = At Risk

Tobacco Use:	Tobacco Type:	Patient age 13 & older: Smoker status:
No		

Smokeless Tobacco Use:	Smokeless Tobacco Type:	Smokeless Tobacco Frequency:
No		

E-Cig/Vape Use:	E-Cig/Vape Type:	E-Cig/Vape Frequency:
No		

Substance Use:	Substance Type:	Substance Frequency:
No		

Alcohol Use:	Alcohol Type:	Alcohol Frequency:
No		

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)

Pt feels they are/have been abused, neglected, or exploited:
** Columbia Suicide Severity Rating Scale (C-SSRS) ** [SHIFT F8] for reference text
Begin questions 1-5 with: 'In the past month...' (If asking caregiver, reframe question)
****Patients 12 and up:
1. Wish to be Dead: Have you wished you were dead or wished you could go to sleep and not wake up?
2. Suicidal Thoughts: Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6
3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Have you been thinking about how you might do this?
4. Suicidal Intent (without Specific Plan): Have you had some intention of acting on them?
5. Suicidal Intent with Specific Plan: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Suicidal Behavior Lifetime Question
a. Have you ever done anything, started to do anything or prepared to do anything to end your life?
b. If 6a = Yes, was this in the past 3 months?

C-SSRS Score :
[SHIFT F8] for reference based on score
Religious preference: Religious restrictions:

Spiritual/cultural concerns or practices: Describe:
Support system in place:

Learning style preferred by patient:

Barriers to learning:

Patient's Discharge Goal:

Pt would like to speak to someone regarding concerns /services:
Community Agencies being used:

Advised to send valuables home w/family:

Intake reviewed for accuracy & completion this admission?
- Document 10/07/21 0305 BC 10/07/21 0306 BC
Adult Admission Intake Assessment

Ht-Ft: 4 In: 8 Cm:
Wt-Lbs: 185 Kg: 84 BMI: .00

Patient admitted from: Emergency Department
Name of Transfer/Other Facility:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)
Reason for Visit: COVID

Information obtained from:
Unable to Obtain Info Due To:
Do you want family notified of your admission?
Name of person notified:
Do you want your primary care provider notified of your admission? Y
List name/method of contact: DR NORDSTROM AT ST ELIZABETHS
Primary Support Person(s): SCOTT - DAD

Patient's preferred name:

Do you think of yourself as:
Describe other sexual orientation:
What is your current gender identity?
Describe other gender identity:

Preferred communication method:
Preferred written language for discussing healthcare: English eng
Preferred verbal language for discussing healthcare: English eng
Is interpretation needed?
Interpreter Services Declined Reason:

Sensory Deficits:	Sensory Devices Needed:	Sensory Devices At Bedside:
Vision Impaired	Glasses	Glasses

Surgical and Hospitalization Hx: NO
[Pertinent &/or within the last year]

Implanted or Applied Medical Device: None

Enrolled in clinical trial: No
Type:
Other:

Enrolled in Palliative Care: N

Advance Directives: NA
Would you like additional information about AD:
Location:

Travel Associated Infectious Disease Screen:
Have you traveled recently: No
Where:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)

Do you have any of the following symptoms? Cough
Fatigue
Fever
Respiratory Illness
Shortness of Breath
Weakness

General Infectious Disease Screen:

Have you been exposed to someone with a suspected infectious disease within the past 3 weeks: Yes
(i.e. Tuberculosis (TB), Ebola, Influenza, Pertussis, Measles, Mumps, Chicken Pox, etc.)
If Yes, what disease have you recently been exposed to: COVID

Communicable Disease History:

CDIFF: N
MRSA: N
MDRO (Multi-Drug Resistant Organism): N
VRE (Vancomycin-Resistant Enterococcus): N
CRE (Carbapenem-Resistant Enterobacteriaceae): N

If BOTH active infection that cannot be contained by dressing AND if Hx of MRSA, VRE or MDRO then initiate Contact Precautions. If patient has a history of or an active infection of CRE then initiate Contact Precautions for every admission

Influenza Vaccine Date (Mo/Yr): N
Tetanus Date:

COVID-19 Vaccine

Vaccine #1 Received: N Date:
Vaccine #2 Received: Date:
Vaccine #3 Received: Date:
Vaccine Booster Received: Date:
Vaccine Manufacturer:

Is pt pregnant? NO Lactating:

Malnutrition Screening Tool [MST]

Have you lost weight recently WITHOUT trying: No

Have you been eating poorly b/c of decreased appetite: No
Malnutrition Screening Tool (MST) Score: 0
Risk: Not at risk
MST of 0-1 = Not at Risk MST of 2 or more = At Risk

Tobacco Use: Tobacco Type: Patient age 13 & older: Smoker status:
No

29063 ADM: Part A - Adult Admission Intake ^ (continued)

Smokeless Tobacco Use: Smokeless Tobacco Type: Smokeless Tobacco Frequency:
No

E-Cig/Vape Use: E-Cig/Vape Type: E-Cig/Vape Frequency:
No

Substance Use: Substance Type: Substance Frequency:
No

Alcohol Use: Alcohol Type: Alcohol Frequency:
No

Pt feels they are/have been abused, neglected, or exploited:

** Columbia Suicide Severity Rating Scale (C-SSRS) ** [SHIFT F8] for reference text
Begin questions 1-5 with: 'In the past month...' (If asking caregiver, reframe question)
****Patients 12 and up:

1. Wish to be Dead: Have you wished you were dead or wished you could go to sleep and not wake up?
2. Suicidal Thoughts: Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Have you been thinking about how you might do this?
4. Suicidal Intent (without Specific Plan): Have you had some intention of acting on them?
5. Suicidal Intent with Specific Plan: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Suicidal Behavior Lifetime Question
   a. Have you ever done anything, started to do anything or prepared to do anything to end your life?
   b. If 6a = Yes, was this in the past 3 months?

C-SSRS Score : [SHIFT F8] for reference based on score
Religious preference: Religious restrictions:

Spiritual/cultural concerns or practices: Describe:
Support system in place:

Learning style preferred by patient:

Barriers to learning:

Patient's Discharge Goal:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

29063 ADM: Part A - Adult Admission Intake ^ (continued)

Pt would like to speak to someone regarding concerns /services:
Community Agencies being used:

Advised to send valuables home w/family:

Intake reviewed for accuracy & completion this admission?

29066 ADM: Part B - Adult Admission Assessment D ON ADMISSION AS
- Create 10/07/21 0123 BC 10/07/21 0126 BC
- Document 10/07/21 0123 BC 10/07/21 0126 BC
Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT

Check if patient has difficulty with:
Problem(s): Y Balance/coordination: Walking: Stairs:
Arm Function: Leg Function: Strength/Endurance: Sensation:
Short of breath with activity: Y

Problem(s): N Eating: Swallowing:
Dressing: Bathing/grooming:

Problem(s): N Speech or communication impairment:

Understands requests/directions: Memory: Hearing:

Comment:

Functional assessment indicators can be viewed by clicking blue ? on toolbar or pressing shift <F8>
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE

2. Therapy Screening Request due to functional impairments identified: N

If NO & functional impairments identified, state reason:

Cardiac Rehab Referral: No Referral

Comments:

29066 ADM: Part B - Adult Admission Assessment (continued)

PAIN ASSESSMENT
Current pain: N Time of onset: Location:
(Acute)

Describe pain: Pain caused by:

Pain interferes with activities:

Chronic pain: N Location:

Describe pain: Obtains relief w/:

Short-term pain relief goal during hospitalization:

Tolerable pain level (0-10):

Comments:

SAFETY

Is patient of small size or stature and at risk for side rail entrapment: N

Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N

Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift
Does patient verbalize or exhibit intent to leave facility: N
Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N
Does the patient demonstrate any of the following behaviors: N

Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29066 ADM: Part B - Adult Admission Assessment (continued)
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment; Known outstanding warrant; Legal detention or 72 hour hold; Family/responsible party voices concerns; Resident of mental health facility; Federal, State or Local inmate; History of elopement/wandering; Suicide attempt

Initiate Elopement Risk Precautions intervention: N (Check all that apply):

Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Comments:

ADMISSION PRESSURE ULCER ASSESSMENT
Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission:

If not assessed, document reason:

Pressure ulcers present on admission: *If yes, document on pressure ulcer intervention.

4 Eye Assessment Complete? Comments

Pre-admission Treatment:

If patient is a Diabetic Initiate Hypoglycemia intervention:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29066 ADM: Part B - Adult Admission Assessment (continued)
****MORSE FALL SCALE**** [SHIFT F8] to view scoring

History of Fall: Has the patient fallen recently or within the last three months? Score:

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Score:

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? Score:

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Score:

Gait-Transferring: ([SHIFT/F8] for gait definitions) Score:

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Score:

Scoring Risk Levels [SHIFT/F8]: Morse Fall Risk Score:
- Document 10/07/21 0303 BC 10/07/21 0304 BC
Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT

Check if patient has difficulty with:
Problem(s): Y Balance/coordination: Walking: Stairs:
Arm Function: Leg Function: Strength/Endurance: Sensation:
Short of breath with activity: Y

Problem(s): N Eating: Swallowing:
Dressing: Bathing/grooming:

Problem(s): N Speech or communication impairment:

Understands requests/directions: Memory: Hearing:

Comment:

Functional assessment indicators can be viewed by clicking blue ? on toolbar or pressing shift <F8>
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE

2. Therapy Screening Request due to functional impairments identified: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29066 ADM: Part B - Adult Admission Assessment (continued)

If NO & functional impairments identified, state reason:

Cardiac Rehab Referral: No Referral

Comments:

PAIN ASSESSMENT

Current pain: N Time of onset: Location:
(Acute)

Describe pain: Pain caused by:

Pain interferes with activities:

Chronic pain: N Location:

Describe pain: Obtains relief w/:

Short-term pain relief goal during hospitalization:

Tolerable pain level (0-10):

Comments:

SAFETY

Is patient of small size or stature and at risk for side rail entrapment: N

Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N

Is patient mobile: Y

If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N

Confusion, dementia, &/or disorientation:

Current alcohol abuse:

Current drug abuse:

Current Psychiatric conditions:

(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

29066 ADM: Part B - Adult Admission Assessment (continued)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N

Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N

Abnormal verbalizations:

Emotional lablity:

Attention changes (hyper vigilance or hypoactive):

Changes in mentation or altered mentation:

Abnormal appearance such as inappropriate dress:

Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement:

Court commitment
Known outstanding warrant
Legal detention or 72 hour hold
Family/responsible party voices concerns
Resident of mental health facility
Federal, State or Local inmate
History of elopement/wandering
Suicide attempt

Initiate Elopement Risk Precautions intervention: N (Check all that apply):

Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Comments:

ADMISSION PRESSURE ULCER ASSESSMENT

Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission:

If not assessed, document reason:

Pressure ulcers present on admission: *If yes, document on pressure ulcer intervention.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29066 ADM: Part B - Adult Admission Assessment (continued)

4 Eye Assessment Complete? Comments

Pre-admission Treatment:

If patient is a Diabetic Initiate Hypoglycemia intervention:

Comments:

****MORSE FALL SCALE**** [SHIFT F8] to view scoring

History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50

- Document 10/07/21 0306 BC 10/07/21 0313 BC
Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT

Check if patient has difficulty with:
Problem(s): Y Balance/coordination: Walking: Stairs:
Arm Function: Leg Function: Strength/Endurance: Sensation:
Short of breath with activity: Y

Problem(s): N Eating: Swallowing:
Dressing: Bathing/grooming:

Problem(s): N Speech or communication impairment:

Understands requests/directions: Memory: Hearing:

Comment: PT HAS DOWN SYNDROME. COGNITIVE AS 11-12 YR OLD

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

29066 ADM: Part B - Adult Admission Assessment (continued)

**Functional assessment indicators can be viewed by clicking blue ? on toolbar
or pressing shift <F8>**
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE

2. Therapy Screening Request due to functional impairments identified: N

If NO & functional impairments identified, state reason:

Cardiac Rehab Referral: No Referral

Comments:

PAIN ASSESSMENT
Current pain: N Time of onset: Location:
(Acute)

Describe pain: Pain caused by:

Pain interferes with activities:

Chronic pain: N Location:

Describe pain: Obtains relief w/:

Short-term pain relief goal during hospitalization:

Tolerable pain level (0-10):

Comments:

SAFETY

Is patient of small size or stature and at risk for side rail entrapment: N

Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N

Is patient mobile: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

29066 ADM: Part B - Adult Admission Assessment (continued)

If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N

Confusion, dementia, &/or disorientation:

Current alcohol abuse:

Current drug abuse:

Current Psychiatric conditions:

(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N

Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N

Abnormal verbalizations:

Emotional lablity:

Attention changes (hyper vigilance or hypoactive):

Changes in mentation or altered mentation:

Abnormal appearance such as inappropriate dress:

Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment Resident of mental health facility
Known outstanding warrant Federal, State or Local inmate
Legal detention or 72 hour hold History of elopement/wandering
Family/responsible party voices concerns Suicide attempt

Initiate Elopement Risk Precautions intervention: N (Check all that apply):

Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

29066 ADM: Part B - Adult Admission Assessment (continued)

ADMISSION PRESSURE ULCER ASSESSMENT

Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission: Y

If not assessed, document reason:

Pressure ulcers present on admission: N *If yes, document on pressure ulcer intervention.

4 Eye Assessment Complete? Y Comments RED BUMPS IN GROIN AREA

Pre-admission Treatment:

If patient is a Diabetic Initiate Hypoglycemia intervention:

Comments:

****MORSE FALL SCALE**** [SHIFT F8] to view scoring

History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50

29099 COVID - 19 SCREEN D ON ADMISSION AS

- Create 10/07/21 0127 BC 10/07/21 0128 BC
- Document 10/07/21 0127 BC 10/07/21 0128 BC

Is pt able to be assessed? Y
Have you recently tested positive for COVID-19? Y
If so, was the test done more than 14 days ago? N
Are you still having symptoms of COVID-19? Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

29099 COVID - 19 SCREEN (continued)
Have you had a recent known exposure to COVID-19?
(defined as un-masked close contact, less than 6 ft. for greater than 15 minutes with an individual with confirmed or suspected case of COVID-19)

Have you had a fever >99.5 (37.5 Celsius), NEW or CHANGING cough, shortness of breath, nasal drainage/congestion or sore throat?

Do you have a NEW loss of taste or smell?

Are you experiencing extreme fatigue, muscle/body aches or headache, more frequent than normal?

Have you had nausea/vomiting or diarrhea, more frequent than normal?

Is pt suspect for COVID-19? Pt is suspect for COVID19

Have you received a COVID-19 vaccination? No
Have you had a COVID-19 Vaccine in the last 7-days?
Was this COVID-19 vaccine your?

29185 High Risk for Readmission Assessment ^ D ON ADMISSION AS
To be completed early in hospitalization
(after patient diagnosis)
- Create 10/07/21 0128 BC 10/07/21 0132 BC
- Document 10/07/21 0128 BC 10/07/21 0132 BC
ASSESSMENT of HIGH RISK for READMISSIONS

Repeat unplanned hospitalizations/ED visits (2 hospital admissions within the past 6 months or 3 ED visits within the past 6 months): Y/N N

ACTIVE diagnosis of mental illness or substance abuse (Depression, suicidal ideation, significant loss, homicidal ideation, intoxicated, psychosis, aggression, chronic alcoholism): Y/N N

Uninsured: (Self pay) Y/N N

Cancer with active treatment: (Surgery, radiation, chemotherapy) Y/N N

Polypharmacy OR warfarin therapy (Greater than 7 chronic prescription medications): Y/N N

ASSESSMENT of HIGH RISK for READMISSIONS

Diagnosis and/or history of (Check all that apply)
Heart failure: Y/N N
Respiratory illness-Pneumonia, asthma, COPD: Y/N Y
Diabetes: Y/N N

29185 High Risk for Readmission Assessment ^ (continued)
Dementia: Y/N N
End stage renal disease: (HD/PD patients) Y/N N
Chronic wound, ulcer, cellulitis: (Greater than 3 weeks) Y/N N
Total Score: 1

High Risk = >/= 6 Moderate Risk = 3-5 Low Risk = 0-2

If the patient scores below a 6 but your professional assessment indicates that the patient is at high risk, score the patient as HIGH RISK. Y/N N

Rationale / Comment:

3110 SAFETY: Fall precautions, adult D CONT OE
*Offer toileting to patient regularly.
*Do not leave unattended in restroom, shower or tub.
*Communicate to transport staff if patient is a Fall Risk.
*Inform and educate patients and/or family members regarding a plan of care to prevent falls and document on Education Record.
*Place clear text fall risk sign outside of patient room, & patient in yellow gown to alert all staff that patient is a fall risk.
- Create 10/07/21 0304 BC 10/07/21 0304 BC

135 PRI: Falls, risk for *129839007 D CONT OE
R/t: HOSPITALIZATION
- Create 10/07/21 0304 BC 10/07/21 0304 BC
- Ed Text 10/09/21 0957 VW 10/09/21 0957 VW

135 PRI: Falls, risk for *129839007 C CONT OE
R/t: HOSPITALIZATION
- Create 10/07/21 0314 BC 10/07/21 0314 BC
- Ed Text 10/09/21 0957 VW 10/09/21 0957 VW
- Ed Status 10/10/21 1831 KRH 10/10/21 1831 KRH A => C

5180 NEUROL: Dysphagia Screening Tool ^ D PER ORDERS AS
Complete if not done in the ED OR
If new diagnosis of Stroke/TIA

Date completed:
Result (pass/fail):
If fail, RN may not retest

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
5180 NEUROL: Dysphagia Screening Tool	^	D	PER ORDERS										AS
- Create					10/07/21	0356	BC	10/07/21	0357	BC			
- Document					10/07/21	0356	BC	10/07/21	0357	BC			

SECTION A: PATIENT STATUS
Can the patient be placed in (& maintain) an upright/seated position: Y
Is the patient alert (not lethargic or comatose): Y

If you answered YES to BOTH of these questions, continue to Section B.
If you answered NO to EITHER of these questions, maintain NPO status. The screen should be repeated daily until both answers are affirmative or until Speech Pathology consult has been completed.

SECTION B: PRE-FEEDING OBSERVATIONS
Can the patient follow simple mouth/lip movements and range of motion: Y
(Have the patient open/close mouth/lips; stick out their tongue, move it side to side)
Is the patient able to cough or clear throat sharply: Y
Is the patient able to swallow own saliva: Y

If you answered YES to ALL of these questions, continue to Section C.
If you answered NO to ANY of these questions, maintain NPO status.

SECTION C: FEEDING OBSERVATIONS
If you observe any of the following signs/symptoms select NO which signifies that the patient did not complete an appropriate swallow: Coughing/choking/frequent throat clearing, pocketing of liquid, watery eyes and runny nose, labial leakage, wet/gurgly vocal quality.

Present the patient with one ice chip. Does the patient complete a swallow:
Present the patient with 30 ml of water in a cup. Does the patient complete a swallow: Y
Is water contained adequately within the mouth and lips: Y

RESULTS:
If ALL responses (Sections B & C) are YES, the patient may be cleared to have oral intake.
If ANY of the above (Sections B & C) are NO responses, the patient must be maintained NPO until a Speech Pathologist completes a full bedside swallowing evaluation.

Patient NPO: Y

Comments:

2551 Vital Signs (VS)	^	D	Q2H										OE
- Create					10/07/21	0425	MM	10/07/21	0426	MM			
- Document					10/07/21	0800	CT	10/07/21	0842	CT			

P 77 R 25
SPO2%: 99 Oxygen (LPM): Oxygen (%):
FiO2 (%): 70 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2551 Vital Signs (VS)	^	(continued)											

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 96/50 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.5 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

- Document					10/07/21	1600	CT	10/07/21	1715	CT			

P 112 R 24
SPO2%: 90 Oxygen (LPM): 40.0 Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: High Flow/Vapotherm

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

RASS Scale (ICU patients)

Position: Lying

BP 128/69 MAP: 90 BP#2: MAP:

Extremity: RIGHT ARM Extremity:

Mode: Non-invasive BP Monitor Mode:

T 98.7 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:

PAS: CPP:

PAD:

PAW/PAOP:

CO: IAP:

CI: APP:

SVR: Corrected CVP:

PVR:

SVO2%: TOF Baseline mA: TOF Current mA:

ScVO2%: TOF:

SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:

Resp:

Circulation:

Neurol (LOC):

O2 Sat (SpO2):

- Ed Directs 10/07/21 2341 LK 10/07/21 2341 LK 10/07 0423 SHIFT => 10/07 0423 SHIFT
10/08 0000 Q1H

- Document 10/08/21 0000 LK 10/08/21 0053 LK

P 86 R 34

SPO2%: 92 Oxygen (LPM): Oxygen (%):

FiO2 (%): 100 PF Ratio (PaO2/FiO2):

Humidified: Pediatric patients (%):

Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?

Resp Quality: Shallow

2551 Vital Signs (VS) ^ (continued)

RASS Scale (ICU patients) -1 Drowsy

Position: Lying

BP 89/53 MAP: 66 BP#2: MAP:

Extremity: RIGHT ARM Extremity:

Mode: Non-invasive BP Monitor Mode:

T 103.0 (degrees F) T (degrees C) Route: Oral

CVP: ICP:

PAS: CPP:

PAD:

PAW/PAOP:

CO: IAP:

CI: APP:

SVR: Corrected CVP:

PVR:

SVO2%: TOF Baseline mA: TOF Current mA:

ScVO2%: TOF:

SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:

Resp:

Circulation:

Neurol (LOC):

O2 Sat (SpO2):

- Document 10/08/21 0106 LK 10/08/21 0106 LK

P 84 R 24

SPO2%: 93 Oxygen (LPM): Oxygen (%):

FiO2 (%): 100 PF Ratio (PaO2/FiO2):

Humidified: Pediatric patients (%):

Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?

Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ (continued)

BP 89/51 MAP: 66 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0200 LK 10/08/21 0215 LK
P 86 R 34
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 93/73 MAP: 79 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ (continued)

T 104.2 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0310 LK 10/08/21 0324 LK
P 77 R 27
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 93/48 MAP: 68 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 103.5 (degrees F) T (degrees C) Route: Axillary

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: TYLENOL GIVEN, WILL PLACE PATIENT ON COOLING MATTRESS. PATIENT IS PACKED IN ICE

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0400 LK 10/08/21 0435 LK
P 75 R 31
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 92/52 MAP: 69 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 102.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: PT PLACED ON COOLING BLANKET

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0500 LK 10/08/21 0506 LK
P 73 R 34
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 86/47 MAP: 63 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

SVR:
PVR:
SVO2%:
ScVO2%:
SpCO2%:
Corrected CVP:
TOF Baseline mA:
TOF Current mA:
TOF:
Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

- Document 10/08/21 0600 LK 10/08/21 0605 LK

P 84 R 32
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 101/56 MAP: 75 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 102.3 (degrees F) T (degrees C) Route: Axillary

CVP:
PAS:
PAD:
PAW/PAOP:
CO:
CI:
SVR:
PVR:
SVO2%:
ICP:
CPP:
IAP:
APP:
Corrected CVP:
TOF Baseline mA:
TOF Current mA:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

ScVO2%:
SpCO2%:
TOF:
Location:

Comments: PT IS ON COOLING BLANKET

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

- Document 10/08/21 0655 LK 10/08/21 0657 LK

P 74 R 32
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 107/61 MAP: 70 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP:
PAS:
PAD:
PAW/PAOP:
CO:
CI:
SVR:
PVR:
SVO2%:
ScVO2%:
SpCO2%:
ICP:
CPP:
IAP:
APP:
Corrected CVP:
TOF Baseline mA:
TOF Current mA:
TOF:
Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)
Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0800 AM 10/08/21 0844 AM
P 73 R 33
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 93/53 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 102.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

2551 Vital Signs (VS) ^ (continued)

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 0900 AM 10/08/21 0959 AM
P 68 R 33
SPO2%: 94 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 83/50 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 1009 AM 10/08/21 1010 AM
P 68 R 34
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 84/52 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 102.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 1100 AM 10/08/21 1153 AM
P 59 R 26
SPO2%: 94 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 94/52 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ (continued)
Neurol (LOC):
O2 Sat (SpO2):
- Document 10/08/21 1211 AM 10/08/21 1219 AM
P 57 R 26
SPO2%: 94 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 97/52 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/08/21 1310 AM 10/08/21 1311 AM
P 54 R 27
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 94/51 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1418	AM	10/08/21	1422	AM			

P 54 R 23
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 91/50 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1500	AM	10/08/21	1608	AM			

P 52 R 32
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 89/54 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1601	AM	10/08/21	1610	AM			

P 39 R 32
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 66/39 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1608	AM	10/08/21	1609	AM			

P 59 R 32
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 108/63 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1709	AM	10/08/21	1710	AM			

P 53 R 27
SPO2%: 94 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 100/60 MAP: 75 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.5 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1821	AM	10/08/21	1822	AM			

P 51 R 30
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 93/58 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1841	AM	10/08/21	1842	AM			

P 52 R 30
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 95/54 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	1955	MP	10/08/21	1957	MP			

P 64 R 27
SPO2%: 91 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 108/72 MAP: 85 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Edit Results					10/08/21	1955	MP	10/08/21	2043	MP			
- Document					10/08/21	2100	MP	10/08/21	2112	MP			

Oxygen (%): [100]
FiO2 (%): 100 []
P 59 R 27
SPO2%: 98 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 108/70 MAP: 83 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/08/21	2200	EF	10/08/21	2229	EF			

P 58 R 29
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Slightly drowsy *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 102/53 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.3 (degrees F) T (degrees C) Route: Oral

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/08/21	2300	MP	10/08/21	2325	MP			
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/09/21	0000	MP	10/09/21	0041	MP			

P 76 R 32
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position:
BP 165/119 MAP: 128 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: HIGH BP D/T PT UPSET FROM JUST PLACING FOLEY CATHETER

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

P 85 R 26
SPO2%: 97 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 118/65 MAP: 83 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0100	MP	10/09/21	0110	MP			

P 93 R 34
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 11/66 MAP: 83 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Edit Results					10/09/21	0100	MP	10/09/21	0211	MP			

BP 110/66 [11/66]
- Document 10/09/21 0200 MP 10/09/21 0209 MP
P 72 R 31
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 98/59 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0300	MP	10/09/21	0320	MP			

P 69 R 37
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 103/56 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0400	MP	10/09/21	0404	MP			

P 78 R 40
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 107/62 MAP: 79 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.2 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0500	MP	10/09/21	0504	MP			

P 73 R 37
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 105/55 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Edit Results					10/09/21	0500	MP	10/09/21	0546	MP			

T 99.0 []
Route: Axillary []
- Document 10/09/21 0600 MP 10/09/21 0616 MP
P 70 R 33
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 130/57 MAP: 82 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0655	MP	10/09/21	0656	MP			

P 82 R 34
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 95/52 MAP: 70 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0733	VW	10/09/21	0734	VW			

P 86 R 34
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 98/60 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0811	VW	10/09/21	0818	VW			

P 86 R 34
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 100/58 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	0911	VW	10/09/21	0938	VW			

P 63 R 34
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 96/53 MAP: 69 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1011	VW	10/09/21	1012	VW			

P 69 R 32
SPO2%: 88 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 103/55 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1111	VW	10/09/21	1131	VW			

P 61 R 40
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 104/58 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1211	VW	10/09/21	1236	VW			

P 69 R 40
SPO2%: 85 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 107/58 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1314	VW	10/09/21	1314	VW			

P 71 R 30
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 94/51 MAP: 68 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1400	VW	10/09/21	1527	VW			

P 61 R 30
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 95/53 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1511	VW	10/09/21	1537	VW			

P 61 R 36
SPO2%: 97 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 98/54 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.0 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: able to tolerate vapotherm for 10 min while eating

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/09/21	1611	VW	10/09/21	1624	VW			
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/09/21	1656	VW	10/09/21	1657	VW			

P 57 R 30
SPO2%: 97 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 99/55 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

P 66 R 30
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 98/50 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1800	VW	10/09/21	1801	VW			

P 53 R 30
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 107/65 MAP: 82 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	1900	EF	10/09/21	2005	EF			

P 52 R 36
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 116/71 MAP: 87 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	2000	EF	10/09/21	2006	EF			

P 62 R 34
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality:

RASS Scale (ICU patients) +1 Restless

Position: Lying
BP 117/56 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	2100	MP	10/09/21	2106	MP			

P 80 R 34
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 127/68 MAP: 87 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	2200	MP	10/09/21	2221	MP			

P 75 R 31
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 113/60 MAP: 77 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/09/21	2300	MP	10/09/21	2328	MP			

P 70 R 25
SPO2%: 88 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 110/54 MAP: 78 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	0000	MP	10/10/21	0040	MP			

P 94 R 32
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 112/58 MAP: 79 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	0054	MP	10/10/21	0105	MP			

P 74 R 28
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 115/63 MAP: 81 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	0200	MP	10/10/21	0202	MP			

P 61 R 32
SPO2%: 89 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 110/57 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	0300	MP	10/10/21	0307	MP			

P 59 R 32
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 106/60 MAP: 78 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/10/21	0400	MP	10/10/21	0404	MP			
P 80 R 30													
SPO2%: 91 Oxygen (LPM): Oxygen (%): FiO2 (%): 100 PF Ratio (PaO2/FiO2): Humidified: Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ? Resp Quality:													
RASS Scale (ICU patients)													
Position: Lying													
BP 111/61 MAP: 79 BP#2: MAP: Extremity: RIGHT ARM Extremity: Mode: Non-invasive BP Monitor Mode:													
T 97.7 (degrees F) T (degrees C) Route: Axillary													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/10/21	0500	MP	10/10/21	0553	MP			
P 69 R 34													
SPO2%: 95 Oxygen (LPM): Oxygen (%): FiO2 (%): 100 PF Ratio (PaO2/FiO2): Humidified: Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ? Resp Quality:													
RASS Scale (ICU patients) 0 Alert and Calm													
Position: Lying													
BP 109/56 MAP: 74 BP#2: MAP: Extremity: RIGHT ARM Extremity: Mode: Non-invasive BP Monitor Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/10/21	0600	MP	10/10/21	0601	MP			

P 65 R 38
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 103/55 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/10/21	0653	MP	10/10/21	0654	MP			

P 63 R 38
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 104/50 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description | Sts | Direction | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE

- Document 10/10/21 0800 KRH 10/10/21 0937 KRH

P 60 R 36
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 112/59 MAP: 80 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.7 (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description | Sts | Direction | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE

- Ed Directs 10/10/21 0940 KRH 10/10/21 0940 KRH 10/07 0423 SHIFT => 10/07 0423 SHIFT
10/08 0000 Q1H 10/08 0000 Q1H
10/10 0800 Q2H
- Ed Text 10/10/21 0940 KRH 10/10/21 0940 KRH
- Document 10/10/21 1000 KRH 10/10/21 1023 KRH

P 69 R 31
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 107/55 MAP: 75 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ (continued)
O2 Sat (SpO2):
- Document 10/10/21 1200 KRH 10/10/21 1316 KRH
P 65 R 34
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 110/59 MAP: 79 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 100.1 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/10/21 1325 KRH 10/10/21 1331 KRH
P R
SPO2%: Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position:
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Edit Results					10/10/21	1325	KRH	10/10/21	1332	KRH			
SPO2%: 99 []													
- Document					10/10/21	1331	KRH	10/10/21	1331	KRH			

P R

SPO2%: Oxygen (LPM): Oxygen (%):
FiO2 (%): 80 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position:
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Edit Results					10/10/21	1331	KRH	10/10/21	1332	KRH			
SPO2%: 98 []													
- Document					10/10/21	1515	KRH	10/10/21	1515	KRH			

P R

SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 75 PF Ratio (PaO2/FiO2):
Humidified: Y Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	1605	KRH	10/10/21	1606	KRH			
P 75 R 31													
SPO2%: 99 Oxygen (LPM): Oxygen (%): FiO2 (%): 70 PF Ratio (PaO2/FiO2): Humidified: Y Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ? Resp Quality: Regular													
RASS Scale (ICU patients)													
Position: Lying													
BP 102/54 MAP: 73 BP#2: MAP: Extremity: RIGHT ARM Extremity: Mode: Non-invasive BP Monitor Mode:													
T 98.7 (degrees F) T (degrees C) Route: Axillary													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	1800	KRH	10/10/21	1808	KRH			
P 83 R 34													
SPO2%: 94 Oxygen (LPM): Oxygen (%): FiO2 (%): 90 PF Ratio (PaO2/FiO2): Humidified: Y Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ? Resp Quality:													
RASS Scale (ICU patients) -1 Drowsy													
Position: Lying													
BP 98/54 MAP: 72 BP#2: MAP: Extremity: RIGHT ARM Extremity: Mode: Non-invasive BP Monitor Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	2000	MP	10/10/21	2045	MP			

P 60 R 41
SPO2%: 98 Oxygen (LPM): Oxygen (%):
FiO2 (%): 80 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 105/55 MAP: 70 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.3 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/10/21	2200	MP	10/10/21	2208	MP			

P 58 R 42
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 80 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 101/64 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	0000	MP	10/11/21	0012	MP			

P 65 R 28
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 94/52 MAP: 67 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.8 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	0200	MP	10/11/21	0205	MP			

P 58 R 36
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients) +1 Restless

Position: Lying
BP 98/56 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	0400	MP	10/11/21	0416	MP			

P 62 R 28
SPO2%: 94 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Position: Lying
BP 100/55 MAP: 72 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	0557	MP	10/11/21	0558	MP			

P 62 R 36
SPO2%: 91 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 101/60 MAP: 75 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	0800	ES	10/11/21	0842	ES			

P 70 R 37
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 105/69 MAP: 78 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	1003	ES	10/11/21	1004	ES			

P 92 R 36
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 99/59 MAP: 75 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	1200	ES	10/11/21	1224	ES			

P 80 R 32
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 106/58 MAP: 78 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.8 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	1400	ES	10/11/21	1510	ES			

P 74 R 37
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 85 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 103/56 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	1600	ES	10/11/21	1633	ES			

P 62 R 33
SPO2%: 93 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 101/55 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.3 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/11/21	1800	ES	10/11/21	1832	ES			

P 74 R 29
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Position: Lying
BP 105/55 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/11/21	2000	CGR	10/11/21	2005	CGR			

P 60 R 41
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +1 Restless

Position: Lying
BP 112/78 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/11/21	2139	CGR	10/11/21	2139	CGR			

P 60 R 40
SPO2%: 88 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 100/56 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	0006	CGR	10/12/21	0100	CGR			

P 54 R 96
SPO2%: 39 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 124/72 MAP: 93 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 96.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	0152	CGR	10/12/21	0153	CGR			

P 53 R 42
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 122/72 MAP: 93 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/12/21	0351	CGR	10/12/21	0355	CGR			

P 53 R 36
SPO2%: 94 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 108/59 MAP: 78 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.5 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/12/21	0440	CGR	10/12/21	0440	CGR			

P 50 R 31
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position:
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)	^	D	Q2H	OE									
- Document					10/12/21	0515	CGR	10/12/21	0515	CGR			

P 56 R 40
SPO2%: 100 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)	^	D	Q2H	OE									
- Document					10/12/21	0656	CGR	10/12/21	0657	CGR			

P 56 R 30
SPO2%: 96 Oxygen (LPM): Oxygen (%):
FiO2 (%): 75 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 101/52 MAP: 77 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	0750	HJM	10/12/21	0750	HJM			

P 58 R 48
SPO2%: 87 Oxygen (LPM): 40.0 Oxygen (%):
FiO2 (%): 75 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position:
BP 104/65 MAP: 80 BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	0831	HJM	10/12/21	0834	HJM			

P 64 R 48
SPO2%: 86 Oxygen (LPM): Oxygen (%):
FiO2 (%): 85 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 95/57 MAP: 71 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 99.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: fio2 increased d/t low sat, precidex gtt increased for high RR, to aid in maintaning bipap

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	0852	HJM	10/12/21	0852	HJM			

P 64 R 35
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 85 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position:
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1000	HJM	10/12/21	1013	HJM			

P 66 R 42
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 85 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 103/68 MAP: 81 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1132	HJM	10/12/21	1133	HJM			

P 65 R 41
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 99/59 MAP: 74 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.9 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1230	HJM	10/12/21	1324	HJM			

P 64 R 34
SPO2%: 88 Oxygen (LPM): Oxygen (%):
FiO2 (%): 95 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 102/72 MAP: 83 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1402	HJM	10/12/21	1403	HJM			

P 58 R 44
SPO2%: 79 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 100/57 MAP: 73 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1416	HJM	10/12/21	1416	HJM			

P 54 R 39
SPO2%: 85 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: BIPAP ADJUSTED TO 20/15 100%

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1442	HJM	10/12/21	1443	HJM			
P 86 R 44													
SPO2%: 89 Oxygen (LPM): Oxygen (%):													
FiO2 (%): 100 PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?													
Resp Quality: Regular													
RASS Scale (ICU patients) -1 Drowsy													
Position: Lying													
BP 100/57 MAP: 73 BP#2: MAP:													
Extremity: RIGHT ARM Extremity:													
Mode: Non-invasive BP Monitor Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1500	HJM	10/12/21	1616	HJM			
P 52 R 43													
SPO2%: 89 Oxygen (LPM): Oxygen (%):													
FiO2 (%): 100 PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?													
Resp Quality: Regular													
RASS Scale (ICU patients) -1 Drowsy													
Position: Lying													
BP 95/48 MAP: BP#2: MAP:													
Extremity: RIGHT ARM Extremity:													
Mode: Non-invasive BP Monitor Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments:													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1646	KS	10/12/21	1651	KS			

P 51 R 37
SPO2%: 88 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP 107/64 MAP: 79 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.7 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/12/21	1800	HJM	10/12/21	1832	HJM			

P 50 R 40
SPO2%: 88 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Freq drowsy, arousable *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 104/58 MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/12/21	2000	SH	10/12/21	2141	SH			

P 59 R 40
SPO2%: 89 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 107/65 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.8 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H	OE									
- Document					10/12/21	2200	SH	10/12/21	2229	SH			

P 63 R 21
SPO2%: 88 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 113/64 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/13/21	0000	SH	10/13/21	0023	SH			
2551 Vital Signs (VS)		^ D	Q2H	- Document	10/13/21	0200	SH	10/13/21	0238	SH			

P 57 R 37
SPO2%: 79 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 112/63 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.8 (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

P 50 R 32
SPO2%: 95 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 113/67 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 97.8 (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	0400	SH	10/13/21	0505	SH			

P 51 R 40
SPO2%: 97 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 111/62 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.0 (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	0600	SH	10/13/21	0629	SH			

P 47 R 37
SPO2%: 98 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 109/59 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	0802	HJM	10/13/21	0808	HJM			

P 82 R 41
SPO2%: 95 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 107/58 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 98.6 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	0900	HJM	10/13/21	0913	HJM			

P 98 R 24
SPO2%: 92 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position: Lying
BP 121/79 MAP: 95 BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: FIO2 DECREASED TO 90%

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/13/21 0913 HJM 10/13/21 0925 HJM
P 116 R 37
SPO2%: 83 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +3 Very Agitated

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: PT KICKING LEGS OVER SIDE OF BED, REPOSITIONED,
O2 SAT RECOVERY TO 91% WHEN CALM

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/13/21 0925 HJM 10/13/21 0925 HJM
P 87 R 48
SPO2%: 90 Oxygen (LPM): Oxygen (%):
FiO2 (%): 90 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) +1 Restless

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/13/21 1139 HJM 10/13/21 1140 HJM
P 93 R 41
SPO2%: 65 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 127/82 MAP: 92 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 101.4 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

2551 Vital Signs (VS) ^ D Q2H OE
- Document 10/13/21 1200 HJM 10/13/21 1210 HJM
P 71 R 50
SPO2%: 82 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Regular

RASS Scale (ICU patients)

Position:
BP 105/58 MAP: 76 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1222	HJM	10/13/21	1223	HJM			

P 68 R 48
SPO2%: 82 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Awake and alert *Blue ?
Resp Quality: Labored

RASS Scale (ICU patients)

Position:
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1405	HJM	10/13/21	1405	HJM			

P 84 R 40
SPO2%: 80 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Slightly drowsy *Blue ?
Resp Quality: Labored

RASS Scale (ICU patients) -1 Drowsy

Position: Lying
BP 100/52 MAP: 70 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1500	HJM	10/13/21	1541	HJM			

P 127 R 54
SPO2%: 56 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Labored

RASS Scale (ICU patients) 0 Alert and Calm

Position:
BP 113/58 MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments: SAT DROP WITH PRONING, PT REPOSITIONED SELF ONTO BACK SOON AFTER POSTION CHANGE

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1530	HJM	10/13/21	1541	HJM			

P 75 R 56
SPO2%: 80 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Labored

RASS Scale (ICU patients) 0 Alert and Calm

Position:
BP 88/50 MAP: 65 BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1600	HJM	10/13/21	1709	HJM			
P 100 R 52													
SPO2%: 80 Oxygen (LPM): Oxygen (%): FiO2 (%): 100 PF Ratio (PaO2/FiO2): Humidified: Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ? Resp Quality: Labored													
RASS Scale (ICU patients) -1 Drowsy													
Position: Lying													
BP 94/51 MAP: BP#2: MAP: Extremity: RIGHT ARM Extremity: Mode: Non-invasive BP Monitor Mode:													
T 100.0 (degrees F) T (degrees C) Route: Axillary													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments: DR SHOKAR AWARE OF SATS, NO FURTHER INTERVENTION AVAILABLE													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1700	HJM	10/13/21	1755	HJM			
P 78 R 54													
SPO2%: 54 Oxygen (LPM): Oxygen (%): FiO2 (%): 100 PF Ratio (PaO2/FiO2): Humidified: Pediatric patients (%): Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Somnolent, min/no respons *Blue ? Resp Quality: Labored													
RASS Scale (ICU patients)													
Position:													
BP MAP: BP#2: MAP: Extremity: Extremity: Mode: Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP: PAS: CPP: PAD: PAW/PAOP: CO: IAP: CI: APP: SVR: Corrected CVP: PVR: SVO2%: TOF Baseline mA: TOF Current mA: ScVO2%: TOF: SpCO2%: Location:													
Comments: SAT DROP WITH PRONING													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>* Activity: Resp: Circulation: Neurol (LOC): O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1730	HJM	10/13/21	1755	HJM			
P 84 R 47													
SPO2%: 46 Oxygen (LPM): Oxygen (%):													
FiO2 (%): 100 PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Somnolent, min/no respons *Blue ?													
Resp Quality: Labored													
RASS Scale (ICU patients)													
Position:													
BP 96/51 MAP: 68 BP#2: MAP:													
Extremity: RIGHT ARM Extremity:													
Mode: Non-invasive BP Monitor Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments: NO RECOVERY IN O2 SAT, SISTER AT BEDSIDE, FATHER													
UPDATED VIA FACETIME, DR SHOKAR PAGED TO UPDATE													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)		^ D	Q2H										OE
- Document					10/13/21	1809	HJM	10/13/21	1810	HJM			
P 80 R 51													
SPO2%: 51 Oxygen (LPM): Oxygen (%):													
FiO2 (%): 100 PF Ratio (PaO2/FiO2):													
Humidified: Pediatric patients (%):													
Device: BiPAP													
ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:													
Pasero Opioid-Induced Sedation Scale (POSS)* Somnolent, min/no respons *Blue ?													
Resp Quality: Labored													
RASS Scale (ICU patients)													
Position:													
BP MAP: BP#2: MAP:													
Extremity: Extremity:													
Mode: Mode:													
T (degrees F) T (degrees C) Route:													
CVP: ICP:													
PAS: CPP:													
PAD:													
PAW/PAOP:													
CO: IAP:													
CI: APP:													
SVR: Corrected CVP:													
PVR:													
SVO2%: TOF Baseline mA: TOF Current mA:													
ScVO2%: TOF:													
SpCO2%: Location:													
Comments: BP UNDETECABLE													
DR SHOKAR PRESENT													
PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*													
Activity:													
Resp:													
Circulation:													
Neurol (LOC):													
O2 Sat (SpO2):													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)	^	D	Q2H										OE
- Document					10/13/21	1837	HJM	10/13/21	1838	HJM			

P 77 R 35
SPO2%: 98 Oxygen (LPM): Oxygen (%):
FiO2 (%): 100 PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* Somnolent, min/no respons *Blue ?
Resp Quality: Labored

RASS Scale (ICU patients)

Position:
BP 98/68 MAP: 79 BP#2: MAP:
Extremity: LEFT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
2551 Vital Signs (VS)	^	D	Q2H										OE
- Edit Results					10/13/21	1837	HJM	10/13/21	1838	HJM			

Comments: GOOD RESPONSE TO IV []
- Document 10/13/21 1927 JC 10/13/21 2327 JC
P 0 R
SPO2%: 0 Oxygen (LPM): Oxygen (%):
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality:

RASS Scale (ICU patients)

Position: Lying
BP MAP: BP#2: MAP:
Extremity: Extremity:
Mode: Mode:

T (degrees F) T (degrees C) Route:

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3003 SAFETY: Restraint (NVNSD) Initiation ^ D	ONCE		OE										
Date/Time family notified of restraint initiation:10/7 1940													
- Create					10/07/21	1928	BB	10/07/21	1928	BB			
- Document					10/07/21	1940	SH	10/07/21	2348	SH			
Interventions attempted prior to restraint: Distractions provided													
Low stimulus environment													
MD consulted													
Pt re-oriented PRN													
Simple,clear instructions													
Toilet patterns evaluated													
Patient behavior leading to restraint: Confusion													
Cognitive impairment													
Unable to follow instruct													
Lack of awareness													
Interference w/med device													
RN Initiation: *If RN initiates restraint, LIP order must be obtained ASAP													
Date LIP notified of restraint initiation: 10/07/21													
Time LIP notified of restraint initiation: 1740													
Date restraint initiated: 10/07/21 Time restraint initiated: 1740													
Type of restraint used: Bilateral Wrist (soft)													
Patient/Family Instruction & Notification:													
Pt instructed on rationale for restraint & release criteria: Y													
Family instructed on rationale & release criteria: Y Date: 10/07/21 Time: 1940													
Next of kin notified if pt is unable to comprehend: Date: Time:													
Notified Activated POA/HC or Guardian: Y Date: 10/07/21 Time: 1940													
Patient/Family response to restraint: FATHER IN ROOM WHEN RESTRAINTS INITIATED. HE IS AWARE OF SITUATION AND AGREES													
LIP restraint order sticker placed on LIP order sheet: (includes Device Type)													
LIP face to face exam & signed order within 24 hours.													
Restraint Flowsheet initiated:													
Care Plan updated:													
- Ed Text					10/07/21	2348	LK	10/07/21	2348	LK			
3021 SAFETY: Restraint (NVNSD) Flowsheet ^ D	PRN		OE										
RN to obtain TO/VO ASAP with restraint initiation. Obtain renewal order from LIP for restraint at least once every calendar day.													
- Create					10/07/21	1928	BB	10/07/21	1928	BB			

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3021 SAFETY: Restraint (NVNSD) Flowsheet ^ D	PRN		OE										
- Document					10/07/21	1940	SH	10/07/21	2345	SH			
Assessment code: Interference w/med device													
Agitated													
Pt's condition warrants continuation of restraints: Y													
Type of restraint: Bilateral Wrist (soft)													
Document position, toileting, hygiene Q2H on appropriate intervention													
Nutrition/hydration adequate: Y *If NO, document in comments below.													
Toileting offered: Yes													
Respiratory status adequate: Y *If NO, document in comments below.													
Circulation of restrained limb adequate: Y *If NO, document in comments below.													
*Check temp, sensation, pulse color.													
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.													
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y													
Discontinuation:													
Care plan updated:													
Comments:													
- Document					10/07/21	2000	SH	10/07/21	2205	SH			
Assessment code: Interference w/med device													
Agitated													
Pt's condition warrants continuation of restraints: Y													
Type of restraint: Bilateral Wrist (soft)													
Document position, toileting, hygiene Q2H on appropriate intervention													
Nutrition/hydration adequate: Y *If NO, document in comments below.													
Toileting offered: Yes													
Respiratory status adequate: Y *If NO, document in comments below.													
Circulation of restrained limb adequate: Y *If NO, document in comments below.													
*Check temp, sensation, pulse color.													
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.													
Temporary restraint release with continuous 1:1 supervision to provide patient cares:													
Discontinuation:													
Care plan updated: Y													
Comments: PT KEEPS TAKING BIPAP OFF, RESTRAINTS IN PLACE SO BIPAP STAYS ON. PATIENT IS VERY AGITATED													
- Document					10/07/21	2000	SH	10/07/21	2345	SH			
Assessment code: Interference w/med device													
Agitated													
Pt's condition warrants continuation of restraints: Y													
Type of restraint: Bilateral Wrist (soft)													
Document position, toileting, hygiene Q2H on appropriate intervention													
Nutrition/hydration adequate: Y *If NO, document in comments below.													
Toileting offered: Yes													
Respiratory status adequate: Y *If NO, document in comments below.													
Circulation of restrained limb adequate: Y *If NO, document in comments below.													
*Check temp, sensation, pulse color.													
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ (continued)
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/07/21 2200 SH 10/07/21 2345 SH
Assessment code: Interference w/med device
Agitated
Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: Yes
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/07/21 2207 SH 10/07/21 2208 SH
Assessment code: Interference w/med device
Agitated
Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: Yes
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated: Y
Comments:
- Document 10/08/21 0000 LK 10/08/21 0053 LK
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: Yes

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ (continued)
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments: WHEN RESTRAINTS OFF PT TRIES TO REMOVE BIPAP
AND IV AND OXYGEN PROBE
- Document 10/08/21 0200 LK 10/08/21 0215 LK
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: Yes
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments:
- Document 10/08/21 0400 LK 10/08/21 0435 LK
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: Yes
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments:
- Document 10/08/21 0600 LK 10/08/21 0605 LK
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ (continued)
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments:
- Document 10/08/21 0815 AM 10/08/21 0948 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments:
- Document 10/08/21 1010 AM 10/08/21 1011 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated:
Comments:

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ D PRN OE
RN to obtain TO/VO ASAP with restraint initiation. Obtain renewal order from LIP for restraint at least once every calendar day.
- Document 10/08/21 1211 AM 10/08/21 1219 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/08/21 1418 AM 10/08/21 1422 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/08/21 1615 AM 10/08/21 1629 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ (continued)
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/08/21 1821 AM 10/08/21 1822 AM
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation:
Care plan updated:
Comments:
- Document 10/08/21 2000 MP 10/08/21 2036 MP
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated: Y
Comments: WHEN RESTRAINTS OFF PT TRIES TO REMOVE BIPAP
AND IV AND OXYGEN PROBE
- Document 10/08/21 2200 MP 10/08/21 2245 MP
Assessment code: Interference w/med device

Pt's condition warrants continuation of restraints: Y
Type of restraint: Bilateral Wrist (soft)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3021 SAFETY: Restraint (NVNSD) Flowsheet ^ (continued)

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: Y *If NO, document in comments below.
Toileting offered: External Catheter
Respiratory status adequate: Y *If NO, document in comments below.
Circulation of restrained limb adequate: Y *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: Y *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares: Y

Discontinuation: N
Care plan updated: Y
Comments: WHEN RESTRAINTS OFF PT TRIES TO REMOVE BIPAP
AND IV AND OXYGEN PROBE
- Document 10/09/21 0000 MP 10/09/21 0041 MP
Assessment code:

Pt's condition warrants continuation of restraints: N
Type of restraint:

Document position, toileting, hygiene Q2H on appropriate intervention
Nutrition/hydration adequate: *If NO, document in comments below.
Toileting offered:
Respiratory status adequate: *If NO, document in comments below.
Circulation of restrained limb adequate: *If NO, document in comments below.
*Check temp, sensation, pulse color.
Skin integrity (related to restraints) intact: *If NO, document in comments below.
Temporary restraint release with continuous 1:1 supervision to provide patient cares:

Discontinuation: Y
Care plan updated:
Comments:
- Ed Directs 10/09/21 0133 MP 10/09/21 0134 MP 10/07 1928 Q2H => 10/07 1928 Q2H
10/08 2330 PRN
27396 Notify Provider To Consult C PRN OE
- Create 10/07/21 2131 SH 10/07/21 2131 SH
- Ed Status 10/09/21 1000 VW 10/09/21 1000 VW A => C
1239 CARES: Personalized Care ^ D 05,21 PS
-Oral Care with moderate assist
-Reposition every 2 hours.
-Teach & encourage small frequent
position changes
-Document when heels propped.
Days: Apply skin barrier to heels
Evenings: Apply lotion to heels

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
1239 CARES: Personalized Care	^	D	05,21										PS
- Create					10/07/21	2222	SH	10/07/21	2224	SH			
- Document					10/08/21	0400	LK	10/08/21	0434	LK			

Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: No indwelling catheter (BID and PRN, separate from bath)
Securement device present:
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: COCCYX
Oral Hygiene:
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:

- Document					10/08/21	2100	MP	10/08/21	2111	MP			

Chlorhexidine (CHG) bath: (Once daily for patients with central line or in ICU)
Foley care: (BID and PRN, separate from bath)
Securement device present:
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Location:
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed:
Linens changed:

Comments:

- Document					10/09/21	0500	MP	10/09/21	0503	MP			

Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath: Complete
Shower:
Shampoo:
Backrub:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
1239 CARES: Personalized Care (continued)	^												

Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:

- Document					10/09/21	2100	MP	10/09/21	2129	MP			

Chlorhexidine (CHG) bath: (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present:
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed:
Linens changed:

Comments:

- Document					10/10/21	0500	MP	10/10/21	0552	MP			

Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath: Complete
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:

- Document					10/10/21	2057	MP	10/10/21	2057	MP			

Chlorhexidine (CHG) bath: (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

1239 CARES: Personalized Care ^ (continued)

Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed:
Linens changed:

Comments:
- Document 10/11/21 0422 MP 10/11/21 0422 MP
Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath: Complete
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:
- Document 10/11/21 2005 CGR 10/11/21 2005 CGR
Chlorhexidine (CHG) bath: (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Location:
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed:

1239 CARES: Personalized Care ^ (continued)

Linens changed:

Comments:
- Document 10/12/21 0351 CGR 10/12/21 0354 CGR
Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath: Complete
Shower:
Shampoo: Y
Backrub: Y
Lotion: Yes Location: BACK, BLE
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:
- Document 10/12/21 2100 SH 10/12/21 2142 SH
Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: N
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Yes Location: INNER THIGHS/GROIN/FOLDS
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed:
Linens changed:

Comments:
- Document 10/13/21 0500 SH 10/13/21 0527 SH
Chlorhexidine (CHG) bath: Yes (Once daily for patients with central line or in ICU)
Foley care: Yes (BID and PRN, separate from bath)
Securement device present: Y
If CHG bath or foley care REFUSED, RN Notified:

Bath:
Shower:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

1239 CARES: Personalized Care ^ (continued)
Shampoo:
Backrub:
Lotion: Location:
Skin barrier applied: Location:
Oral Hygiene: Yes
Peri-care: Yes
Telemetry patches changed: Y
Linens changed: Yes

Comments:
23001 PAIN: Pain Management ^ D Q4H* PS
Tolerable pain level:
-If not having pain, may change intervention to Q4H
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/07/21 2320 LK 10/07/21 2332 LK
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: 34 Resp Quality: Shallow

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 0000
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;
sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw,
distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion
to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity,
constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, :
rhythmic respirations
1 - Squirming, shifting back and forth, tense or guarded
movements; mildly agitated, shallow/splinting respirations,
intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging
shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional
verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints,
repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		
0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:
CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	
BREATHING PATTERNS		
0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS		Score:
0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
LEGS		
0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
STATE OF AROUSAL		
0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/08/21 0000 LK 10/08/21 0058 LK
Pain: N Pain Scale: Y Unable to express pain: .
Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality: Shallow

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 0100
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

23001 PAIN: Pain Management ^ (continued)
APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

23001 PAIN: Pain Management ^ (continued)

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:

23001 PAIN: Pain Management ^ (continued)

1 - Whimper	Mild moaning, intermittent
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Ed Directs 10/08/21 0105 LK 10/08/21 0105 LK 10/07 2222 Q1H => 10/07 2222 Q1H
  10/08 0105 Q4H*
- Document 10/08/21 0105 LK 10/08/21 0105 LK
  Pain: N Pain Scale: Y Unable to express pain: .
  Location:
  Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: 24 Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 0400
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging

23001 PAIN: Pain Management ^ (continued)

shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent	0-Not observed		

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

shifting of position, rocking
intermittent or constant hand
motions, inability to keep still — 1-Observed :

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Score w/movement | Score at rest:

Rubbing (Massaging affected area) — 0-Not observed / 1-Observed : :

Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough]) — 0-Not observed / 1-Observed : :

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old — A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles — Restful face, neutral expression
1 - Grimace — Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)

Score :

CRY

0 - No Cry — Quiet, not crying
1 - Whimper — Mild moaning, intermittent
2 - Vigorous Cry — Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

:

BREATHING PATTERNS

0-Relaxed — Usual pattern for this infant
1-Change in Breathing — Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS

0-Relaxed/Restrained — No muscular rigidity; occasional random movements of arms
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

Score: :

LEGS

23001 PAIN: Pain Management ^ (continued)

0-Relaxed/Restrained — No muscular rigidity; occasional random leg movement
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

:

STATE OF AROUSAL

0-Sleeping/Awake — Quiet, peaceful sleeping or alert random leg movement
1-Fussy — Alert, restless & thrashing

:

Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/08/21 0400 LK 10/08/21 0436 LK
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality: Regular

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 0800
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description		Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
23001	PAIN: Pain Management		^ (continued)											

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

Intervention Description		Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
23001	PAIN: Pain Management		^ (continued)											

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away

23001 PAIN: Pain Management ^ (continued)
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8

- Document 10/08/21 0800 AM 10/08/21 0950 AM
Pain: N Pain Scale: Unable to express pain: .
Location:
Description:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC?	All patients 8 & up with ability to understand & recognize value of numbers
FACES?	Use for all patients age 4 and up. (Revised)
FLACC?	Use for non-verbal, non-intubated (2 month-18 yrs of age)
FLACC-R?	Use for Children (2mon-18yrs) with Cognitive Impairment
PAIN-AD?	Advanced Dementia - Adult patients with dx of dementia (non-intubated)
APP?	(Assume Pain Present) All patient populations If patient is .
CPOT?	Adult (18 & older) ICU patients (Intubated OR extubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

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ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)
FACIAL EXPRESSION Score:
0 - Relaxed, neutral :

23001 PAIN: Pain Management ^ (continued)
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:
==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

	Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed :	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed :	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed :	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed :	
Rubbing (Massaging affected area)	0-Not observed 1-Observed :	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed :	:

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Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed — Usual pattern for this infant

1-Change in Breathing — Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS — Score:

0-Relaxed/Restrained — No muscular rigidity; occasional random movements of arms

1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained — No muscular rigidity; occasional random leg movement

1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake — Quiet, peaceful sleeping or alert random leg movement

1-Fussy — Alert, restless & thrashing

Total:

Perceived Location:

Comfort Measures:

Response:

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- Document 10/08/21 1211 AM 10/08/21 1220 AM

Pain: N Pain Scale: Unable to express pain: .

Location:

Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?

Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:

PCA 24hr total amount infused at 2200: PCA pump cleared:

Current Epidural amount infused:

Epidural 24hr total amount infused at 2200:

Additional pain site:

Pain rating: Location:

Description:

23001 PAIN: Pain Management ^ (continued)

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint

23001 PAIN: Pain Management ^ (continued)
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating

23001 PAIN: Pain Management ^ (continued)
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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Score w/movement | Score at rest:

Intervention Description Sts Direction From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score :
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/08/21 1615 AM 10/08/21 1636 AM
Pain: N Pain Scale: Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

23001 PAIN: Pain Management ^ (continued)

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

23001 PAIN: Pain Management ^ (continued)
Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
		Copyright at Shift F8	
		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

23001 PAIN: Pain Management ^ (continued)
Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/08/21 2000 MP 10/08/21 2042 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality: Regular

RASS Scale (ICU patients) 0 Alert and Calm

Medication given: N Time pain reassessment due: 2100

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

23001 PAIN: Pain Management ^ (continued)

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop,	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
distorted expressions)

Bracing — 0-Not observed / 1-Observed
Clutching or holding onto furniture, equipment or affected area during movement

Restlessness
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still — 0-Not observed / 1-Observed

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Score w/movement | Score at rest:

Rubbing — 0-Not observed / 1-Observed
(Massaging affected area)

Vocal complaints: verbal — 0-Not observed / 1-Observed
(Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)

Score:

CRY
0 - No Cry Quiet, not crying
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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23001 PAIN: Pain Management ^ (continued)

ARMS — Score:
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement
1-Fussy Alert, restless & thrashing — Total:

Perceived Location:
Comfort Measures:
Response:

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- Document 10/09/21 0000 MP 10/09/21 0044 MP
Pain: N Pain Scale: Y Unable to express pain:
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0100
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;
sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw,
distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion
to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity,
constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, :
rhythmic respirations
1 - Squirming, shifting back and forth, tense or guarded
movements; mildly agitated, shallow/splinting respirations,
intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging
shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional
verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints,
repeated outbursts, constant grunting

23001 PAIN: Pain Management ^ (continued)

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia

Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
(e.g. ouch, that hurts, cursing
during movement, exclamation of protest
[e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw :
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is
intubated as evidence by obvious mouth &
facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than Copyright @ Shift F8
usual, gagging; breath holding

ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional :
random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional :
random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :

23001 PAIN: Pain Management ^ (continued)
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/09/21 0400 MP 10/09/21 0406 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0500
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:
NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

1 - Grimace — Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow) :

CRY

0 - No Cry — Quiet, not crying :
1 - Whimper — Mild moaning, intermittent
2 - Vigorous Cry — Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed — Usual pattern for this infant
1-Change in Breathing — Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained — No muscular rigidity; occasional random movements of arms :
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained — No muscular rigidity; occasional random leg movement :
1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake — Quiet, peaceful sleeping or alert random leg movement :
1-Fussy — Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/09/21 0811 VW 10/09/21 0822 VW
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: 24 Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 0900
Non-pharmacological interventions: Rest
Repositioning
Distraction

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? — All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y — Use for all patients age 4 and up. (Revised)

FLACC? — Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? — Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? — Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? — (Assume Pain Present) All patient populations If patient is .

CPOT? — Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? — Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? — Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense

23001 PAIN: Pain Management ^ (continued)
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION

23001 PAIN: Pain Management ^ (continued)

Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up

Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture,	0-Not observed 1-Observed	:	:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)
equipment or affected area during movement

Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

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Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		
0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:
CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	
BREATHING PATTERNS		
0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	
ARMS		Score:
0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or	

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/09/21 1153 VW 10/09/21 1156 VW
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: 24 Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 1300
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
FPS-R: Faces Pain Scale: 0

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

23001 PAIN: Pain Management ^ (continued)
FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total: :

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		
0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:
CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	
BREATHING PATTERNS		
0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS		Score:
0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
LEGS		
0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	
STATE OF AROUSAL		
0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/09/21 1611 VW 10/09/21 1625 VW
Pain: N Pain Scale: Y Unable to express pain: .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: 24 Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 1700
Non-pharmacological interventions: Rest
Repositioning
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

23001 PAIN: Pain Management ^ (continued)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

23001 PAIN: Pain Management ^ (continued)

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:

0 - Relaxed, neutral :

1 - Tense

2 - Grimacing

BODY MOVEMENTS

0 - Absense of movements :

1 - Protection

2 - Restlessness

MUSCLE TENSION

Evaluate by passive flexion & extension of upper extremities :

0 - Relaxed

1 - Tense, rigid

2 - Very tense or rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated

0 - Tolerating ventilator or movement :

1 - Coughing but tolerating

2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)

0 - Talking in normal tone, or no sound :

1 - Sighing, moaning

2 - Crying out, sobbing

Critical Care Pain Score Total:

PAIN AD- Assessment in Advance Dementia

Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==

0-Normal :

1-Occasional labored breathing. Short period of hyperventilation

2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

23001 PAIN: Pain Management ^ (continued)

==Negative Vocalization==

0-None :

1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==

0-Smiling or inexpressive

1-Sad, Frightened, Frown

2-Facial grimacing

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==Body Language==

0-Relaxed :

1-Tense, distressed pacing, fidgeting

2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==

0-No need to console :

1-Distracted or reassured by voice or touch

2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

23001 PAIN: Pain Management ^ (continued)

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/09/21 2000 MP 10/09/21 2129 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Medication given: N Time pain reassessment due: 2100
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

23001 PAIN: Pain Management ^ (continued)

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities
0 - Relaxed
1 - Tense, rigid

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :

23001 PAIN: Pain Management ^ (continued)

1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking	0-Not observed 1-Observed	:	

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change

23001 PAIN: Pain Management ^ (continued)
intermittent or constant hand motions, inability to keep still

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional	:

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change

23001 PAIN: Pain Management ^ (continued)

	random leg movement	
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/10/21 0000 MP 10/10/21 0041 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0100
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

23001 PAIN: Pain Management ^ (continued)

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw :
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is
intubated as evidence by obvious mouth &
facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than Copyright @ Shift F8
usual, gagging; breath holding

ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional :
random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional :
random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/10/21 0400 MP 10/10/21 0406 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0500
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:
NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers
FACES? Use for all patients age 4 and up. (Revised)
FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)
FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment
PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)
APP? (Assume Pain Present) All patient populations If patient is .
CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;
sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw,
distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion
to limbs

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)
FACIAL EXPRESSION Score:
0 - Relaxed, neutral :

23001 PAIN: Pain Management ^ (continued)
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:
==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

	Score w/movement	Score at rest:

23001 PAIN: Pain Management ^ (continued)

Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed — Usual pattern for this infant

1-Change in Breathing — Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS — Score:

0-Relaxed/Restrained — No muscular rigidity; occasional random movements of arms

1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained — No muscular rigidity; occasional random leg movement

1-Flexed/Extended — Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake — Quiet, peaceful sleeping or alert random leg movement

1-Fussy — Alert, restless & thrashing — Total:

Perceived Location:

Comfort Measures:

Response:

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- Document 10/10/21 0800 KRH 10/10/21 0939 KRH

Pain: N Pain Scale: Y Unable to express pain: .

Location:

Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?

Resp Rate: 24 Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: N Time pain reassessment due: 0900

Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:

PCA 24hr total amount infused at 2200: PCA pump cleared:

Current Epidural amount infused:

Epidural 24hr total amount infused at 2200:

Additional pain site:

Pain rating: Location:

Description:

23001 PAIN: Pain Management ^ (continued)

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint

23001 PAIN: Pain Management ^ (continued)
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating

23001 PAIN: Pain Management ^ (continued)
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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Score w/movement Score at rest:

23001 PAIN: Pain Management ^ (continued)

Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score :
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/10/21 1230 KRH 10/10/21 1321 KRH
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 1300
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:
NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

23001 PAIN: Pain Management ^ (continued)

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

23001 PAIN: Pain Management ^ (continued)
Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
		Copyright at Shift F8	
		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

23001 PAIN: Pain Management ^ (continued)
Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/10/21 1606 KRH 10/10/21 1617 KRH
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) -1 Drowsy

Medication given: N Time pain reassessment due: 1700

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Non-pharmacological interventions: Rest
Distraction

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY

23001 PAIN: Pain Management ^ (continued)

0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==

23001 PAIN: Pain Management ^ (continued)
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to
conclude that the patient is likely experiencing pain and you are planning
your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Bracing — 0-Not observed / 1-Observed
Clutching or holding onto furniture, equipment or affected area during movement

Restlessness — 0-Not observed / 1-Observed
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still

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Score w/movement | Score at rest:

Rubbing — 0-Not observed / 1-Observed
(Massaging affected area)

Vocal complaints: verbal — 0-Not observed / 1-Observed
(Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

23001 PAIN: Pain Management ^ (continued)
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location:
Comfort Measures:
Response:

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- Document 10/10/21 2000 MP 10/10/21 2050 MP
Pain: N Pain Scale: Y Unable to express pain:
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 2100
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

23001 PAIN: Pain Management ^ (continued)

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

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ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

23001 PAIN: Pain Management ^ (continued)

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
during movement, exclamation of protest
[e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw :
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is
intubated as evidence by obvious mouth &
facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than Copyright @ Shift F8
usual, gagging; breath holding

ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional :
random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional :
random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Response: Copyright at Shift F8
- Document 10/11/21 0000 MP 10/11/21 0014 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Medication given: N Time pain reassessment due: 0100
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:
NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is
intubated as evidence by obvious mouth &
facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than
usual, gagging; breath holding

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ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional :
random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional :
random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or
rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/11/21 0400 MP 10/11/21 0418 MP
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* Sleep, easy to arouse *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients) 0 Alert and Calm

Medication given: N Time pain reassessment due: 0500
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

23001 PAIN: Pain Management ^ (continued)

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations,

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging
shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional
verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints,
repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :

23001 PAIN: Pain Management ^ (continued)

0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

		Score w/movement	Score at rest:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

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Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION		
0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:
CRY		
0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	
BREATHING PATTERNS		
0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	
ARMS		Score:
0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/11/21 0800 ES 10/11/21 0844 ES
Pain: N Pain Scale: Y Unable to express pain: .
Location: PT DENIES PAIN AT THIS TIME
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: 37 Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 1200
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/11/21 1157 ES 10/11/21 1159 ES
Pain: N Pain Scale: Y Unable to express pain: .
Location: PT DENIES PAIN AT THIS TIME

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 1600
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

23001 PAIN: Pain Management ^ (continued)

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==

23001 PAIN: Pain Management ^ (continued)
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:

23001 PAIN: Pain Management ^ (continued)

1 - Whimper	Mild moaning, intermittent
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/11/21 1536 ES 10/11/21 1537 ES
Pain: N Pain Scale: Y Unable to express pain: .
Location: PT DENIES PAIN AT THIS TIME
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: 37 Resp Quality: Regular

RASS Scale (ICU patients) +2 Agitated

Medication given: N Time pain reassessment due: 2000
Non-pharmacological interventions: Rest
Distraction
Repositioning

Therapeutic Activity Goal (TAG)/Pain management progress: Progressing toward goal

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

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Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch

Intervention Description Sts Direction From

Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand	0-Not observed 1-Observed	:	

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
motions, inability to keep still

		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:

23001 PAIN: Pain Management ^ (continued)

1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 2100
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

23001 PAIN: Pain Management ^ (continued)

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

23001 PAIN: Pain Management ^ (continued)

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw :
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/12/21 0006 CGR 10/12/21 0102 CGR
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality: Regular

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 0200
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :

23001 PAIN: Pain Management ^ (continued)
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense

Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

23001 PAIN: Pain Management ^ (continued)

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From / Change

23001 PAIN: Pain Management ^ (continued)
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:

23001 PAIN: Pain Management ^ (continued)

Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained No muscular rigidity; occasional random leg movement
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location:
Comfort Measures:
Response:

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- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality: Regular

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 0800
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Y Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale: 0

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY

23001 PAIN: Pain Management ^ (continued)
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)

23001 PAIN: Pain Management ^ (continued)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:

23001 PAIN: Pain Management ^ (continued)

Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough]) 0-Not observed 1-Observed : :

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score :
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/12/21 0800 HJM 10/12/21 0859 HJM
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 0900
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Y Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score

23001 PAIN: Pain Management ^ (continued)
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral : 0
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements : 0
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities : 0
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound : 0
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total: 0

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :

23001 PAIN: Pain Management ^ (continued)

1-Occasional labored breathing. Short period
of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/12/21 1130 HJM 10/12/21 1131 HJM
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 1300
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)
Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Y Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.

23001 PAIN: Pain Management ^ (continued)
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded

23001 PAIN: Pain Management ^ (continued)

movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT

Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral : 0
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements : 0
1 - Protection
2 - Restlessness

MUSCLE TENSION

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Evaluate by passive flexion & extension of upper extremities : 0
0 - Relaxed
1 - Tense, rigid
2 - Very tense or rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound : 0
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total: 0

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture,	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
equipment or affected area during movement

Restlessness
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still
0-Not observed
1-Observed :

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Score w/movement | Score at rest:

Rubbing
(Massaging affected area)
0-Not observed : :
1-Observed

Vocal complaints: verbal
(Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])
0-Not observed : :
1-Observed

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION
0 - Relaxed Muscles Restful face, neutral expression Score
1 - Grimace Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow) :

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/12/21 1531 HJM 10/12/21 1532 HJM
Pain: N Pain Scale: Y Unable to express pain: . Y
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 1700
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Y Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral : 0
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements : 0
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities : 0
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound : 0
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

Copyright at Shift F8

		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/12/21 2000 SH 10/12/21 2142 SH
Pain: N Pain Scale: Y Unable to express pain: .
Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC?	Y	All patients 8 & up with ability to understand & recognize value of numbers
FACES?		Use for all patients age 4 and up. (Revised)
FLACC?		Use for non-verbal, non-intubated (2 month-18 yrs of age)
FLACC-R?		Use for Children (2mon-18yrs) with Cognitive Impairment
PAIN-AD?		Advanced Dementia - Adult patients with dx of dementia (non-intubated)
APP?		(Assume Pain Present) All patient populations If patient is .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

23001 PAIN: Pain Management ^ (continued)
Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Vigorous Cry Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS

0-Relaxed Usual pattern for this infant

1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:

0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :

1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS

0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :

1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL

0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :

1-Fussy Alert, restless & thrashing Total:

Perceived Location: :

Comfort Measures:

Response:

Copyright at Shift F8

- Document 10/13/21 0000 SH 10/13/21 0024 SH

Pain: N Pain Scale: Y Unable to express pain: .

Location:

Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?

Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:

PCA 24hr total amount infused at 2200: PCA pump cleared:

Current Epidural amount infused:

Epidural 24hr total amount infused at 2200:

Additional pain site:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Pain rating: Location:

Description:

Medication given: Time pain reassessment due:

Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY

23001 PAIN: Pain Management ^ (continued)
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)
FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated

23001 PAIN: Pain Management ^ (continued)
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:
==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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Score Score

23001 PAIN: Pain Management ^ (continued)

		w/movement	at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	

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ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert :
random leg movement
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/13/21 0400 SH 10/13/21 0505 SH
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

PAIN SCALE USED:

NUMERIC? Y All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score: 0

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright Information

****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

23001 PAIN: Pain Management ^ (continued)

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid
2 - Very tense or rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)
Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	
		Copyright at Shift F8	
		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

23001 PAIN: Pain Management ^ (continued)

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/13/21 0802 HJM 10/13/21 0810 HJM
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Medication given: Time pain reassessment due: 0900
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Y Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested; sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total: :

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral : 0
1 - Tense
2 - Grimacing

BODY MOVEMENTS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

0 - Absense of movements : 0
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities : 0
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound : 0
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total: 0

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)
SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

23001 PAIN: Pain Management ^ (continued)

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched	0-Not observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

teeth, tightened lips, jaw drop, distorted expressions) 1-Observed

Bracing 0-Not observed
Clutching or holding onto furniture, equipment or affected area during movement 1-Observed : :

Restlessness
(Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still 0-Not observed
1-Observed :

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Score w/movement Score at rest:

Rubbing 0-Not observed : :
(Massaging affected area) 1-Observed

Vocal complaints: verbal 0-Not observed : :
(Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough]) 1-Observed

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding

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23001 PAIN: Pain Management ^ (continued)

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :
Comfort Measures:
Response:

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- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
Pain: N Pain Scale: Y Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 1300
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC? All patients 8 & up with ability to understand & recognize value of numbers

FACES? Use for all patients age 4 and up. (Revised)

FLACC? Use for non-verbal, non-intubated (2 month-18 yrs of age)

FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Y Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking

FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;
sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw,
distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion
to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity,
constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, :
rhythmic respirations
1 - Squirming, shifting back and forth, tense or guarded
movements; mildly agitated, shallow/splinting respirations,
intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging
shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional
verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints,
repeated outbursts, constant grunting

23001 PAIN: Pain Management ^ (continued)

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being
talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away
resisting care or comfort measures

FLACC-R Pain score total:

:

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral : 0
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements : 0
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities : 0
0 - Relaxed
1 - Tense, rigid

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COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound : 0
1 - Sighing, moaning

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

2 - Crying out, sobbing

Critical Care Pain Score Total: 0

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia

Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation
2-Noisy labored breathing. Long period of hyperventilation Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

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CNPI: Checklist of Nonverbal Pain Indicators

Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain	0-Not observed 1-Observed	:	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
(e.g. ouch, that hurts, cursing
during movement, exclamation of protest
[e.g., stop, that's enough])

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

0 - Relaxed Muscles	Restful face, neutral expression	Score
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw (neg.facial expression-nose, mouth & brow)	:

CRY

0 - No Cry	Quiet, not crying	:
1 - Whimper	Mild moaning, intermittent	
2 - Vigorous Cry	Loud scream; rising, shrill, continuous (NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)	

BREATHING PATTERNS

0-Relaxed	Usual pattern for this infant	
1-Change in Breathing	Indrawing, irregular, faster than usual, gagging; breath holding	Copyright @ Shift F8

ARMS Score:

0-Relaxed/Restrained	No muscular rigidity; occasional random movements of arms	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

LEGS

0-Relaxed/Restrained	No muscular rigidity; occasional random leg movement	:
1-Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion	

STATE OF AROUSAL

0-Sleeping/Awake	Quiet, peaceful sleeping or alert random leg movement	:
1-Fussy	Alert, restless & thrashing	Total:

Perceived Location: :

23001 PAIN: Pain Management ^ (continued)
Comfort Measures:
Response: Copyright at Shift F8
- Document 10/13/21 1600 HJM 10/13/21 1614 HJM
Pain: N Pain Scale: Unable to express pain: .
Location:
Description:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Rate: Resp Quality:

RASS Scale (ICU patients)

Medication given: Time pain reassessment due: 1700
Non-pharmacological interventions:

Therapeutic Activity Goal (TAG)/Pain management progress:

Current PCA amount infused:
PCA 24hr total amount infused at 2200: PCA pump cleared:
Current Epidural amount infused:
Epidural 24hr total amount infused at 2200:
Additional pain site:
Pain rating: Location:
Description:

Medication given: Time pain reassessment due:
Non-pharmacological interventions:

Comments:

Epidural pump cleared:

PAIN SCALE USED:

NUMERIC?	All patients 8 & up with ability to understand & recognize value of numbers
FACES?	Use for all patients age 4 and up. (Revised)
FLACC?	Use for non-verbal, non-intubated (2 month-18 yrs of age)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
FLACC-R? Use for Children (2mon-18yrs) with Cognitive Impairment

PAIN-AD? Advanced Dementia - Adult patients with dx of dementia (non-intubated)

APP? (Assume Pain Present) All patient populations If patient is .

CPOT? Adult (18 & older) ICU patients (Intubated OR extubated)

CNPI? Adult patients, ICU & non-ICU (non-intubated and non-verbal)

NIPS? Newborn (non-intubated), full-term newborn up to 1 yr of age

NUMERIC PAIN SCALE

Used for all patients age 8 and up.
(must have ability to understand and recognize value of numbers)

Numeric Pain Score:

These patients are typically in nursery or pediatric unit.

FPS-R: Faces Pain Scale - Revised

FPS-R: Faces Pain Scale:

23001 PAIN: Pain Management ^ (continued)

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****FLACC : Face, Legs, Activity, Cry and Consolability****

Pediatric Pain Assessment Tool (2 months - 18 years of age)
Use for non-verbal, non-intubated.

FACE Score:
0 - No particular expression or smile :
1 - Occasional grimace or frown, withdrawn, disinterested
2 - Frequent to constant quivering chin, clenched jaw

LEGS :
0 - Normal position or relaxed
1 - Uneasy, restless, tense
2 - Kicking, or legs drawn up

ACTIVITY
0 - Lying quietly, normal position, moves easily :
1 - Squirming, shifting back and forth, tense Shift F8 for Copyright:

CRY
0 - No cry (awake or asleep) :
1 - Moans or whimpers, occasional complaint
2 - Crying steadily, screams or sobs, frequent complaints

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficult to console or comfort

FLACC Pain Score Total:

2 - Arched, rigid or jerking
FLACC-R: Face,Legs,Activity,Cry and Consolability (Revised)

Use for Children (2mon-18yrs) with Cognitive Impairment

FACE Score
0 - No particular expression or smile :
1 - Occasional grimace or frown; withdrawn or disinterested;

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)

sad, appears worried
2 - Frequent to constant quivering chin, clenched jaw, distressed-looking face, expression of fright or panic

LEGS
0 - Normal position or relaxed: usual tone and motion to limbs
1 - Uneasy, restless, tense, occasional tremors
2 - Kicking, or legs drawn up-marked increase in spasticity, constant tremors, jerking

Shift F8 for Copyright:

ACTIVITY
0 - Lying quietly, normal position, moves easily; regular, rhythmic respirations :
1 - Squirming, shifting back and forth, tense or guarded movements; mildly agitated, shallow/splinting respirations, intermittent sighs
2 - Arched, rigid or jerking, severe agitation, head banging shivering, breath holding, gasping, severe splinting

CRY
0 - No cry (awake or asleep)
1 - Moans or whimpers; occasional complaint; occasional verbal outburst or grunt :
2 - Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting

CONSOLABILITY
0 - Content, relaxed :
1 - Reassured by occasional touching, hugging or being talked to, distractable
2 - Difficulty to console or comfort, pushing caregiver away resisting care or comfort measures

FLACC-R Pain score total:

:

23001 PAIN: Pain Management ^ (continued)

Critical Care Pain Observation Tool : CPOT
Use for (18 and older) ICU patients (intubated & extubated)

FACIAL EXPRESSION Score:
0 - Relaxed, neutral :
1 - Tense
2 - Grimacing

BODY MOVEMENTS
0 - Absense of movements :
1 - Protection
2 - Restlessness

MUSCLE TENSION
Evaluate by passive flexion & extension of upper extremities :
0 - Relaxed
1 - Tense, rigid

Shift F8 for Copyright

COMPLIANCE WITH VENTILATOR **OR Answer Vocalization if patient is extubated
0 - Tolerating ventilator or movement :
1 - Coughing but tolerating
2 - Fighting ventilator

VOCALIZATION (EXTUBATED Patients ONLY)
0 - Talking in normal tone, or no sound :
1 - Sighing, moaning
2 - Crying out, sobbing

Critical Care Pain Score Total:

2 - Very tense or rigid

PAIN AD- Assessment in Advance Dementia
Adult patients, with diagnosis of dementia both ICU and non-ICU paitents (Non-intubated)

SCORE:

==Breathing independent of vocalization==
0-Normal :
1-Occasional labored breathing. Short period of hyperventilation

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

2-Noisy labored breathing. Long period of hyperventilation
Cheyne-Stokes respirations

==Negative Vocalization==
0-None :
1-Occasional moan or groan, low level speech with
or disapproving quality

==Facial Expression==
0-Smiling or inexpressive
1-Sad, Frightened, Frown
2-Facial grimacing

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==Body Language==
0-Relaxed :
1-Tense, distressed pacing, fidgeting
2-Rigid, rists clenched, knees pulled up
Pulling or pushing away, striking out

==Consolability==
0-No need to console :
1-Distracted or reassured by voice or touch
2-Unable to console, distract, or reassure

Total Score:

:

APP: Assume Pain Present

Assume Pain Present?

Using this tool indicates that in your judgement, it is reasonable to conclude that the patient is likely experiencing pain and you are planning your care based on that assumption.

Comment:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

23001 PAIN: Pain Management ^ (continued)

Shift F8 for Copyright

CNPI: Checklist of Nonverbal Pain Indicators
Adult patients, both ICU & non-ICU nonintubated & nonverbal

		Score w/movement	Score at rest:
Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)	0-Not observed 1-Observed	:	:
Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)	0-Not observed 1-Observed	:	:
Bracing Clutching or holding onto furniture, equipment or affected area during movement	0-Not observed 1-Observed	:	:
Restlessness (Constant or intermittent shifting of position, rocking intermittent or constant hand motions, inability to keep still	0-Not observed 1-Observed	:	

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		Score w/movement	Score at rest:
Rubbing (Massaging affected area)	0-Not observed 1-Observed	:	:
Vocal complaints: verbal (Words expressing discomfort or pain (e.g. ouch, that hurts, cursing during movement, exclamation of protest [e.g., stop, that's enough])	0-Not observed 1-Observed	:	:

Movement Score: Rest Score:

Total Score:

:

**********NEWBORN/INFANT PAIN ASSESSMENT**********

Recommended for children less than 1 year old A score greater than 3 indicates pain

FACIAL EXPRESSION

		Score
0 - Relaxed Muscles	Restful face, neutral expression	
1 - Grimace	Tight facial muscles; furrowed brow, chin, jaw	:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

23001 PAIN: Pain Management ^ (continued)
(neg.facial expression-nose, mouth & brow)

CRY
0 - No Cry Quiet, not crying :
1 - Whimper Mild moaning, intermittent
2 - Vigorous Cry Loud scream; rising, shrill, continuous
(NOTE: Silent cry may be scored if baby is intubated as evidence by obvious mouth & facial movement.)

BREATHING PATTERNS
0-Relaxed Usual pattern for this infant
1-Change in Breathing Indrawing, irregular, faster than usual, gagging; breath holding

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ARMS Score:
0-Relaxed/Restrained No muscular rigidity; occasional random movements of arms :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

LEGS
0-Relaxed/Restrained No muscular rigidity; occasional random leg movement :
1-Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion

STATE OF AROUSAL
0-Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement :
1-Fussy Alert, restless & thrashing Total:

Perceived Location: :
Comfort Measures:
Response:

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506 Assessment, shift ^ D Q4H* PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0000 LK 10/08/21 0112 LK

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

506 Assessment, shift ^ (continued)

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: PT QUITE AGITATED, REFUSING TO ANSWER ORIENTATION QUESTIONS, RIPPING AT BIPAP MASK AND IV TUBING TRYING TO GET OUT OF BED. ALERT TO SELF. MAE. COUGHING APPROPRIATELY.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. DRY MOUTH-BIOTENE AT BEDSIDE W/FREQUENT ORAL SWABS.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Y Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Hot RUE: Hot
LLE: Hot RLE: Hot

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR/ST 80'S-130'S; BP SOFT, MD AWARE, OKAY AS LONG AS MAP IS 65 OR HIGHER. ARTIFACT ON MONITOR WHEN PATIENT COUGHS.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Coarse
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Labored Short of breath at rest: Y
Shallow Short of breath with exertion: Y
Oxygen: Y

506 Assessment, shift ^ (continued)

Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: N Nailbeds: Pale Lips cyanotic: N

Comments: CURRENTLY ON BIPAP, 12/8 100% WITH SATS IN MID 90'S. WORK OF BREATHING IS IMPROVED WITH PRECEDEX.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: DENIES ISSUES

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Y Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)
removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity:

Comments: SMALL INCONTINENCE/DRIBBLING- NORMAL PER PT. USES PANT LINER
@ BASELINE AND CURRENTLY. PURWICK PLACED

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: N :

Musculoskeletal swelling: N Location:
Musculoskeletal tenderness: N Location:

Comments: AMBULATES WELL, OCCASIONALLY LOSES BALANCE. SBA/GB.
DENIES PAIN CURRENTLY. WAFFLE MATTRESS IN PLACE.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/08/21 0324 LK 10/08/21 0327 LK

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: PT QUITE AGITATED, REFUSING TO ANSWER ORIENTATION QUESTIONS, RIPPING AT BIPAP MASK AND IV TUBING TRYING TO GET OUT OF BED. ALERT TO SELF. MAE. COUGHING APPROPRIATELY. PT IS SEDATED USING PRECEDEX.

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. DRY MOUTH-BIOTENE AT BEDSIDE W/FREQUENT ORAL SWABS.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Y Irregular:
Abnormal heart sounds:
BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Hot RUE: Hot
LLE: Hot RLE: Hot

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR/ST 70'S-130'S; BP SOFT, MD AWARE, OKAY AS LONG AS MAP IS 65 OR HIGHER. ARTIFACT ON MONITOR WHEN PATIENT COUGHS.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Coarse
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Labored Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic: N

Comments: CURRENTLY ON BIPAP, 12/8 100%. WORK OF BREATHING IS IMPROVED WITH PRECEDEX.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: DENIES ISSUES

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Y Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: SMALL INCONTINENCE/DRIBBLING- NORMAL PER PT. USES PANT LINER @ BASELINE AND CURRENTLY. PURWICK PLACED

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: N :

Musculoskeletal swelling: N Location:
Musculoskeletal tenderness: N Location:

506 Assessment, shift ^ (continued)

Comments: AMBULATES WELL, OCCASIONALLY LOSES BALANCE. SBA/GB.
DENIES PAIN CURRENTLY. WAFFLE MATTRESS IN PLACE.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
506 Assessment, shift ^ D Q4H*			PS	- Document	10/08/21	0815	AM	10/08/21	0948	AM			

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess: Orientation
Speech
Swallowing
Weakness

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL NOT OPEN EYES.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
506 Assessment, shift ^ (continued)													

Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: Hearing aides: Left: Right:
Vision impaired: Glasses: Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. WILL NOT ALLOW ORAL CARES AT THIS TIME.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Y Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Coarse
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Labored Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:

506 Assessment, shift ^ (continued)
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate
(i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for
removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL:
If abnormal: Impaired skin integrity: Location:
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Describe:
Rash: Describe:
Ecchymosis: Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: N :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/08/21 1211 AM 10/08/21 1217 AM
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Y Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Tremors:

ICU: Areas unable to assess: Orientation
Speech
Swallowing
Weakness

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL NOT OPEN EYES.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Coarse
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Labored Short of breath at rest:
Short of breath with exertion:

Oxygen: Y
Cough: Y Productive: N Sputum Color:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

506 Assessment, shift ^ (continued)

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/08/21 1615 AM 10/08/21 1628 AM

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech: Mute

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess: Orientation
Speech
Swallowing
Weakness

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL NOT OPEN EYES.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:

506 Assessment, shift ^ (continued)
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: ATROPINE GIVEN

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Coarse
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Labored Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ D Q4H* PS
- Document 10/08/21 2000 MP 10/08/21 2035 MP
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess: Orientation
Speech
Swallowing

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED. TONGUE CRACKED AND DRY.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Y Irregular: Y
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:
LLE: Trace RLE: Trace
Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SINUS ARRHYTHMIA 50-100S

506 Assessment, shift ^ (continued)

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Crackles/rales, fine

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP TURNED UP TO 100%

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Y Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:

506 Assessment, shift ^ (continued)
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: 2 OINTMENTS IN ROOM FOR RASH, APPLY WITH CARES.
SKIN OTHERWISE GROSSLY INTACT.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness:
Diminished ROM: Y : UTA, RESISTANCE TO MOVEMENET

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 0000 MP 10/09/21 0039 MP

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors:

506 Assessment, shift ^ (continued)

ICU: Areas unable to assess: Orientation
Speech
Swallowing

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS BUT NOT ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED. TONGUE CRACKED AND DRY.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Y Irregular: Y
Abnormal heart sounds:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SINUS ARRHYTHMIA 60-100s

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Oral suction: N Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/BOILS/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: N :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm:

If Yes to any of the above, describe in comments

Comments:

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 0359 MP 10/09/21 0402 MP

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess: Orientation
Speech
Swallowing

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION QUESTIONS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: Right:
Dorsalis Pedis: Left: Right:
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100S

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

506 Assessment, shift ^ (continued)

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: .

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 0811 VW 10/09/21 0825 VW
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Whispers/soft spoken

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS BUT NOT ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: RUE:
LLE: RLE:

Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100S

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y

Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate
(i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE. .

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 1153 VW 10/09/21 1154 VW

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Whispers/soft spoken

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS APPROP

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:

506 Assessment, shift ^ (continued)
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

506 Assessment, shift ^ (continued)

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 1611 VW 10/09/21 1618 VW
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Whispers/soft spoken

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: PT ABLE TO FOLLOW COMMANDS. WILL ANSWER YES/NO QUESTIONS APPROP

EENT

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: Right:
Dorsalis Pedis: Left: Right:
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:

506 Assessment, shift ^ (continued)
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Y Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/09/21 2000 MP 10/09/21 2126 MP
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation
Speech
Swallowing

Due to:

Comments: PUPILS HARD TO ASSESS, PT RESISTS LIGHT IN EYES

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED. TONGUE CRACKED AND DRY.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:
LLE: Trace RLE: Trace
Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100S

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: Diminished RLL: Diminished

506 Assessment, shift ^ (continued)

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: Y Sputum Color:

Amount: Small Consistency: Thick
Oral suction: Y Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
(i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED.

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 0000 MP 10/10/21 0038 MP

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation
Speech
Swallowing

Due to:

Comments: PUPILS HARD TO ASSESS, PT RESISTS LIGHT IN EYES

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: GLASSES AT BEDSIDE. ORAL CARES COMPLETED. TONGUE CRACKED AND DRY.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100S

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:

506 Assessment, shift ^ (continued)
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED IMPROVING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

506 Assessment, shift ^ (continued)

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 0357 MP 10/10/21 0402 MP
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Due to:

Comments: PUPILS HARD TO ASSESS, PT RESISTS LIGHT IN EYES. COUGHS FREQUENTLY WITH SIPS.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:

506 Assessment, shift ^ (continued)
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments: SR/SB 50-100s

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Hypoactive
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:

506 Assessment, shift ^ (continued)
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED IMPROVING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: STRONG ROM OF LEGS

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ALL CARES EXPLAINED PRIOR TO INITIATION. DAD IN ROOM AT BEDSIDE.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 0800 KRH 10/10/21 0936 KRH
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: N :

Weakness: Paralysis:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: SLEEPY, BUT RESPONSIVE TO VOICE. MAEW

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE/LIPS CRACKED/DRY

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: N Tachycardia: N Irregular: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Abnormal heart sounds: NONE NOTED
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: N Right: N
Neck veins distended: N
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60'S. SCD'S ON.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)
Amount: Consistency:
Oral suction: Y Nailbeds: Pale Lips cyanotic: N

Comments: BIPAP, ATTEMPTING TO WEAN FIO2

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Y Nausea: N Vomiting: N Gastric tube: N
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: WILL WORK ON NUTRITION TODAY, BALANCING WITH OXYGEN NEEDS

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

506 Assessment, shift ^ (continued)
Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED IMPROVING.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. WILL ATTEMPT TO PRONE TODAY

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: PLEASANT, OCC RESISTANT TO SOME CARES (I.E. TURNS, LOVENOX SHOT)
BUT COMPLIANT AFTER EDUCATION FOR NEED AND REINFORCEMENT FROM MD
.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)
2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 1230 KRH 10/10/21 1319 KRH

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: N :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: SLEEPY, BUT RESPONSIVE TO VOICE. MAEW

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE/LIPS CRACKED/DRY

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: N Tachycardia: N Irregular: N
Abnormal heart sounds: NONE NOTED
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:
LLE: RLE:

506 Assessment, shift ^ (continued)

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: N Right: N
Neck veins distended: N
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60'S. SCD'S ON.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:
LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Y Nailbeds: Pale Lips cyanotic: N

Comments: BIPAP, UNABLE TO WEAN FIO2

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Y Nausea: N Vomiting: N Gastric tube: N
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: WILL WORK ON NUTRITION TODAY, BALANCING WITH OXYGEN NEEDS

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED IMPROVING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. WILL PRONE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: PT RESISTANT TO MANY CARES, BUT WILL COMPLY WITH ENCOURAGEMENT

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 1606 KRH 10/10/21 1615 KRH

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: N :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: SLEEPY, BUT RESPONSIVE TO VOICE. SOMETIMES DIFFICULT TO HEAR
OVER BIPAP / MASKS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE/LIPS CRACKED/DRY

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: N Tachycardia: N Irregular: N
Abnormal heart sounds: NONE NOTED
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: N Right: N
Neck veins distended: N
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60'S. SCD'S ON.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

506 Assessment, shift ^ (continued)

Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Small Consistency: Thick
Oral suction: Y Nailbeds: Pale Lips cyanotic: N

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: N Vomiting: N Gastric tube: N
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS
Rash: Y Describe: INNER THIGHS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

506 Assessment, shift ^ (continued)

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS. TONGUE AND LIPS DRY AND CRACKED IMPROVING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. PRONED

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments: PLEASANT AND COOPERATIVE. ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/10/21 2000 MP 10/10/21 2041 MP
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Due to:

Comments:

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:

LUE: RUE:

LLE: RLE:

Temperature:

LUE: RUE:

LLE: RLE:

Capillary refill > 3 sec: N

Calf tenderness: Left: Right:

Neck veins distended:

Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.

Implanted pacemaker: AICD:

Comments: SR 60-100s

RESPIRATORY

**Normal Parameters can be viewed by using shift F8.

**Document all abnormal findings. If reassessment, document current findings.

Resp WNL: N If abnormal:

Breath Sounds: Throughout: Clear
Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:

Short of breath with exertion:

Oxygen: Y

Cough: Y Productive: N Sputum Color:

Amount: Consistency:

Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT

GASTROINTESTINAL

**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

**Document all abnormal findings. If reassessment, document current findings.

GI WNL: N If abnormal:

Bowel Sounds: All quad: Hypoactive

LUQ: RUQ:

LLQ: RLQ:

Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:

Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:

Loose/liquid: Constipation: No flatus: Incontinent of stool:

Last BM: 10/6

Comments:

GENITOURINARY

**Normal Parameters can be viewed by using shift F8.

**Document all abnormal findings. If reassessment, document current findings.

GU WNL: N If abnormal:

Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:

Urgency: Nocturia: Bladder distention: Retention: Oliguria:

Perineal edema: Describe:

Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention

Indication for leaving indwelling urinary catheter in place (check all that apply)

Patient has acute or chronic urinary retention or bladder outlet obstruction

Need for accurate urine output measurements Y

Use for selected surgical procedures

To assist in healing of open sacral or perineal wounds

Patient requires prolonged immobilization

To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:

Devices: Suprapubic: Urostomy: External Cath: Catheter traction:

Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS
Rash: Y Describe: INNER THIGHS, BUTTOCKS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS. TONGUE DRY AND CRACKED IMPROVING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. PRONED. STRONG ROM.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/11/21 0000 MP 10/11/21 0011 MP

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Due to:

Comments:

EENT

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: Right:
Dorsalis Pedis: Left: Right:
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: RLE:

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: If abnormal:
Breath Sounds: Throughout:

LUL: RUL:

LLL: RLL:

Respiratory pattern: Short of breath at rest:
Short of breath with exertion:
Oxygen:
Cough: Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM:

Comments:

GENITOURINARY

506 Assessment, shift ^ (continued)

**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Clarity:

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: INTEG WNL:
If abnormal: Impaired skin integrity: Location:
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Dry/flaky: Describe:
Redness: Describe:
Rash: Describe:
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: .

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/11/21 0400 MP 10/11/21 0415 MP
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands: N
Speech:

Facial droop: Left: Right:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess: Orientation

Due to:

Comments: WILL ANSWER YES/NO QUESTIONS AND MAKE NEEDS KNOWN BUT NOT ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: RUE:
LLE: RLE:

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments:

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: RLL:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Respiratory pattern: Tachypnea
Short of breath at rest:
Short of breath with exertion:

Oxygen: Y
Cough: Y Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGH RASH, MOUTH
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS
Rash: Y Describe: INNER THIGHS, BUTTOCKS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/BACK UPPER THIGH

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS. TONGUE DRY AND CRACKED IMPROVING.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.
STRONG ROM

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN

.

506 Assessment, shift ^ (continued)
** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Edit Results 10/11/21 0400 MP 10/11/21 0532 MP
Clarity: Sediment [Clear]
Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT [INNER THIGH RASH, MOUTH]
Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS [INNER THIGHS, BUTTOCKS]
Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS [INNER THIGHS, BUTTOCKS]
Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS
[SCATTERED BUTTOCKS/BACK UPPER THIGH]
Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
[RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS. TONGUE DRY AND]
TONGUE DRY AND CRACKED IMPROVING. [CRACKED IMPROVING.]
- Edit Results 10/11/21 0400 MP 10/11/21 0542 MP
Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
TONGUE DRY AND CRACKED IMPROVING. SEE WOUND CHARTING.
[TONGUE DRY AND CRACKED IMPROVING.]
- Edit Results 10/11/21 0400 MP 10/11/21 0545 MP
Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS.
[RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS]
TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND
[TONGUE DRY AND CRACKED IMPROVING. SEE WOUND CHARTING.]
CHARTING. []
- Edit Results 10/11/21 0400 MP 10/11/21 0623 EF
Productive: Y []
Sputum Color: White []
Amount: Small []
Oral suction: Y []
Comments: BIPAP DEPENDENT
INCREASED SPUTUM/ COUGH. ORAL SUCTIONING TO CLEAR SECRETIONS. []
- Document 10/11/21 0800 ES 10/11/21 0841 ES
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Due to:

Comments: WILL ANSWER YES/NO QUESTIONS AND MAKE NEEDS KNOWN BUT NOT ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:

506 Assessment, shift ^ (continued)
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100s. SBP 100s

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: Y Sputum Color: White

Amount: Small Consistency: Thick
Oral suction: Y Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT
INCREASED SPUTUM/ COUGH. ORAL SUCTIONING TO CLEAR SECRETIONS.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Y Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: WILL WORK ON NUTRITION TODAY, BALANCING WITH OXYGEN NEEDS

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction

506 Assessment, shift ^ (continued)
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate
(i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING. STRONG ROM

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN .

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/11/21 1155 ES 10/11/21 1157 ES

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: N Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

ICU: Areas unable to assess: Orientation

Due to:

Comments: WILL ANSWER YES/NO QUESTIONS AND MAKE NEEDS KNOWN BUT NOT ANSWER ORIENTATION QUESTIONS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments:

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: NONE NOTED
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:

506 Assessment, shift ^ (continued)

Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100s. SBP 100s

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:
LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: Y Sputum Color: White

Amount: Small Consistency: Thick
Oral suction: Y Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT
INCREASED SPUTUM/ COUGH. ORAL SUCTIONING TO CLEAR SECRETIONS.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Y Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: Y No flatus: Incontinent of stool:
Last BM: 10/6

Comments: WILL WORK ON NUTRITION TODAY, BALANCING WITH OXYGEN NEEDS

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.
STRONG ROM

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)
3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/11/21 1533 ES 10/11/21 1536 ES
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Due to:

Comments: WILL ANSWER YES/NO QUESTIONS AND MAKE NEEDS KNOWN BUT NOT ANSWER
ORIENTATION QUESTIONS

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm

506 Assessment, shift ^ (continued)
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100s. SBP 100s

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: Y Sputum Color: White

Amount: Small Consistency: Thick
Oral suction: Y Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT
INCREASED SPUTUM/ COUGH. ORAL SUCTIONING TO CLEAR SECRETIONS.
GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: N All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Y Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: Y No flatus: Incontinent of stool:
Last BM: 10/6

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Y Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING-INTERDRY APPLIED TO FOLDS.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING. STRONG ROM

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/11/21 1952 CGR 10/11/21 1956 CGR

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:

506 Assessment, shift ^ (continued)
Unable to follow commands:
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Y Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace
Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SR 60-100s. SBP 100s.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished

506 Assessment, shift ^ (continued)
LUL: RUL:
LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Y Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 88-93% SPO2, MD AWARE.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: POOR NUTRITIONAL INTAKE D/T RESP STATUS.

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS.
TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND

506 Assessment, shift ^ (continued)

CHARTING-INTERDRY APPLIED TO FOLDS.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, SISTER IN ROOM TODAY.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/12/21 0006 CGR 10/12/21 0059 CGR
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

506 Assessment, shift ^ (continued)

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE.

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: Y Sputum Color: Tan/Beige

Amount: Scant Consistency: Thick
Oral suction: N Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 88-93% SPO2, MD AWARE.
PRECEDEX INCREASED AND PT PRONED, SATS AND RR IMPROVED
GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Y Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: POOR NUTRITIONAL INTAKE D/T RESP STATUS.

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: FOLEY TO GRAVITY.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS.
TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND
CHARTING-INTERDRY APPLIED TO FOLDS.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MS WNL: N If abnormal:
Generalized muscle weakness:
Diminished ROM: Y : CRITICAL ILLNESS, RESP STATUS

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, ALL CARES EXPLAINED. FATHER UPDATED
VIA PHONE.
.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score

- Document 10/12/21 0351 CGR 10/12/21 0353 CGR

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE.

EENT
**Normal Parameters can be viewed by using shift F8.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: Trace RUE: Trace

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: Y Sputum Color: Tan/Beige

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 88-93% SPO2, MD AWARE. PRECEDEX INCREASED AND PT PRONED, SATS AND RR IMPROVED SINCE PRONING.

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: N If abnormal:
Bowel Sounds: All quad: Active
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen: Distended, soft

Poor appetite: Y Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: POOR NUTRITIONAL INTAKE D/T RESP STATUS.

GENITOURINARY

506 Assessment, shift ^ (continued)

**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Yellow Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING-INTERDRY APPLIED TO FOLDS.

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: Y : CRITICAL ILLNESS, RESP STATUS

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/12/21 0800 HJM 10/12/21 0856 HJM
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

LLL: RLL:

Respiratory pattern: Short of breath at rest:
Short of breath with exertion:

Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: N Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 88-93% SPO2, MD AWARE. PRECEDEX INCREASED AND PT PRONED, SATS AND RR IMPROVED SINCE PRONING.--CONT' SAME TREATMENT

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/6

Comments: ENSURE OFFERED WITH BIPAP/ ORAL CARE BREAKS. TOOK APPROX 1/2 CUP

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization Y
To improve comfort for end of life care:

506 Assessment, shift ^ (continued)

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING-INTERDRY APPLIED TO FOLDS. CREAMS FOR REDDENED GROIN

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
506 Assessment, shift		^ (continued)											

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, ALL CARES EXPLAINED.

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Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
506 Assessment, shift		^ (continued)											

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/12/21 1126 HJM 10/12/21 1127 HJM

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

506 Assessment, shift ^ (continued)
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Clear
Diminished
LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: N Nailbeds: Lips cyanotic:

Comments: BIPAP DEPENDENT, 90%. FREQ COUGH. 88-93% SPO2, MD AWARE. PRECEDEX INCREASED AND PT PRONED, INCREASING O2 NEEDS THIS AM, TOLERATING PRONE POSITION

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

GI WNL: If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM:

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Clarity:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: INTEG WNL:
If abnormal: Impaired skin integrity: Location:
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Describe:
Rash: Describe:
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MS WNL: If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments:

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

506 Assessment, shift ^ (continued)
5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Edit Results 10/12/21 1126 HJM 10/12/21 1129 HJM
GI WNL: Y []
Last BM: 10/12 []
Comments: MEDIUM FORMED BROWN STOOL []
GU WNL: N []
Indwelling foley: Y []
Patient requires prolonged immobilization Y []
If observed, urine color: Amber []
Clarity: Clear []
Skin integrity assessed under medical devices: Y []
INTEG WNL: N []
Impaired skin integrity: Y []
Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT []
Dry/flaky: N []
Redness: Y []
Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS []
Rash: Y []
Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS []
Scab: Y []
Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS []
MS WNL: N []
Generalized muscle weakness: Y []
PSYCH WNL: Y []
- Document 10/12/21 1526 HJM 10/12/21 1528 HJM
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

ICU: Areas unable to assess:

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 885-87% SPO2, MD AWARE. INCREASING O2 NEEDS THIS AM, SUPINE, MOVED SELF OUT OF PRONE POSITION, NOT WILLING TO ATTEMPT AT THIS TIME

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/12

Comments: MEDIUM FORMED BROWN STOOL

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization Y
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING-INTERDRY APPLIED TO FOLDS. CREAMS FOR REDDENED GROIN

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments:

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

506 Assessment, shift ^ (continued)

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/12/21 2000 SH 10/12/21 2140 SH
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: N Right: N
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: N :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess: Orientation

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS. HX OF DOWNS SYNDROME

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:
LLE: RLE:

506 Assessment, shift ^ (continued)

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Labored Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color: Tan/Beige

Amount: Scant Consistency: Thick
Oral suction: N Nailbeds: Pale Lips cyanotic:

Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. 85-87% SPO2, MD AWARE.
INCREASING O2 NEEDS THIS AM, SUPINE, MOVED SELF OUT OF PRONE
POSITION, NOT WILLING TO ATTEMPT AT THIS TIME

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Last BM: 10/12

Comments: MEDIUM FORMED BROWN STOOL

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Y Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

506 Assessment, shift ^ (continued)
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS. TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND CHARTING-INTERDRY APPLIED TO FOLDS. CREAMS FOR REDDENED GROIN

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: Y : CRITICAL ILLNESS, RESP STATUS

Musculoskeletal swelling: N Location:
Musculoskeletal tenderness: N Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/13/21 0000 SH 10/13/21 0023 SH
NEUROLOGICAL

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands: N
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors: NONE NOTED

ICU: Areas unable to assess:

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS. HX OF DOWNS SYNDROME

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Labored Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments:

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM:

Comments:

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: *Document insertion on cath insertion intervention

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Clarity:

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: INTEG WNL:
If abnormal: Impaired skin integrity: Location:
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: Describe:
Redness: Describe:
Rash: Describe:
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Skin Tear: Describe:
Laceration: Describe:
Scab: Describe:

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If Yes to any of the above, describe in comments

Comments:

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/13/21 0400 SH 10/13/21 0459 SH

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Y Lethargic: Non-responsive: Obtunded: Impaired memory: Y
Unable to follow commands:
Speech: Garbled/mumbled

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light: N
Impaired sensation: N :

Weakness: Paralysis:

Tremors: NONE NOTED

506 Assessment, shift ^ (continued)

ICU: Areas unable to assess: Orientation

Due to:

Comments: DROWSY BUT WAKES TO VOICE. ORIENTED TO SELF, RESPONDS YES/NO TO QUESTIONS. MAE. MAKES NEEDS KNOWN, RESTING COMFORTABLY IN BETWEEN ASSESSMENTS. HX OF DOWNS SYNDROME

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Y Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: N Hearing aides: Left: Right:
Vision impaired: Y Glasses: Y Contacts:
Dentures: N Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Y Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: N
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema: N
Peripheral edema:
LUE: Trace RUE: Trace
LLE: Trace RLE: Trace
Describe:

Color:
LUE: RUE:
LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec: N
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: SB 50-60s, SBP STABLE.

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished
LUL: RUL:
LLL: Diminished RLL: Diminished

Respiratory pattern: Tachypnea Short of breath at rest: Y
Labored Short of breath with exertion: Y
Oxygen: Y
Cough: Y Productive: N Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

506 Assessment, shift ^ (continued)
Comments: BIPAP DEPENDENT, 100%. FREQ COUGH. CURRENTLY PRONING. SATURATION 90'S% SINCE PRONING

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/13 SMALL

Comments: SMALL FORMED BROWN STOOL

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements Y
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If observed, urine color: Amber Clarity: Clear

Comments: FOLEY TO GRAVITY.

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: N Clammy: Diaphoretic: Cool: Hot:
Skin color: Pale

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments: RASH/REDNESS/OPEN/SCABS ON INNER THIGHS/BUTTOCKS/BREASTS/FOLDS.
TONGUE DRY AND CRACKED IMPROVING. FISSURE ON COCCYX. SEE WOUND
CHARTING-INTERDRY APPLIED TO FOLDS. CREAMS FOR REDDENED GROIN

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: N If abnormal:
Generalized muscle weakness: Y
Diminished ROM: Y : CRITICAL ILLNESS, RESP STATUS

Musculoskeletal swelling: N Location:
Musculoskeletal tenderness: N Location:

Comments: 2A, PT ASSISTS WITH TURNS IN THE BED. INTERMITTENT PRONING.

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments: ABLE TO MAKE NEEDS KNOWN, ALL CARES EXPLAINED.

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score

- Document 10/13/21 0802 HJM 10/13/21 0807 HJM

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: MORE ALERT TODAY, SPEAKS IN SENTENCES, MAKES NEEDS KNOW

506 Assessment, shift ^ (continued)

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry: Y
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: Hearing aides: Left: Right:
Vision impaired: Glasses: Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds:
BP outside normal range: Y
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

506 Assessment, shift ^ (continued)

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: NSR 80'S, NO ECTOPY
NORMALTENSIVE

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout:

LUL: Clear RUL: Diminished

LLL: Diminished RLL: Diminished

Respiratory pattern: Short of breath at rest:
Short of breath with exertion:
Oxygen: Y
Cough: N Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP 20/15 100%, O2 SAT 70-80 SUPINE, SAT 95% IN PRONE POSITION

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/14

Comments: SMALL FORMED BROWN STOOL

506 Assessment, shift ^ (continued)

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization Y
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: MOVES WELL IN BED
AMBULATORY AT BASELINE

506 Assessment, shift ^ (continued)

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments:

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/13/21 1141 HJM 10/13/21 1143 HJM
NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Comments: MORE ALERT TODAY, SPEAKS IN SENTENCES, MAKES NEEDS KNOW, RESTLESS AT TIMES, KICKING LEGS OVER BED RAIL AND SITTING UP AT ONE POINT

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: Hearing aides: Left: Right:
Vision impaired: Glasses: Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: NSR 80'S- ST 120'S NO ECTOPY
NORMALTENSIVE

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

LUL: RUL:

LLL: RLL:

Respiratory pattern: Short of breath at rest: Y
Short of breath with exertion:
Oxygen: Y
Cough: N Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP 20/15 100%,

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:
Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/14

Comments: SMALL BORE NG PLACED L NARE
STARTING TF TODAY

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)
Patient requires prolonged immobilization Y
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate
(i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Clear

Comments:

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments:

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments:

506 Assessment, shift ^ (continued)

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
- Document 10/13/21 1600 HJM 10/13/21 1612 HJM

NEUROLOGICAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
NEURO WNL: N If abnormal:
Disoriented to: Person: Place: Time:
Drowsy: Lethargic: Non-responsive: Obtunded: Impaired memory:
Unable to follow commands:
Speech:

Facial droop: Left: Right:
Difficulty swallowing: Pupils unequal/nonreactive to light:
Impaired sensation: :

Weakness: Paralysis:

Tremors:

ICU: Areas unable to assess:

Due to:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Comments: ORIENTED TO SELF
VERBAL AT TIMES

EENT
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

EENT WNL: N If abnormal:
Sclera: Blood-shot: Cloudy: Jaundiced: Edema:
Mucous membranes: Mucous membrane dry:
Oral mucosa impaired: Oral bleeding: White patches:
Nasal airway impaired:

**Check all corrective devices used during hospitaization:
Hearing impaired: Hearing aides: Left: Right:
Vision impaired: Glasses: Contacts:
Dentures: Full: Upper: Lower:
Partial: Upper: Lower:

Comments: TONGUE CRACKED/DRY-FREQUENT ORAL CARES.

CARDIOVASCULAR
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
CV WNL: N If abnormal:
Heart Rate: Bradycardia: Tachycardia: Irregular:
Abnormal heart sounds: DISTANT
BP outside normal range:
Radial Pulse: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Dorsalis Pedis: Left: 2+ Normal/easy to palpate Right: 2+ Normal/easy to palpate
Post-tibial: Left: Right:
Generalized edema:
Peripheral edema:
LUE: RUE:

506 Assessment, shift ^ (continued)
LLE: Trace RLE: Trace

Describe:

Color:
LUE: RUE:

LLE: RLE:

Temperature:
LUE: Warm RUE: Warm
LLE: Warm RLE: Warm

Capillary refill > 3 sec:
Calf tenderness: Left: Right:
Neck veins distended:
Telemetry/cardiac monitoring: Y *Document rhythm strip interpretation on telemetry interv.
Implanted pacemaker: AICD:

Comments: NSR 80'S- ST 120'S NO ECTOPY
NORMALTENSIVE

RESPIRATORY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Resp WNL: N If abnormal:
Breath Sounds: Throughout: Diminished

LUL: RUL:

LLL: RLL:

Respiratory pattern: Tachypnea Short of breath at rest:
Labored Short of breath with exertion:
Oxygen: Y
Cough: N Productive: Sputum Color:

Amount: Consistency:
Oral suction: Nailbeds: Lips cyanotic:

Comments: BIPAP 20/15 100%, WILL NOT STAY IN PRONE POSITION

GASTROINTESTINAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GI WNL: Y If abnormal:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

506 Assessment, shift ^ (continued)

Bowel Sounds: All quad:
LUQ: RUQ:
LLQ: RLQ:
Pain with palpation: All quad: LUQ: LLQ: RUQ: RLQ:
Abdomen:

Poor appetite: Nausea: Vomiting: Gastric tube:
Loose/liquid: Constipation: No flatus: Incontinent of stool:
Last BM: 10/14

Comments: SMALL BORE NG PLACED L NARE
STARTING TF TODAY
LG BM

GENITOURINARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
GU WNL: N If abnormal:
Frequency: Incontinent: Anuresis: Dysuria: Hematuria: Menses:
Urgency: Nocturia: Bladder distention: Retention: Oliguria:
Perineal edema: Describe:
Suprapubic tenderness: Costovertebral angle pain or tenderness:

Indwelling foley: Y *Document insertion on cath insertion intervention
Indication for leaving indwelling urinary catheter in place (check all that apply)
Patient has acute or chronic urinary retention or bladder outlet obstruction
Need for accurate urine output measurements
Use for selected surgical procedures
To assist in healing of open sacral or perineal wounds
Patient requires prolonged immobilization Y
To improve comfort for end of life care:

**Alternatives to indwelling catheters should be considered and utilized as appropriate (i.e. external catherters, frequent toileting schedules, intermittent catherterization)

If indications for urinary catheter are not met, follow the Nurse Driven Protocol for removal, unless LIP order not to follow Nurse Driven Protocol

Self-cath: CBI: Indwelling catheter present on admission:
Devices: Suprapubic: Urostomy: External Cath: Catheter traction:
Nephrostomy tube, right: Nephrostomy tube, left:

If observed, urine color: Amber Clarity: Sediment

Comments:

506 Assessment, shift ^ (continued)

INTEGUMENTARY
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
Skin integrity assessed under medical devices: Y INTEG WNL: N
If abnormal: Impaired skin integrity: Y Location: INNER THIGHS,AB FOLDS,BREASTS,BUTT
*If skin not intact, document on appropriate intervention.
*If Incision, document on WOUND: Incision/Dressing Management intervention
*If Wound/Pressure Ulcer, document on
WOUND: Wound or Pressure Ulcer/Drs Management intervention
Skin turgor abnormal: Clammy: Diaphoretic: Cool: Hot:
Skin color:

Dry/flaky: N Describe:
Redness: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Rash: Y Describe: INNER THIGHS, BUTTOCKS, BREASTS, FOLDS
Ecchymosis: Describe:
Petechiae: Describe:
Mottled: Describe:

Skin Tear: Describe:
Laceration: Describe:
Scab: Y Describe: SCATTERED BUTTOCKS/INNER THIGHS, BREASTS, FOLDS

Comments:

MUSCULOSKELETAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Sts	Direction	Documented Change	From

506 Assessment, shift ^ (continued)

MS WNL: Y If abnormal:
Generalized muscle weakness:
Diminished ROM: :

Musculoskeletal swelling: Location:
Musculoskeletal tenderness: Location:

Comments: MOVES WELL IN BED
AMBULATORY AT BASELINE

PSYCHOSOCIAL
**Normal Parameters can be viewed by using shift F8.
**Document all abnormal findings. If reassessment, document current findings.
PSYCH WNL: Y If abnormal:
Characteristics of appearance inappropriate to situation:
Characteristics of behavior inappropriate to situation:
Verbalizations inappropriate to situation:
Mood swings:
Inappropriate affect:
Expressed NEW suicidal ideation or comments about self harm: .

If Yes to any of the above, describe in comments

Comments:

.

** Columbia Suicide Severity Reassessment Scale ** [SHIFT F8] for reference text
Begin questions 1 through 5 with: Since Last Contact (If asking caregiver, reframe question)
****Patients 12 and up:
1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6

3. Have you been thinking about how you might do this?

4. Have you had these thoughts and had some intention of acting on them?

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Sts	Direction	Documented Change	From

506 Assessment, shift ^ (continued)
5. Have you started to work out or worked out the details of how to kill yourself?
Do you intend to carry out this plan?

6. Have you done anything, started to do anything or prepared to do anything
to end your life?

C-SSRS Score : [SHIFT F8] for reference based on score
2551 Vital Signs (VS) ^ C Q1H PS
-Every 1hr & PRN with vasoactive drips
-Admission & immediate post-op:
every 15min x4, every 30min x2, every
1hr x4, then every 2hr

CONTINUOUS PULSE OXIMETRY
CONTINUOUS CARDIAC MONITOR
TEMP Q4H

OXIMETRY:
Oxygen per nasal cannula at:
liters/min or per mask at: % x 24hr
- Document 10/07/21 2200 SH 10/07/21 2245 SH
P 109 R 40
SPO2%: 92 Oxygen (LPM): Oxygen (%): 100
FiO2 (%): PF Ratio (PaO2/FiO2):
Humidified: Pediatric patients (%):
Device: BiPAP

ETCO2%: Pediatric Patients| Respiratory Score: BPEWS:

Pasero Opioid-Induced Sedation Scale (POSS)* *Blue ?
Resp Quality: Shallow

RASS Scale (ICU patients) +3 Very Agitated

Position: Lying
BP 130/62 MAP: BP#2: MAP:
Extremity: RIGHT ARM Extremity:
Mode: Non-invasive BP Monitor Mode:

T 104.0 (degrees F) T (degrees C) Route: Axillary

CVP: ICP:
PAS: CPP:
PAD:
PAW/PAOP:
CO: IAP:
CI: APP:
SVR: Corrected CVP:
PVR:
SVO2%: TOF Baseline mA: TOF Current mA:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2551 Vital Signs (VS) ^ (continued)
ScVO2%: TOF:
SpCO2%: Location:

Comments:

PARS: *PARS definitions can be viewed by clicking blue ? on toolbar or pressing shift <F8>*
Activity:
Resp:
Circulation:
Neurol (LOC):
O2 Sat (SpO2):
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Ed Status 10/07/21 2341 LK 10/07/21 2341 LK A => C

2559 Weight ^ D DAILYNOC PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0400 LK 10/08/21 0435 LK
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 176.9 Kg: 80.240
BMI: 39.66 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET
- Document 10/09/21 0500 MP 10/09/21 0547 MP
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 183.7 Kg: 83.325
BMI: 41.18 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET
- Document 10/10/21 0500 MP 10/10/21 0553 MP
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 180.6 Kg: 81.919
BMI: 40.49 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET
- Document 10/11/21 0500 MP 10/11/21 0529 MP
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 179.7 Kg: 81.511
BMI: 40.29 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2559 Weight ^ D DAILYNOC PS
- Document 10/12/21 0438 CGR 10/12/21 0438 CGR
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 177.6 Kg: 80.558
BMI: 39.82 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET
- Document 10/13/21 0500 SH 10/13/21 0527 SH
Ht-Ft: 4 In: 8 Cm: 142.24
Wt-Lbs: 177.6 Kg: 80.558
BMI: 39.82 . -

Method: Bed Scale
Comments: WAFFLE, ONE PILLOW, FLAT SHEET

9015 CV: Telemetry, monitor as ordered ^ D SHIFT PS
Telemetry - Continuously

Change patches daily with bath.
RN to document at end of shift.

ICU RN TO POST RHYTHM STRIP WITH
MEASUREMENTS AND INTERPRETATION AT
BEGINNING OF EACH SHIFT & WITH CHANGES
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0054 LK 10/08/21 0054 LK
Rhythm Interpretation/Telemetry Tech report: SR/ST 80'S-130'S

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/08/21 0815 AM 10/08/21 0949 AM
Rhythm Interpretation/Telemetry Tech report: SR/ST 80'S-130'S

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:
- Document 10/08/21 1615 AM 10/08/21 1633 AM
Rhythm Interpretation/Telemetry Tech report: SB 40-50

Alarm parameter settings adjusted this shift? N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

9015 CV: Telemetry, monitor as ordered ^ (continued)
If yes, list parameter changes:

Comments:
- Document 10/09/21 0100 MP 10/09/21 0112 MP
Rhythm Interpretation/Telemetry Tech report: SA/SB/ST 60-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/09/21 0811 VW 10/09/21 0821 VW
Rhythm Interpretation/Telemetry Tech report: SA/SB/ST 60-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/09/21 1611 VW 10/09/21 1624 VW
Rhythm Interpretation/Telemetry Tech report: SA/SB/ST 60-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/10/21 0054 MP 10/10/21 0054 MP
Rhythm Interpretation/Telemetry Tech report: SINUS RHYTHM 60-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/10/21 0800 KRH 10/10/21 0938 KRH
Rhythm Interpretation/Telemetry Tech report: SR 60'S

Alarm parameter settings adjusted this shift? N

9015 CV: Telemetry, monitor as ordered ^ (continued)
If yes, list parameter changes:

Comments:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Rhythm Interpretation/Telemetry Tech report: SR 60'S

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/11/21 0029 MP 10/11/21 0030 MP
Rhythm Interpretation/Telemetry Tech report: SINUS RHYTHM/SINUS BRADY 50-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/11/21 0800 ES 10/11/21 0842 ES
Rhythm Interpretation/Telemetry Tech report: SINUS RHYTHM/SINUS BRADY 50-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/11/21 1527 ES 10/11/21 1527 ES
Rhythm Interpretation/Telemetry Tech report: SINUS RHYTHM/SINUS BRADY 50-100s

Alarm parameter settings adjusted this shift? N

If yes, list parameter changes:

Comments:
- Document 10/12/21 0006 CGR 10/12/21 0101 CGR
Rhythm Interpretation/Telemetry Tech report: SB/SR 50-80s.

Alarm parameter settings adjusted this shift?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

9015 CV: Telemetry, monitor as ordered ^ (continued)
If yes, list parameter changes:

Comments:
- Document 10/12/21 0800 HJM 10/12/21 0857 HJM
Rhythm Interpretation/Telemetry Tech report: SB/NSR 50-66, NO ECTOPY

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:
- Document 10/12/21 1529 HJM 10/12/21 1529 HJM
Rhythm Interpretation/Telemetry Tech report: SB 53-57, NO ECTOPY

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:
- Document 10/13/21 0100 SH 10/13/21 0237 SH
Rhythm Interpretation/Telemetry Tech report: 50'S - 60'S

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:
- Document 10/13/21 0802 HJM 10/13/21 0809 HJM
Rhythm Interpretation/Telemetry Tech report: NSR 80, NO ECTOPY

Alarm parameter settings adjusted this shift?

If yes, list parameter changes:

Comments:
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
Rhythm Interpretation/Telemetry Tech report: NSR 79-100'S

Alarm parameter settings adjusted this shift?

9015 CV: Telemetry, monitor as ordered ^ (continued)
If yes, list parameter changes:

Comments:
17058 INTEG: Braden scale ^ D 14 PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 1425 AM 10/08/21 1425 AM
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 3 - NO APPARENT PROBLEMS
Braden Total Score: 19

Is this a decline in condition from last assessment:
- Document 10/09/21 1411 VW 10/09/21 1435 VW
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 1 - BEDFAST
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 2 - POTENTIAL PROBLEMS
Braden Total Score: 16

Is this a decline in condition from last assessment:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17058 INTEG: Braden scale ^ (continued)
Degree of physical activity: 1 - BEDFAST
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 2 - POTENTIAL PROBLEMS
Braden Total Score: 16

Is this a decline in condition from last assessment:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 1 - BEDFAST
MOBILITY
Ability to change and control body position: 3 - SLIGHTLY LIMITED
NUTRITION
Usual food intake pattern: 3 - ADEQUATE
FRICTION AND SHEAR
Friction: 1 - PROBLEMS
Braden Total Score: 15

Is this a decline in condition from last assessment:
- Document 10/12/21 1400 HJM 10/12/21 1411 HJM
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 1 - BEDFAST
MOBILITY
Ability to change and control body position: 2 - VERY LIMITED
NUTRITION
Usual food intake pattern: 2 - PROBABLY INADEQUATE
FRICTION AND SHEAR
Friction: 2 - POTENTIAL PROBLEMS
Braden Total Score: 14

Is this a decline in condition from last assessment:
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
Scoring criteria can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

SENSORY PERCEPTION

17058 INTEG: Braden scale ^ (continued)
Meaningful response to pressure-related discomfort: 4 - NO IMPAIRMENT
MOISTURE
Degree to which skin is exposed to moisture: 3 - OCCASIONALLY MOIST
ACTIVITY
Degree of physical activity: 1 - BEDFAST
MOBILITY
Ability to change and control body position: 2 - VERY LIMITED
NUTRITION
Usual food intake pattern: 2 - PROBABLY INADEQUATE
FRICTION AND SHEAR
Friction: 2 - POTENTIAL PROBLEMS
Braden Total Score: 14

Is this a decline in condition from last assessment:
3130 SAFETY: Fall Morse Scale ^ D 08,20 PS
Assessment to be completed BID & with condition change.
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0815 AM 10/08/21 0949 AM
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/08/21 2000 MP 10/08/21 2037 MP
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3130 SAFETY: Fall Morse Scale ^ (continued)

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/09/21 0811 VW 10/09/21 0821 VW
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/09/21 2000 MP 10/09/21 2127 MP
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3130 SAFETY: Fall Morse Scale ^ (continued)

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/10/21 0800 KRH 10/10/21 0938 KRH
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/10/21 2000 MP 10/10/21 2045 MP
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP Yes-15 Score: 15

Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation? None, bedrest, uses W/C Score: 0

IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment? Yes Score: 20

Gait-Transferring: ([SHIFT/F8] for gait definitions) Normal, or Immobile-0 Score: 0

Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?' Forgets Limitations Score: 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 Morse Fall Risk Score: 50
- Document 10/11/21 0800 ES 10/11/21 0842 ES
****MORSE FALL SCALE**** [SHIFT F8] to view scoring
History of Fall: Has the patient fallen recently or within the last three months? No-0 Score: 0

Secondary Diagnosis: Does the patient have >1 diagnosis? Yes-15

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3130 SAFETY: Fall Morse Scale ^ (continued)													
consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP			Score: 15										
Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation?		None, bedrest, uses W/C	Score: 0										
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?		Yes	Score: 20										
Gait-Transferring: ([SHIFT/F8] for gait definitions)		Normal, or Immobile-0	Score: 0										
Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'		Forgets Limitations	Score: 15										
Scoring Risk Levels [SHIFT/F8]:		High Risk >44	Morse Fall Risk Score: 50										
- Document 10/11/21 1952 CGR 10/11/21 1959 CGR													
****MORSE FALL SCALE****			[SHIFT F8] to view scoring										
History of Fall: Has the patient fallen recently or within the last three months?		No-0	Score: 0										
Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP		Yes-15	Score: 15										
Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation?		None, bedrest, uses W/C	Score: 0										
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?		Yes	Score: 20										
Gait-Transferring: ([SHIFT/F8] for gait definitions)		Normal, or Immobile-0	Score: 0										
Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'		Forgets Limitations	Score: 15										
Scoring Risk Levels [SHIFT/F8]:		High Risk >44	Morse Fall Risk Score: 50										
- Document 10/12/21 0800 HJM 10/12/21 0857 HJM													
****MORSE FALL SCALE****			[SHIFT F8] to view scoring										
History of Fall: Has the patient fallen recently or within the last three months?		No-0	Score: 0										
Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP		Yes-15	Score: 15										
Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation?		None, bedrest, uses W/C	Score: 0										
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?		Yes	Score: 20										

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3130 SAFETY: Fall Morse Scale ^ (continued)													
Gait-Transferring: ([SHIFT/F8] for gait definitions)		Normal, or Immobile-0	Score: 0										
Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'		Forgets Limitations	Score: 15										
Scoring Risk Levels [SHIFT/F8]:		High Risk >44	Morse Fall Risk Score: 50										
- Document 10/12/21 2000 SH 10/12/21 2141 SH													
****MORSE FALL SCALE****			[SHIFT F8] to view scoring										
History of Fall: Has the patient fallen recently or within the last three months?		No-0	Score: 0										
Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP		Yes-15	Score: 15										
Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation?		None, bedrest, uses W/C	Score: 0										
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?		Yes	Score: 20										
Gait-Transferring: ([SHIFT/F8] for gait definitions)		Normal, or Immobile-0	Score: 0										
Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'		Forgets Limitations	Score: 15										
Scoring Risk Levels [SHIFT/F8]:		High Risk >44	Morse Fall Risk Score: 50										
- Document 10/13/21 0802 HJM 10/13/21 0808 HJM													
****MORSE FALL SCALE****			[SHIFT F8] to view scoring										
History of Fall: Has the patient fallen recently or within the last three months?		No-0	Score: 0										
Secondary Diagnosis: Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP		Yes-15	Score: 15										
Use of Ambulatory Aid: Does the patient use any of the following to assist with ambulation?		None, bedrest, uses W/C	Score: 0										
IV or IV Lock: Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?		Yes	Score: 20										
Gait-Transferring: ([SHIFT/F8] for gait definitions)		Normal, or Immobile-0	Score: 0										
Mental Status: To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'		Forgets Limitations	Score: 15										
Scoring Risk Levels [SHIFT/F8]:		High Risk >44	Morse Fall Risk Score: 50										

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3127 SAFETY: Fall Risk Intervention- Adult ^ D 08,20 Assessment to be completed BID & with condition change.			PS										
- Create					10/07/21	2222	SH	10/07/21	2224	SH			
- Document					10/08/21	0815	AM	10/08/21	0949	AM			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids											
Hourly rounding	Y	Toileting schedule											
Safe Exit Side		Within Arms reach when toileting											
Call light within reach	Y	Patient Education/brochure											
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan		Pharmacy review of medications	Y										
Non-skid socks		Bed in low position/wheels locked	Y										
Hand off of fall risk status		Free of clutter	Y										
Gait Belt		Call Don't Fall Poster	Y										
Identify fall risk category or score		Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)		Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place		Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/08/21	2000	MP	10/08/21	2036	MP			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/09/21	0811	VW	10/09/21	0818	VW			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
3127 SAFETY: Fall Risk Intervention- Adult ^ (continued)													
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/09/21	2000	MP	10/09/21	2127	MP			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/10/21	0800	KRH	10/10/21	0937	KRH			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids											
Hourly rounding	Y	Toileting schedule											
Safe Exit Side	Y	Within Arms reach when toileting											
Call light within reach	Y	Patient Education/brochure											
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks		Bed in low position/wheels locked	Y										
Hand off of fall risk status		Free of clutter	Y										
Gait Belt		Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)		Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/10/21	2000	MP	10/10/21	2045	MP			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3127 SAFETY: Fall Risk Intervention- Adult ^ (continued)													
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/11/21	0800	ES	10/11/21	0842	ES			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/11/21	1952	CGR	10/11/21	1959	CGR			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side		Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/12/21	0800	HJM	10/12/21	0857	HJM			
Fall Risk Interventions													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3127 SAFETY: Fall Risk Intervention- Adult ^ (continued)													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/12/21	2000	SH	10/12/21	2141	SH			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)		Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										
Additional Interventions*													
- Document					10/13/21	0802	HJM	10/13/21	0808	HJM			
Fall Risk Interventions													
Basic Safety Fall Prevention Reviewed?	Y	Corrective eye wear/hearing aids	Y										
Hourly rounding	Y	Toileting schedule	Y										
Safe Exit Side	Y	Within Arms reach when toileting	Y										
Call light within reach	Y	Patient Education/brochure	Y										
Re-orientation	Y	Assistive device(s)	Y										
Risk for Fall Care Plan	Y	Pharmacy review of medications	Y										
Non-skid socks	Y	Bed in low position/wheels locked	Y										
Hand off of fall risk status	Y	Free of clutter	Y										
Gait Belt	Y	Call Don't Fall Poster	Y										
Identify fall risk category or score	Y	Bed close to nurse station	Y										
1:1 in diagnostic/treatment areas		Yellow gown	Y										
Fall Risk armband on (specific pts only)	Y	Lap belt when in chair/wheelchair											
Bed/Mobility Alarm in place	Y	Clear Text Fall Risk sign	Y										

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3127 SAFETY: Fall Risk Intervention- Adult ^ (continued)
Additional Interventions*
750 RN Sedation Risk Assessment ^ D 17 PS
Date general anesthesia received:
Length of time under general anesthesia:
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 1711 AM 10/08/21 1711 AM
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:
If increase in risk, Respiratory Therapy referral:

Comments:
- Document 10/09/21 1656 VW 10/09/21 1656 VW
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:
If increase in risk, Respiratory Therapy referral:

Comments:
- Document 10/10/21 1700 KRH 10/10/21 1806 KRH
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

750 RN Sedation Risk Assessment ^ (continued)
Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral: No Referral
If increase in risk, Respiratory Therapy referral: No Referral

Comments:
- Document 10/11/21 1634 ES 10/11/21 1634 ES
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:
If increase in risk, Respiratory Therapy referral:

Comments:
- Document 10/12/21 1702 HJM 10/12/21 1702 HJM
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:
If increase in risk, Respiratory Therapy referral:

Comments:
- Document 10/13/21 1700 HJM 10/13/21 1707 HJM
Prolonged general anesthesia during surgery (>3hrs) in the past 24 hours: N

Continuous, PCA, transdermal or long acting opioids: N
(Examples: extended release morphine or oxycodone,any methadone)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

750 RN Sedation Risk Assessment ^ (continued)

Receiving frequent doses of scheduled or PRN opioids: N
(every 2-3 hours)

Multiple sedating medications: N
(Opioids, benzodiazepine, sleeper, antihistamine, other CNS depressants)

Is there an increase in risk for respiratory compromise from last assessment: N

If increase in risk, Pharmacy referral:
If increase in risk, Respiratory Therapy referral:

Comments:

1750 Intake, food, monitor ^ D PRN PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0900 AM 10/08/21 1000 AM
Meal:
Diet:
% eaten:
Level of assist with meals:

Comments:
- Ed Directs 10/08/21 1000 AM 10/08/21 1000 AM 10/07 2222 PC => 10/07 2222 PC
10/08 1000 PRN
- Document 10/10/21 1800 KRH 10/10/21 1832 KRH
Meal: Dinner
Diet: GENERAL
% eaten: 50
Level of assist with meals: Maximum (does <50%)

Comments: drank 1/2 of Ensure Clear
- Ed Status 10/13/21 1344 HJM 10/13/21 1344 HJM A => H
31014 Review Plan of Care with pt/family ^ D SHIFT END PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0436 LK 10/08/21 0436 LK
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: New intervention added

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/08/21 1425 AM 10/08/21 1425 AM
Plan of care reviewed: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/08/21 2200 MP 10/08/21 2247 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/09/21 0600 MP 10/09/21 0618 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/09/21 1411 VW 10/09/21 1435 VW
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/09/21 2152 MP 10/09/21 2152 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/10/21 0553 MP 10/10/21 0554 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/10/21 2200 MP 10/10/21 2209 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/11/21 0536 MP 10/11/21 0536 MP
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition N
that requires sepsis screening?
**If yes: Complete sepsis screening

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)

Comments:
- Document 10/12/21 0513 CGR 10/12/21 0514 CGR
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Cont current care plan

1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Document 10/12/21 1400 HJM 10/12/21 1411 HJM
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Interv text updated
Interv directions updated
Interv status updated
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Interv text updated
Interv directions updated
Interv status updated
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Document 10/13/21 0600 SH 10/13/21 0630 SH
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Interv text updated
Interv directions updated

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31014 Review Plan of Care with pt/family ^ (continued)
Interv status updated
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
Plan of care reviewed: Y
Actions taken this shift for individualizing care plan: Referrals initiated
New intervention added
Interv text updated
Interv status updated
Interv directions updated
1:1 Monitoring initiated this shift: N

Has the LPN provided care to this patient this shift: N
I have observed the pt and updated the care plan as needed: Y

New infection or change in VS, organ function, or condition that requires sepsis screening? N
**If yes: Complete sepsis screening

Comments:
1607 ADL: Toileting, offer ^ D PRN PS
Last BM:10/13
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Ed Text 10/07/21 2341 LK 10/07/21 2341 LK
- Ed Text 10/08/21 0113 LK 10/08/21 0113 LK
- Ed Text 10/13/21 1401 HJM 10/13/21 1401 HJM
- Document 10/13/21 1401 HJM 10/13/21 1401 HJM
Toileting:
Assist:

BM Stated: Observed: Y
Amount: Large
Consistency: Tarry
Color: Brown

Peri-care: Yes Moisture barrier applied: Y

Foley care: Yes (After any BM)
If refused, RN Notified:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
1607 ADL: Toileting, offer	^	(continued)											
Comments:													
34005 LABS: Obtain specimen MRSA Swab	D	PRN	PS										
- Create					10/07/21	2222	SH	10/07/21	2224	SH			
31710 EDUC: Medication education	^ D	SHIFT END	PS										
- Create					10/07/21	2222	SH	10/07/21	2224	SH			
- Document					10/08/21	0436	LK	10/08/21	0440	LK			

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:
Method:
Learner Response/Outcome:

Medication(s): PRECEDEX, TYLENOL, GUAIFENESIN

Learners, if other than patient: Family member

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
31710 EDUC: Medication education	^	(continued)											

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:
Method:
Learner Response/Outcome:

Comments:

- Document					10/08/21	1425	AM	10/08/21	1425	AM			

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:
Method:
Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:
Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome:

Medication(s): NO NEW MEDS GIVEN

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/08/21 2200 MP 10/08/21 2323 MP
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

31710 EDUC: Medication education ^ (continued)
Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 0600 MP 10/09/21 0619 MP
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 1411 VW 10/09/21 1436 VW
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):

31710 EDUC: Medication education ^ (continued)
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Method:

Learner Response/Outcome:

Comments:
- Document 10/09/21 2152 MP 10/09/21 2156 MP

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

31710 EDUC: Medication education ^ (continued)

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 0553 MP 10/10/21 0555 MP

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

31710 EDUC: Medication education ^ (continued)
Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/10/21 2200 MP 10/10/21 2211 MP
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 0536 MP 10/11/21 0538 MP
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):

31710 EDUC: Medication education ^ (continued)
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: LOVENOX

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 1353 ES 10/11/21 1356 ES

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Enoxaparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient: Family member

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2139 CGR

Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments: NO EDUCATION DONE
- Document 10/12/21 0513 CGR 10/12/21 0514 CGR
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: N
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Topic: Anticoagulation Therapy:

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s): EMAR MEDS REVIEWED

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/12/21 1400 HJM 10/12/21 1412 HJM
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Enoxaparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Verbalizes understanding

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):

31710 EDUC: Medication education ^ (continued)
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Enoxaparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)

Method:

Learner Response/Outcome:

Comments:
- Document 10/13/21 0600 SH 10/13/21 0630 SH
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Enoxaparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

31710 EDUC: Medication education ^ (continued)

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
Warfarin: N
Compliance (takes Warfarin as prescribed, lab monitoring):
Dietary advice (Vit K, avoid major changes in diet habits):
Follow-up monitoring (taking Warfarin, INR/PT):
Potential for adverse drug reactions/interactions:

Written VTE education/discharge instructions regarding Warfarin given to patient:
Patient refused written education/discharge instructions:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Other Anticoagulation Medication Education: Y
e.g. Enoxaparin, Heparin, Fondaparinux, Apixaban, Rivaroxaban, etc.

Topic: Anticoagulation Therapy: Enoxaparin

Include indications, importance of follow-up monitoring, compliance issues, dietary restrictions, potential for adverse drug interactions.

Learners, if other than patient: Family member

Method: Verbal

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

31710 EDUC: Medication education ^ (continued)
Learner Response/Outcome: Verbalizes understanding

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Medication(s):

Learners, if other than patient:

Method:

Learner Response/Outcome:

Comments:

3160 SAFETY: Patient checks ^ D Q1HWA,Q2HWS PS
Alarm:
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0000 LK 10/08/21 0054 LK
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 0200 LK 10/08/21 0215 LK
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 0400 LK 10/08/21 0435 LK
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worth by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 0600 LK 10/08/21 0605 LK
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 0655 LK 10/08/21 0657 LK
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

3160 SAFETY: Patient checks ^ (continued)
Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3160 SAFETY: Patient checks Alarm:		^ D	Q1HWA,Q2HWS										PS

- Document 10/08/21 0815 AM 10/08/21 0949 AM

Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3160 SAFETY: Patient checks (continued)		^											

Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

- Document 10/08/21 0900 AM 10/08/21 1000 AM

Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/08/21 1010 AM 10/08/21 1011 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/08/21 1100 AM 10/08/21 1154 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)
Bed Alarm
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1211 AM 10/08/21 1219 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1310 AM 10/08/21 1311 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1418 AM 10/08/21 1422 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1509 FD 10/08/21 1510 FD
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1615 AM 10/08/21 1630 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1711 AM 10/08/21 1711 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1817 FD 10/08/21 1817 FD
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/08/21 1841 AM 10/08/21 1842 AM
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ D Q1HWA,Q2HWS PS
Alarm:
- Document 10/08/21 2000 MP 10/08/21 2037 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/08/21 2100 MP 10/08/21 2113 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/08/21 2200 MP 10/08/21 2246 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/09/21 0000 MP 10/09/21 0042 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Y Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/09/21 0200 MP 10/09/21 0209 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 0400 MP 10/09/21 0405 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 0600 MP 10/09/21 0617 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 0654 MP 10/09/21 0655 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Y Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Y Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 0811 VW 10/09/21 0821 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/09/21 0911 VW 10/09/21 0938 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3160 SAFETY: Patient checks Alarm:		^ D	Q1HWA,Q2HWS										PS
- Document					10/09/21	1011	VW	10/09/21	1012	VW			
# Siderails up while in bed: 2 *If Subacute/Beh Health, no more than Crib: 3 siderails up at one time.													
Patient location, if other than patient room: Patient off unit: Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room: Refocus Room: Exercise Room: Latency Room: Classroom: Group: Ambulating: Bed: Y Chair: Other:													
Family present: Y Ancillary staff present: Video monitoring: Safety device in use: Call light (Beh Health)													
If Medical Peds, <13 yrs of age, security band worn by patient:													
Pain: N Location: Non-pharmacological interventions: Rest Repositioning Distraction													
Behavior Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused: Impulsive: Anxious: Restless: Crying: Wandering: Interference w/medical device: Awake: Calm: Withdrawn:													
Activity Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's Eating:													
Is the patient a Suicide Risk? Risk level:													
Safety Precautions Room Search? 1:1 observation? Disposable items on food trays? Food tray checked for utensils after meals? Belongings searched for contraband? Send Notifications to Case Management,Social worker, etc?													
Additional alternative safety action(s) taken at present time (check all that apply): Patient placed near or at nursing station: Frequent ambulation: Appropriate cue cards or reminder signs are in place: Back rub: Volunteer used for diversion activities: Low noise level: Toolbox in use for diversion activities: Music (patient's preference) used: Pain, anxiety, new or current medications evaluated: Consistent caregiver assigned: IV lines and device tubing covered: Sleep patterns or routine reviewed: Toilet patterns reviewed:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3160 SAFETY: Patient checks (continued) Toileting schedule in place: Activity schedule established: Patient needs discussed with family: Patient's home or facility routine investigated: Patient history and familiar objects obtained: Comments:		^											
- Document					10/09/21	1111	VW	10/09/21	1131	VW			
# Siderails up while in bed: 2 *If Subacute/Beh Health, no more than Crib: 3 siderails up at one time.													
Patient location, if other than patient room: Patient off unit: Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room: Refocus Room: Exercise Room: Latency Room: Classroom: Group: Ambulating: Bed: Y Chair: Other:													
Family present: Y Ancillary staff present: Video monitoring: Safety device in use: Call light (Beh Health)													
If Medical Peds, <13 yrs of age, security band worn by patient:													
Pain: N Location: Non-pharmacological interventions: Rest Repositioning Distraction													
Behavior Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused: Impulsive: Anxious: Restless: Crying: Wandering: Interference w/medical device: Awake: Calm: Withdrawn:													
Activity Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's Eating:													
Is the patient a Suicide Risk? Risk level:													
Safety Precautions Room Search? 1:1 observation? Disposable items on food trays? Food tray checked for utensils after meals? Belongings searched for contraband? Send Notifications to Case Management,Social worker, etc?													
Additional alternative safety action(s) taken at present time (check all that apply): Patient placed near or at nursing station: Frequent ambulation: Appropriate cue cards or reminder signs are in place: Back rub: Volunteer used for diversion activities: Low noise level: Toolbox in use for diversion activities: Music (patient's preference) used:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1153 VW 10/09/21 1155 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1314 VW 10/09/21 1315 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1411 VW 10/09/21 1434 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1511 VW 10/09/21 1537 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1611 VW 10/09/21 1624 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction

Behavior

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1656 VW 10/09/21 1657 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1800 VW 10/09/21 1801 VW
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Repositioning
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 1900 EF 10/09/21 2005 EF
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions: Rest
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ D Q1HWA,Q2HWS PS
Alarm:
- Document 10/09/21 2000 MP 10/09/21 2127 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 2100 MP 10/09/21 2130 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/09/21 2157 MP 10/09/21 2218 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/10/21 0000 MP 10/10/21 0040 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:

Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/10/21 0200 MP 10/10/21 0203 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 0400 MP 10/10/21 0404 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 0600 MP 10/10/21 0602 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 0653 MP 10/10/21 0653 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 0800 KRH 10/10/21 0938 KRH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: Y Video monitoring: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 0900 KRH 10/10/21 0940 KRH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1000 KRH 10/10/21 1024 KRH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1100 KRH 10/10/21 1124 KRH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1230 KRH 10/10/21 1319 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1300 KRH 10/10/21 1321 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's Y
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1417 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/10/21 1512 KRH 10/10/21 1513 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1702 MMG 10/10/21 1702 MMG
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1800 KRH 10/10/21 1809 KRH
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: N Ancillary staff present: N Video monitoring: N
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Y Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? N Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 1851 MMG 10/10/21 1851 MMG
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 2000 MP 10/10/21 2046 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions: Rest
Distraction
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/10/21 2058 MP 10/10/21 2058 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:

- Document 10/10/21 2200 MP 10/10/21 2208 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 0000 MP 10/11/21 0013 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 0200 MP 10/11/21 0205 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 0400 MP 10/11/21 0416 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 0556 MP 10/11/21 0556 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Y Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 0652 MP 10/11/21 0652 MP
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions: Rest
Distraction
Repositioning

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 0800 ES 10/11/21 0842 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: N Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 0851 ES 10/11/21 0851 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 1003 ES 10/11/21 1004 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: N Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: Y TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 1052 ES 10/11/21 1052 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 1157 ES 10/11/21 1158 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: N Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 1302 ES 10/11/21 1303 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: N Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Comments:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: N Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 1500 ES 10/11/21 1512 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: Y TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 1600 ES 10/11/21 1633 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 1643 ES 10/11/21 1643 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 1800 ES 10/11/21 1832 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Y Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: Y In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/11/21 1906 ES 10/11/21 1907 ES
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Call light (Beh Health)

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: N Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 1952 CGR 10/11/21 1959 CGR
Siderails up while in bed: 2 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 2120 RS 10/11/21 2120 RS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 0006 CGR 10/12/21 0100 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 0152 CGR 10/12/21 0153 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
3160 SAFETY: Patient checks Alarm:	^	D	Q1HWA,Q2HWS										PS

- Document 10/12/21 0551 CGR 10/12/21 0552 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 0654 CGR 10/12/21 0654 CGR
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 0800 HJM 10/12/21 0857 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 0900 HJM 10/12/21 0900 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 0940 KS 10/12/21 0940 KS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1100 HJM 10/12/21 1125 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1144 KS 10/12/21 1144 KS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1259 KS 10/12/21 1259 KS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1400 HJM 10/12/21 1410 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1440 KS 10/12/21 1441 KS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1530 HJM 10/12/21 1530 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 1558 KS 10/12/21 1558 KS
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change
3160 SAFETY: Patient checks Alarm:	^	D	Q1HWA,Q2HWS	PS									
- Document					10/12/21	1642	KS	10/12/21	1642	KS			
# Siderails up while in bed: 3 *If Subacute/Beh Health, no more than Crib: 3 siderails up at one time.													
Patient location, if other than patient room: Patient off unit:													
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:													
Refocus Room: Exercise Room: Latency Room: Classroom: Group:													
Ambulating: Bed: Y Chair: Other:													
Family present: Ancillary staff present: Video monitoring:													
Safety device in use: Bed Alarm Call light (Beh Health)													
If Medical Peds, <13 yrs of age, security band worn by patient:													
Pain: Location:													
Non-pharmacological interventions:													
Behavior													
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:													
Impulsive: Anxious: Restless: Crying: Wandering:													
Interference w/medical device: Awake: Calm: Y Withdrawn:													
Activity													
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's													
Eating:													
Is the patient a Suicide Risk? Risk level:													
Safety Precautions													
Room Search?													
1:1 observation?													
Disposable items on food trays?													
Food tray checked for utensils after meals?													
Belongings searched for contraband?													
Send Notifications to Case Management,Social worker, etc?													
Additional alternative safety action(s) taken at present time (check all that apply):													
Patient placed near or at nursing station: Frequent ambulation:													
Appropriate cue cards or reminder signs are in place:													
Back rub:													
Volunteer used for diversion activities:													
Low noise level:													
Toolbox in use for diversion activities:													
Music (patient's preference) used:													
Pain, anxiety, new or current medications evaluated:													
Consistent caregiver assigned:													
IV lines and device tubing covered:													
Sleep patterns or routine reviewed:													
Toilet patterns reviewed:													
Toileting schedule in place:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change
3160 SAFETY: Patient checks (continued)	^												
Activity schedule established:													
Patient needs discussed with family:													
Patient's home or facility routine investigated:													
Patient history and familiar objects obtained:													
Comments:													
- Document					10/12/21	1800	HJM	10/12/21	1831	HJM			
# Siderails up while in bed: 3 *If Subacute/Beh Health, no more than Crib: 3 siderails up at one time.													
Patient location, if other than patient room: Patient off unit:													
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:													
Refocus Room: Exercise Room: Latency Room: Classroom: Group:													
Ambulating: Bed: Y Chair: Other:													
Family present: Y Ancillary staff present: Video monitoring:													
Safety device in use:													
If Medical Peds, <13 yrs of age, security band worn by patient:													
Pain: Location:													
Non-pharmacological interventions:													
Behavior													
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:													
Impulsive: Anxious: Restless: Crying: Wandering:													
Interference w/medical device: Awake: Y Calm: Y Withdrawn:													
Activity													
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's													
Eating:													
Is the patient a Suicide Risk? Risk level:													
Safety Precautions													
Room Search?													
1:1 observation?													
Disposable items on food trays?													
Food tray checked for utensils after meals?													
Belongings searched for contraband?													
Send Notifications to Case Management,Social worker, etc?													
Additional alternative safety action(s) taken at present time (check all that apply):													
Patient placed near or at nursing station: Frequent ambulation:													
Appropriate cue cards or reminder signs are in place:													
Back rub:													
Volunteer used for diversion activities:													
Low noise level:													
Toolbox in use for diversion activities:													
Music (patient's preference) used:													
Pain, anxiety, new or current medications evaluated:													
Consistent caregiver assigned:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 1853 HJM 10/12/21 1853 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use:

If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/12/21 2000 BV 10/12/21 2055 BV
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Y Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 2055 BV 10/12/21 2055 BV
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0000 SH 10/13/21 0024 SH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0200 SH 10/13/21 0239 SH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0401 BV 10/13/21 0401 BV
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0600 SH 10/13/21 0629 SH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0648 SH 10/13/21 0649 SH
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 0802 HJM 10/13/21 0809 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ (continued)
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

3160 SAFETY: Patient checks ^ D Q1HWA,Q2HWS PS
Alarm:
- Document 10/13/21 0900 KS 10/13/21 0907 KS
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Y Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1050 HJM 10/13/21 1050 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Y Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:

Comments:
- Document 10/13/21 1300 HJM 10/13/21 1345 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Y Crying: Wandering:
Interference w/medical device: Awake: Y Calm: Withdrawn:
Activity
Sleeping: Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1405 HJM 10/13/21 1405 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1501 HJM 10/13/21 1501 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1600 HJM 10/13/21 1612 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)
Activity
Sleeping: Y Resting: On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1700 HJM 10/13/21 1707 HJM
Siderails up while in bed: 4 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Y Chair: Other:

Family present: Y Ancillary staff present: Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

Pain: Location:
Non-pharmacological interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3160 SAFETY: Patient checks ^ (continued)

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Y Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:
- Document 10/13/21 1805 HJM 10/13/21 1806 HJM
Siderails up while in bed: 3 *If Subacute/Beh Health, no more than
Crib: 3 siderails up at one time.

Patient location, if other than patient room: Patient off unit:
Bathroom/Shower: Nurses' Station/Hall: Dining Room/Lounge: Day Room:
Refocus Room: Exercise Room: Latency Room: Classroom: Group:
Ambulating: Bed: Chair: Other:

Family present: Y Ancillary staff present: Y Video monitoring:
Safety device in use: Bed Alarm
Call light (Beh Health)
If Medical Peds, <13 yrs of age, security band worn by patient:

3160 SAFETY: Patient checks ^ (continued)

Pain: Location:
Non-pharmacological interventions:

Behavior
Uncooperative: Agitated: Aggressive: Combative: Confusion/Confused:
Impulsive: Anxious: Restless: Crying: Wandering:
Interference w/medical device: Awake: Calm: Withdrawn:
Activity
Sleeping: Resting: Y On phone: Interactions: TV: In therapy: ADL's
Eating:

Is the patient a Suicide Risk? Risk level:

Safety Precautions
Room Search?
1:1 observation?
Disposable items on food trays?
Food tray checked for utensils after meals?
Belongings searched for contraband?
Send Notifications to Case Management,Social worker, etc?

Additional alternative safety action(s) taken at present time (check all that apply):
Patient placed near or at nursing station: Frequent ambulation:
Appropriate cue cards or reminder signs are in place:
Back rub:
Volunteer used for diversion activities:
Low noise level:
Toolbox in use for diversion activities:
Music (patient's preference) used:
Pain, anxiety, new or current medications evaluated:
Consistent caregiver assigned:
IV lines and device tubing covered:
Sleep patterns or routine reviewed:
Toilet patterns reviewed:
Toileting schedule in place:
Activity schedule established:
Patient needs discussed with family:
Patient's home or facility routine investigated:
Patient history and familiar objects obtained:
Comments:

520 Bedside Procedure Time Out ^ D PRE-PROCEDURE PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH

3150 SAFETY: Elopement Risk Assessment ^ D 16 PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 1615 AM 10/08/21 1629 AM
Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3150 SAFETY: Elopement Risk Assessment ^ (continued)

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment; Known outstanding warrant; Legal detention or 72 hour hold; Family/responsible party voices concerns; Resident of mental health facility; Federal, State or Local inmate; History of elopement/wandering; Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason: LOW RISK

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Comments:
- Document 10/09/21 1611 VW 10/09/21 1624 VW
Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

3150 SAFETY: Elopement Risk Assessment ^ (continued)

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment; Known outstanding warrant; Legal detention or 72 hour hold; Family/responsible party voices concerns; Resident of mental health facility; Federal, State or Local inmate; History of elopement/wandering; Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason: LOW RISK

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Comments:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Is patient mobile: Y
*If patient is mobile & YES is answered to any of the following questions, initiate

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3150 SAFETY: Elopement Risk Assessment ^ (continued)
elopement precautions & document every shift*

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment
Known outstanding warrant
Legal detention or 72 hour hold
Family/responsible party voices concerns
Resident of mental health facility
Federal, State or Local inmate
History of elopement/wandering
Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason: LOW RISK

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Comments:
- Document 10/11/21 1526 ES 10/11/21 1527 ES
Is patient mobile: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3150 SAFETY: Elopement Risk Assessment ^ (continued)
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment
Known outstanding warrant
Legal detention or 72 hour hold
Family/responsible party voices concerns
Resident of mental health facility
Federal, State or Local inmate
History of elopement/wandering
Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason: LOW RISK

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3150 SAFETY: Elopement Risk Assessment ^ D 16			PS										
- Document					10/12/21	1529	HJM	10/12/21	1529	HJM			

Is patient mobile: N
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment Resident of mental health facility
Known outstanding warrant Federal, State or Local inmate
Legal detention or 72 hour hold History of elopement/wandering
Family/responsible party voices concerns Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
3150 SAFETY: Elopement Risk Assessment ^ (continued)													
Comments:													
- Document					10/13/21	1600	HJM	10/13/21	1612	HJM			

Is patient mobile: N
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift

Does patient verbalize or exhibit intent to leave facility: N

Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)

History of wandering &/or elopement from any setting: N

Does the patient demonstrate any of the following behaviors: N
Agitation: Verbal or physical aggressive behavior: Aimless wandering: Pacing:

Does the patient exhibit any of the following NEW behaviors or status changes: N
Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:

*Patients who are on legal hold as outlined below are automatically considered at risk for elopement: Court commitment Resident of mental health facility
Known outstanding warrant Federal, State or Local inmate
Legal detention or 72 hour hold History of elopement/wandering
Family/responsible party voices concerns Suicide attempt

Initiate Elopement Risk Precautions intervention: N
(Check all that apply):
Wander gaurd: Bed alarm: Chair alarm: Video monitoring:
1:1 Pt in hospital gown: Frequent checks:

If NO, state reason:

Continue Elopement Risk Protocol:
(Check all that apply):
Wander guard: Bed alarm Chair alarm: Video monitoring:
1:1 Patient in hospital gown: Frequent checks:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

3150 SAFETY: Elopement Risk Assessment ^ (continued)

Comments:

22200 PSYCH: ICU, CAM-ICU Worksheet ^ D Q4H* PS

Assess for delirium with Confusion Assessment Method (CAM ICU):
-Every 4 hours for all ICU level patients
-If patient screens CAM-ICU positive consult with LIP to initiate Delirium Management Order Set

- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0000 LK 10/08/21 0055 LK
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: SEDATED W/PRECEDEX BUT TOO AGITATED TO ACCURATELY OBTAIN DELIRIUM SCORE

- Document 10/08/21 0327 LK 10/08/21 0327 LK
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: SEDATED W/PRECEDEX BUT TOO AGITATED TO ACCURATELY OBTAIN DELIRIUM SCORE
- Document 10/08/21 0800 AM 10/08/21 0950 AM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: SEDATED W/PRECEDEX BUT TOO AGITATED TO ACCURATELY

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
OBTAIN DELIRIUM SCORE
- Document 10/08/21 1211 AM 10/08/21 1220 AM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: SEDATED W/PRECEDEX BUT TOO AGITATED TO ACCURATELY
OBTAIN DELIRIUM SCORE
- Document 10/08/21 1615 AM 10/08/21 1636 AM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: SEDATED W/PRECEDEX BUT TOO AGITATED TO ACCURATELY
OBTAIN DELIRIUM SCORE
- Document 10/08/21 2000 MP 10/08/21 2041 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/09/21 0000 MP 10/09/21 0043 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/09/21 0400 MP 10/09/21 0406 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/09/21 0811 VW 10/09/21 0822 VW
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline:
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/09/21 1153 VW 10/09/21 1155 VW
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline:
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/09/21 1611 VW 10/09/21 1625 VW
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set: N
Non-pharmacological delirium prevention interventions: Television on

Comments:
- Document 10/09/21 2000 MP 10/09/21 2129 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/10/21 0000 MP 10/10/21 0041 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status:
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline:
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT ANSWER ORIENTATION/DELIRIUM QUESTIONS

- Document 10/10/21 0400 MP 10/10/21 0405 MP
CAM (Confusion Assessment Method)-ICU Worksheet

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status:
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline:
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/10/21 0800 KRH 10/10/21 0939 KRH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/10/21 1230 KRH 10/10/21 1320 KRH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: Y

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: Y
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/10/21 1606 KRH 10/10/21 1617 KRH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/10/21 2000 MP 10/10/21 2049 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): N
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/11/21 0000 MP 10/11/21 0014 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: Y
OR

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: Y
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): N
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/11/21 0400 MP 10/11/21 0417 MP
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Comments:
- Document 10/11/21 0800 ES 10/11/21 0843 ES
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors: N
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1: N

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set: N
Non-pharmacological delirium prevention interventions: Television on

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/11/21 1157 ES 10/11/21 1158 ES
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

**Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar
or pressing shift <F8>**

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors: N
Feature 3 - RASS: score other than zero: Y

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Feature 4 - Disorganized Thinking: combined errors > 1: N

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set: N
Non-pharmacological delirium prevention interventions: Television on

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/11/21 1527 ES 10/11/21 1528 ES
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

**Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar
or pressing shift <F8>**

RASS anything other than zero: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors: N
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1: N

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set: N
Non-pharmacological delirium prevention interventions: Television on

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
22200 PSYCH: ICU, CAM-ICU Worksheet		^ (continued)											

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/12/21 0006 CGR 10/12/21 0102 CGR
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
22200 PSYCH: ICU, CAM-ICU Worksheet		^ (continued)											

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ D Q4H* PS

Assess for delirium with Confusion Assessment Method (CAM ICU):
-Every 4 hours for all ICU level patients
-If patient screens CAM-ICU positive consult with LIP to initiate Delirium Management Order Set

- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments:
- Document 10/12/21 0800 HJM 10/12/21 0859 HJM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
SAYS- LEAVE ME ALONE
- Document 10/12/21 1130 HJM 10/12/21 1131 HJM

CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: PATIENT WILL ANSWER YES/NO QUESTIONS BUT NOT
ANSWER ORIENTATION/DELIRIUM QUESTIONS
SAYS- LEAVE ME ALONE
- Document 10/12/21 1531 HJM 10/12/21 1531 HJM
CAM (Confusion Assessment Method)-ICU Worksheet

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/12/21 2000 SH 10/12/21 2142 SH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors: N
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1: N

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Non-pharmacological delirium prevention interventions:

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/13/21 0000 SH 10/13/21 0024 SH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium): Y
Criteria met: CAM-ICU Positive (delirium present): N
CAM-ICU Positive - Provider Contacted to initiate delirium management order set: N
Non-pharmacological delirium prevention interventions: Television on

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/13/21 0400 SH 10/13/21 0505 SH
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess:

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero: Y

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero: Y
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/13/21 0802 HJM 10/13/21 0810 HJM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Documented Change

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)
Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status: N
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
CAM (Confusion Assessment Method)-ICU Worksheet

FEATURE 1: Acute Onset or Fluctuating Course
Is patient different than his/her baseline status: N
OR
Has pt had any fluctuation in mental status in past 24 hrs as evidenced by fluctuation on sedation scale (ie. RASS), GCS, or previous delirium assess: N

FEATURE 2: Inattention
LETTERS ATTENTION TEST (see training manual for alt picture)
Directions: Say to the patient, 'I am going to read you a series of 10 letters. Whenever you hear the letter 'A', indicate by squeezing my hand.' Read letters from the following letter list in a normal tone 3 seconds apart.

S A V E A H A A R T

Errors are counted when patient fails to squeeze on the letter 'A' and when the patient squeezes on any letter other than 'A'.

Patient had more than 2 errors:
FEATURE 3: Altered Level of Consciousness
Present if the Actual RASS score is anything other than alert and calm (zero).

Richmond Agitation-Sedation Scale (RASS) can be viewed by clicking blue ? on toolbar or pressing shift <F8>

RASS anything other than zero:

22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)

FEATURE 4: Disorganized Thinking
YES/NO QUESTIONS (see training manual for alt set of ?)
1. Will a stone float on water?
2. Are there fish in the sea?
3. Does one pound weigh more than two pounds?
4. Can you use a hammer to pound a nail?

Errors are counted when the patient incorrectly answers a question.

COMMAND
Say to patient: 'Hold up this many fingers' (Hold 2 fingers in front of patient)
'Now do the same thing with the other hand' (Do not repeat number of fingers)
*If pt is unable to move both arms, for 2nd part of command ask pt to 'Add one more finger'

An error is counted if patient is unable to complete the entire command.

Combined number of errors is > 1:

OVERALL CAM-ICU
Feature 1 PLUS 2 AND either 3 OR 4 present = CAM-ICU positive.
Review of Feature answers: Press <enter> to see response
Feature 1 - Different from baseline: N
Feature 1 - Fluctuation in mental status:
Feature 2 - Inattention: 2 or more errors:
Feature 3 - RASS: score other than zero:
Feature 4 - Disorganized Thinking: combined errors > 1:

Criteria Not Met: CAM-ICU Negative (no delirium):
Criteria met: CAM-ICU Positive (delirium present):
CAM-ICU Positive - Provider Contacted to initiate delirium management order set:
Non-pharmacological delirium prevention interventions:

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change
22200 PSYCH: ICU, CAM-ICU Worksheet ^ (continued)												
Comments: DOES NOT ANSWER QUESTIONS, ALREADY ON PRECIDEX												
60601 MU: VTE LIP required documentation ^ C 06,10,18												PS
Refer to LIP Required Documentation for VTE Quality Objectives (MU & core measures). Change status of intervention to complete once the LIP has completed this documentation.												
- Create		10/07/21	2222	SH	10/07/21	2224	SH					
- Document		10/08/21	0249	LK	10/08/21	0249	LK					
LIP documentation completed: Y												
Date LIP documentation completed: 10/07/21												
Per LIP Required documentation for VTE Meaningful Use:												
VTE medication prophylaxis initiated: Y												
Reason for no VTE medication prophylaxis prescribed:												
VTE mechanical prophylaxis initiated: Y												
Reason for no VTE mechanical prophylaxis prescribed:												
- Ed Status		10/08/21	0249	LK	10/08/21	0249	LK					A => C
2505 ADL: Activity/mobility ^ D Q2H												PS
Activity Order:Q2H REPO												
- Create		10/07/21	2222	SH	10/07/21	2224	SH					
- Ed Text		10/07/21	2348	LK	10/07/21	2348	LK					
- Document		10/08/21	0000	LK	10/08/21	0052	LK					
*Document what applies												
Activity: Bed: Yes												
Patient position in bed: Right Patient refused repositioning: N												
HOB elevated: Y Degrees: 30 Heels propped: No												
Medical Devices checked and repositioned: ALL LINES/WIRES												
Dangle: Stand:												
Chair: Chair type:												
Weight shift: Y												
Ambulate: Distance:												
Weight bearing status:												
Assist: *Blue ?												
Staff Assisting: Assistive Devices:												
CLRT on: Degree rotation - right: Degree rotation - left:												
Comments: PT CONTINUES TO KICK PILLOWS OUT FROM UNDER LEGS PREFERS TO SLEEP ON SIDE WITH LEGS TUCKED UNDER HER IT APPEARS												
- Document		10/08/21	0200	LK	10/08/21	0214	LK					
*Document what applies												
Activity: Bed: Yes												
Patient position in bed: Left Patient refused repositioning: N												

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change
2505 ADL: Activity/mobility ^ (continued)												
HOB elevated: Y Degrees: 30 Heels propped: Yes												
Medical Devices checked and repositioned: ALL LINES/WIRES												
Dangle: Stand:												
Chair: Chair type:												
Weight shift: Y												
Ambulate: Distance:												
Weight bearing status:												
Assist: *Blue ?												
Staff Assisting: Assistive Devices:												
CLRT on: Degree rotation - right: Degree rotation - left:												
Comments:												
- Document		10/08/21	0400	LK	10/08/21	0434	LK					
*Document what applies												
Activity: Bed: Yes												
Patient position in bed: Right Patient refused repositioning: N												
HOB elevated: Y Degrees: 30 Heels propped: Yes												
Medical Devices checked and repositioned: ALL LINES/WIRES												
Dangle: Stand:												
Chair: Chair type:												
Weight shift: Y												
Ambulate: Distance:												
Weight bearing status:												
Assist: *Blue ?												
Staff Assisting: Assistive Devices:												
CLRT on: Degree rotation - right: Degree rotation - left:												
Comments:												
- Document		10/08/21	0600	LK	10/08/21	0603	LK					
*Document what applies												
Activity: Bed: Yes												
Patient position in bed: Supine Patient refused repositioning: N												
HOB elevated: Y Degrees: 30 Heels propped: Yes												
Medical Devices checked and repositioned: ALL LINES/WIRES												
Dangle: Stand:												
Chair: Chair type:												
Weight shift: Y												
Ambulate: Distance:												
Weight bearing status:												

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/08/21 0800 AM 10/08/21 0845 AM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/08/21 1012 AM 10/08/21 1012 AM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/08/21 1211 AM 10/08/21 1218 AM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/08/21 1418 AM 10/08/21 1418 AM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/08/21 1615 AM 10/08/21 1629 AM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2505 ADL: Activity/mobility ^ (continued)													
Assist: Maximum Assist *Blue ?													
Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document 10/08/21 1817 FD 10/08/21 1817 FD													
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Left Patient refused repositioning:													
HOB elevated: Y Degrees: 30 Heels propped: Yes													
Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand:													
Chair: Chair type:													
Weight shift: Y													
Ambulate: Distance:													
Weight bearing status:													
Assist: Maximum Assist *Blue ?													
Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document 10/08/21 2000 MP 10/08/21 2036 MP													
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Right Patient refused repositioning: N													
HOB elevated: Y Degrees: 50 Heels propped: Yes													
Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand:													
Chair: Chair type:													
Weight shift:													
Ambulate: Distance:													
Weight bearing status:													
Assist: Maximum Assist *Blue ?													
Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document 10/08/21 2200 MP 10/08/21 2244 MP													
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Left Patient refused repositioning: N													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2505 ADL: Activity/mobility ^ (continued)													
HOB elevated: Y Degrees: 50 Heels propped: Yes													
Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand:													
Chair: Chair type:													
Weight shift:													
Ambulate: Distance:													
Weight bearing status:													
Assist: Maximum Assist *Blue ?													
Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document 10/09/21 0000 MP 10/09/21 0040 MP													
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Right Patient refused repositioning: N													
HOB elevated: Y Degrees: 50 Heels propped: Yes													
Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand:													
Chair: Chair type:													
Weight shift:													
Ambulate: Distance:													
Weight bearing status:													
Assist: Maximum Assist *Blue ?													
Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left:													
Comments:													
- Document 10/09/21 0200 MP 10/09/21 0208 MP													
*Document what applies													
Activity: Bed: Yes													
Patient position in bed: Supine Patient refused repositioning: N													
HOB elevated: Y Degrees: 50 Heels propped: Yes													
Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand:													
Chair: Chair type:													
Weight shift:													
Ambulate: Distance:													
Weight bearing status:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 0400 MP 10/09/21 0403 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 0600 MP 10/09/21 0616 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 0811 VW 10/09/21 0817 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 1011 VW 10/09/21 1012 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 1153 VW 10/09/21 1154 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 1411 VW 10/09/21 1433 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 1611 VW 10/09/21 1623 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: side to side for cares and linen change
- Document 10/09/21 1800 VW 10/09/21 1800 VW
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: side to side for cares and linen change
- Document 10/09/21 2000 MP 10/09/21 2127 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/09/21 2157 MP 10/09/21 2211 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 0000 MP 10/10/21 0038 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 0200 MP 10/10/21 0202 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT WEIGHT SHIFTS ON OWN
- Document 10/10/21 0400 MP 10/10/21 0403 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning: N

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 0555 MP 10/10/21 0556 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 0800 KRH 10/10/21 0937 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1000 KRH 10/10/21 1123 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1123 KRH 10/10/21 1123 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 1 Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1305 KRH 10/10/21 1322 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: N Degrees: Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1400 KRH 10/10/21 1417 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Degrees: Heels propped:
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift: N

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1606 KRH 10/10/21 1615 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Degrees: Heels propped:
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift: N

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 1800 KRH 10/10/21 1808 KRH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: Y
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: N

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: N Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 2000 MP 10/10/21 2043 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/10/21 2200 MP 10/10/21 2206 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:

2505 ADL: Activity/mobility ^ (continued)
HOB elevated: Y Degrees: 15 Heels propped: Yes
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Independent *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT WEIGHT SHIFTS ON OWN
- Document 10/11/21 0000 MP 10/11/21 0012 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/11/21 0200 MP 10/11/21 0203 MP
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 15 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2505 ADL: Activity/mobility ^ (continued)													
Assist: Maximum Assist *Blue ? Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left: Comments: - Document 10/11/21 0400 MP 10/11/21 0415 MP *Document what applies Activity: Bed: Yes Patient position in bed: Supine Patient refused repositioning: N HOB elevated: Y Degrees: 30 Heels propped: Yes Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand: Chair: Chair type: Weight shift:													
Ambulate: Distance: Weight bearing status:													
Assist: Maximum Assist *Blue ? Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left: Comments: - Document 10/11/21 0555 MP 10/11/21 0556 MP *Document what applies Activity: Bed: Yes Patient position in bed: Right Patient refused repositioning: N HOB elevated: Y Degrees: 30 Heels propped: Yes Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand: Chair: Chair type: Weight shift:													
Ambulate: Distance: Weight bearing status:													
Assist: Maximum Assist *Blue ? Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left: Comments: - Document 10/11/21 0800 ES 10/11/21 0841 ES *Document what applies Activity: Bed: Yes Patient position in bed: Left Patient refused repositioning: N													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
2505 ADL: Activity/mobility ^ (continued)													
HOB elevated: Y Degrees: 30 Heels propped: Yes Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand: Chair: Chair type: Weight shift:													
Ambulate: Distance: Weight bearing status:													
Assist: Maximum Assist *Blue ? Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left: Comments: - Document 10/11/21 1003 ES 10/11/21 1003 ES *Document what applies Activity: Bed: Yes Patient position in bed: Right Patient refused repositioning: N HOB elevated: Y Degrees: 30 Heels propped: Yes Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand: Chair: Chair type: Weight shift:													
Ambulate: Distance: Weight bearing status:													
Assist: Maximum Assist *Blue ? Staff Assisting: 2 Assistive Devices: Booster Sheet													
CLRT on: Degree rotation - right: Degree rotation - left: Comments: PT WEIGHT SHIFTS ON OWN, PUT ON SIDE AS MUCH AS TOLERABLE - Document 10/11/21 1200 ES 10/11/21 1224 ES *Document what applies Activity: Bed: Yes Patient position in bed: Right Patient refused repositioning: N HOB elevated: Y Degrees: 30 Heels propped: Yes Medical Devices checked and repositioned: ALL LINES/WIRES													
Dangle: Stand: Chair: Chair type: Weight shift:													
Ambulate: Distance:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: ATTMPET TO PRONE, PT REFUSED AND WOULDNT PRONE
WITH THE HELP OF STAFF. WILL CONTINUE TO TRY TO
PRONE. PT PUT ON SIDE AS MUCH AS TOLERATED.
- Document 10/11/21 1353 ES 10/11/21 1354 ES
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/11/21 1600 ES 10/11/21 1632 ES
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: RIGHT BELLY/RIGHT SIDE

2505 ADL: Activity/mobility ^ D Q2H PS
Activity Order:Q2H REPO
- Document 10/11/21 1800 ES 10/11/21 1831 ES
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 35 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: EDUCATED PT AND FAMILY MEMBER ON PRONING, PT
REFUSED TO STAY PRONE
- Document 10/11/21 1952 CGR 10/11/21 1959 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning:
HOB elevated: Y Degrees: 15 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/11/21 2120 RS 10/11/21 2120 RS
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 15 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/11/21 2157 CGR 10/11/21 2158 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: DESAT IN PREV POSITION, PRONED, PRECEDEX INCREASED
D/T PT ANXIETY. O2 SAT IMPROVED.
- Document 10/12/21 0006 CGR 10/12/21 0100 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

2505 ADL: Activity/mobility ^ (continued)

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: SHIFTED HEAD/ARMS
- Document 10/12/21 0152 CGR 10/12/21 0153 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: SHIFTED HEAD/ARMS, laying partially on r side
- Document 10/12/21 0351 CGR 10/12/21 0354 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: SUPINE FOR BATH, LOG ROLLED MULTIPLE TIMES
- Document 10/12/21 0551 CGR 10/12/21 0552 CGR
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Dangle: Stand:
Chair: Chair type:
Weight shift: Y

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: REV TREND, HEAD AND BODY SHIFTED WITH L SIDE UP.
- Document 10/12/21 0800 HJM 10/12/21 0857 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Chair position Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 1000 HJM 10/12/21 1012 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 35 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 1125 HJM 10/12/21 1126 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 10 Heels propped:
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: REV TREND
- Document 10/12/21 1330 HJM 10/12/21 1407 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Chair position Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 1558 KS 10/12/21 1558 KS
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: Heels propped:
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: Maximum Assist *Blue ?
Staff Assisting: 2 Assistive Devices: Booster Sheet

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 1800 HJM 10/12/21 1831 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 2000 SH 10/12/21 2140 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/12/21 2200 SH 10/12/21 2225 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 0000 SH 10/13/21 0023 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 0200 SH 10/13/21 0238 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 0401 BV 10/13/21 0401 BV
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT IS PRONING
- Document 10/13/21 0600 SH 10/13/21 0626 SH
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning: N
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

2505 ADL: Activity/mobility ^ (continued)

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 0802 HJM 10/13/21 0808 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Prone Patient refused repositioning:
HOB elevated: Y Degrees: 15 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES/WIRES
Foley Tubing

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT HAD ROLLED SELF ONTO BACK, ASSISTED INTO PRONE POSITION ONCE AGAIN
- Document 10/13/21 0820 HJM 10/13/21 0911 HJM
*Document what applies
Activity: Bed:
Patient position in bed: Patient refused repositioning:
HOB elevated: Degrees: Heels propped:
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT ROLLED ONTO BACK, ASSISTED INTO PRONE POSITION, PRECIDEX INCREASED
- Document 10/13/21 0840 HJM 10/13/21 0911 HJM
*Document what applies
Activity: Bed:
Patient position in bed: Patient refused repositioning:
HOB elevated: Degrees: Heels propped:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT ROLLED ONTO BACK, ASSISTED INTO PRONE POSITION, PRECIDEX AT MAX DOSE
- Document 10/13/21 0900 HJM 10/13/21 0911 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Chair position Patient refused repositioning:
HOB elevated: Y Degrees: 45 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT ROLLED ONTO BACK, SHEETS CHANGED, POSITIONED SUPINE
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Left Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Right Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments:
- Document 10/13/21 1400 HJM 10/13/21 1400 HJM
*Document what applies
Activity: Bed: Yes
Patient position in bed: Supine Patient refused repositioning:
HOB elevated: Y Degrees: 30 Heels propped: Yes
Medical Devices checked and repositioned: ALL LINES

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: S/S FOR LINNEN CHANGE WITH STOOL
- Document 10/13/21 1523 HJM 10/13/21 1538 HJM
*Document what applies
Activity: Bed:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

2505 ADL: Activity/mobility ^ (continued)
Patient position in bed: Patient refused repositioning:
HOB elevated: Degrees: Heels propped:
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT PRONED 1 MIN, ROLLED SELF ONTO BACK.
SISTER PRESENT. SAT DROP TO 56% WITH PRONING. PT
REPOSITIONED ONTO RIGHT SIDE
- Document 10/13/21 1730 HJM 10/13/21 1731 HJM
*Document what applies
Activity: Bed:
Patient position in bed: Patient refused repositioning:
HOB elevated: Degrees: Heels propped:
Medical Devices checked and repositioned:

Dangle: Stand:
Chair: Chair type:
Weight shift:

Ambulate: Distance:
Weight bearing status:

Assist: *Blue ?
Staff Assisting: Assistive Devices:

CLRT on: Degree rotation - right: Degree rotation - left:
Comments: PT TURNED FROM SUPINE TO PRONE AT FAMILY REQUEST.
DIFFICULTY MAINTAINING O2 SAT IN ANY POSITION.
33095 MED: Influenza/Pneumococcal vaccine ^ D 06,14,20 PS
INPT: Change status to Complete when the
assessment is complete.
OBS/SDC: Change direction to PRN and
leave active

33095 MED: Influenza/Pneumococcal vaccine ^ D 06,14,20 PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0436 LK 10/08/21 0440 LK
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/08/21 1425 AM 10/08/21 1425 AM
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/08/21 2000 MP 10/08/21 2042 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/09/21 0600 MP 10/09/21 0619 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/09/21 1411 VW 10/09/21 1436 VW
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/09/21 2000 MP 10/09/21 2129 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/10/21 0553 MP 10/10/21 0555 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/10/21 2000 MP 10/10/21 2050 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/11/21 0536 MP 10/11/21 0538 MP
Has the Influenza/Pneumococcal assessment been completed: N

Comments:
- Document 10/11/21 1353 ES 10/11/21 1356 ES
Has the Influenza/Pneumococcal assessment been completed: N

Comments: ICU STATUS
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
Has the Influenza/Pneumococcal assessment been completed: N

Comments:

Intervention Description	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Sts	Direction	From Change
33095 MED: Influenza/Pneumococcal vaccine INPT: Change status to Complete when the assessment is complete. OBS/SDC: Change direction to PRN and leave active										^	D	PS
- Document		10/12/21	0513	CGR	10/12/21	0514	CGR					
Has the Influenza/Pneumococcal assessment been completed: N												
Comments:												
- Document		10/12/21	1400	HJM	10/12/21	1412	HJM					
Has the Influenza/Pneumococcal assessment been completed: N												
Comments:												
- Document		10/12/21	2000	SH	10/12/21	2142	SH					
Has the Influenza/Pneumococcal assessment been completed: N												
Comments: ICU STATUS												
- Document		10/13/21	0600	SH	10/13/21	0630	SH					
Has the Influenza/Pneumococcal assessment been completed:												
Comments:												
- Document		10/13/21	1405	HJM	10/13/21	1407	HJM					
Has the Influenza/Pneumococcal assessment been completed: N												
Comments:												
60675 MU: VTE ongoing assessment VTE - to be documented throughout the hospital stay & upon discharge.										^	D	PS
- Create		10/07/21	2222	SH	10/07/21	2224	SH					
- Document		10/08/21	0436	LK	10/08/21	0440	LK					
*Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy):												
If no, reason for discontinuing overlap therapy:												
*Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider:												
To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.												
- Document		10/08/21	1010	AM	10/08/21	1012	AM					
*Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag												

Intervention Description	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Sts	Direction	From Change
60675 MU: VTE ongoing assessment (continued) therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N										^		
If no, reason for discontinuing overlap therapy:												
*Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider:												
To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.												
- Document		10/08/21	1821	AM	10/08/21	1822	AM					
*Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N												
If no, reason for discontinuing overlap therapy:												
*Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider:												
To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.												
- Document		10/09/21	0600	MP	10/09/21	0620	MP					
*Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N												
If no, reason for discontinuing overlap therapy:												
*Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider:												
To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.												
- Document		10/09/21	1011	VW	10/09/21	1013	VW					
*Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least												

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

60675 MU: VTE ongoing assessment ^ (continued)
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/09/21 1800 VW 10/09/21 1801 VW
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged
on both meds. Overlap therapy must be admin for at least
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/10/21 0553 MP 10/10/21 0555 MP
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged
on both meds. Overlap therapy must be admin for at least
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/10/21 1000 KRH 10/10/21 1024 KRH
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

60675 MU: VTE ongoing assessment ^ (continued)
on both meds. Overlap therapy must be admin for at least
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/10/21 1800 KRH 10/10/21 1809 KRH
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged
on both meds. Overlap therapy must be admin for at least
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/11/21 0536 MP 10/11/21 0538 MP
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged
on both meds. Overlap therapy must be admin for at least
5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag
therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation
(overlap therapy): N
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING
problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/11/21 1003 ES 10/11/21 1007 ES
*Patients diagnosed with confirmed VTE: N

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
60675 MU: VTE ongoing assessment ^ (continued) Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider: To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis. - Document 10/11/21 1742 ES 10/11/21 1742 ES *Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider: To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis. - Document 10/12/21 0513 CGR 10/12/21 0514 CGR *Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): N If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider: To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.												

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
60675 MU: VTE ongoing assessment ^ D 06,10,18 PS VTE - to be documented throughout the hospital stay & upon discharge. - Document 10/12/21 1000 HJM 10/12/21 1013 HJM *Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider: To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis. - Document 10/12/21 1800 HJM 10/12/21 1832 HJM *Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider: To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis. - Document 10/13/21 0600 SH 10/13/21 0630 SH *Patients diagnosed with confirmed VTE: N Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR LIP documentation required for discontinuing overlap therapy Patient received Warfarin & IV or subcut anticoagulation (overlap therapy): If no, reason for discontinuing overlap therapy: *Has the LIP documented a current condition of Thrombocytopenia? N Thrombocytopenia? Date documented by provider:												

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

60675 MU: VTE ongoing assessment ^ (continued)

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation (overlap therapy):
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
- Document 10/13/21 1805 HJM 10/13/21 1807 HJM
*Patients diagnosed with confirmed VTE: N
Pts who received <5 days overlap therapy, must be discharged on both meds. Overlap therapy must be admin for at least 5 days with INR >/= 2 PRIOR to DC of IV/Subcut anticoag therapy or pt must be discharged on both meds. ***OR
LIP documentation required for discontinuing overlap therapy
Patient received Warfarin & IV or subcut anticoagulation (overlap therapy):
If no, reason for discontinuing overlap therapy:

*Has the LIP documented a current condition of Thrombocytopenia? N
Thrombocytopenia? Date documented by provider:

To find documentation for Thrombocytopenia: Review Progress Notes, H&P as PRESENTING problem, NOTE: This CORE Measure EXCLUDES hx of thrombocytopenia diagnosis.
2520 Intake & Output ^ D SHIFT END PS
- Create 10/07/21 2222 SH 10/07/21 2224 SH
- Document 10/08/21 0600 LK 10/08/21 0604 LK
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: N | TPN: | TF:
PO: | Lipids: | TF/NG Flush:
Supplement(s): | Packed RBC: | Cardiac Output flush:
Parenteral: 779.0 | Fresh Frozen Plasma: | Other #1:
Propofol: | Albumin: | Other #2:
Cleviprex: | Platelets:
Chemotherapy:
Comments: PT REFUSED WATER
Total Intake/8hr shift: 779

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2520 Intake & Output ^ (continued)
OUTPUT
Urine: 250 | Chest Tube #2: | Autologous Reinfuser:
# of Unmeasured Voids: 1 | Chest Tube #3: | CSF:
# of Bowel Movements: | Bile Drain: | Ultrafiltrate:
Stool (liquid): | JP/Hemovac #1: | Other #1:
Emesis: | JP/Hemovac #2: | Other #2:
NG Tube: | JP/Hemovac #3:
Chest Tube #1: | JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 250
- Document 10/08/21 1418 AM 10/08/21 1419 AM
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: Y | TPN: | TF:
PO: | Lipids: | TF/NG Flush:
Supplement(s): | Packed RBC: | Cardiac Output flush:
Parenteral: 1336.0 | Fresh Frozen Plasma: | Other #1:
Propofol: | Albumin: | Other #2:
Cleviprex: | Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 1336
OUTPUT
Urine: 300 | Chest Tube #2: | Autologous Reinfuser:
# of Unmeasured Voids: 2 | Chest Tube #3: | CSF:
# of Bowel Movements: | Bile Drain: | Ultrafiltrate:
Stool (liquid): | JP/Hemovac #1: | Other #1:
Emesis: | JP/Hemovac #2: | Other #2:
NG Tube: | JP/Hemovac #3:
Chest Tube #1: | JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 300
- Document 10/08/21 2200 EF 10/08/21 2228 EF
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: | TPN: | TF:
PO: | Lipids: | TF/NG Flush:
Supplement(s): | Packed RBC: | Cardiac Output flush:
Parenteral: 1050.0 | Fresh Frozen Plasma: | Other #1:
Propofol: | Albumin: | Other #2:
Cleviprex: | Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 1050
OUTPUT
Urine: 1500 | Chest Tube #2: | Autologous Reinfuser:
# of Unmeasured Voids: 1 | Chest Tube #3: | CSF:
# of Bowel Movements: | Bile Drain: | Ultrafiltrate:
Stool (liquid): | JP/Hemovac #1: | Other #1:
Emesis: | JP/Hemovac #2: | Other #2:
NG Tube: | JP/Hemovac #3:
Chest Tube #1: | JP/Hemovac #4:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2520 Intake & Output ^ (continued)

Comments:

Total Ouput/8hr shift: 1500

- Document 10/09/21 0600 MP 10/09/21 0653 MP

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:	TPN:	TF:
PO:	Lipids:	TF/NG Flush:
Supplement(s):	Packed RBC:	Cardiac Output flush:
Parenteral: 856.0	Fresh Frozen Plasma:	Other #1:
Propofol:	Albumin:	Other #2:
Cleviprex:	Platelets:	
Chemotherapy:		

Comments:

Total Intake/8hr shift: 856

OUTPUT

Urine: 575	Chest Tube #2:	Autologous Reinfuser:
# of Unmeasured Voids:	Chest Tube #3:	CSF:
# of Bowel Movements:	Bile Drain:	Ultrafiltrate:
Stool (liquid):	JP/Hemovac #1:	Other #1:
Emesis:	JP/Hemovac #2:	Other #2:
NG Tube:	JP/Hemovac #3:	
Chest Tube #1:	JP/Hemovac #4:	

Comments:

Total Ouput/8hr shift: 575

- Document 10/09/21 1400 VW 10/09/21 1526 VW

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO: N	TPN:	TF:
PO: 250	Lipids:	TF/NG Flush:
Supplement(s):	Packed RBC:	Cardiac Output flush:
Parenteral: 850.0	Fresh Frozen Plasma:	Other #1:
Propofol:	Albumin:	Other #2:
Cleviprex:	Platelets:	
Chemotherapy:		

Comments:

Total Intake/8hr shift: 1100

OUTPUT

Urine: 625	Chest Tube #2:	Autologous Reinfuser:
# of Unmeasured Voids:	Chest Tube #3:	CSF:
# of Bowel Movements:	Bile Drain:	Ultrafiltrate:
Stool (liquid):	JP/Hemovac #1:	Other #1:
Emesis:	JP/Hemovac #2:	Other #2:
NG Tube:	JP/Hemovac #3:	
Chest Tube #1:	JP/Hemovac #4:	

Comments:

Total Ouput/8hr shift: 625

- Document 10/09/21 2200 MP 10/09/21 2220 MP

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:	TPN:	TF:
PO: 240	Lipids:	TF/NG Flush:
Supplement(s):	Packed RBC:	Cardiac Output flush:
Parenteral: 742.0	Fresh Frozen Plasma:	Other #1:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2520 Intake & Output ^ (continued)

Propofol:	Albumin:	Other #2:
Cleviprex:	Platelets:	
Chemotherapy:		

Comments:

Total Intake/8hr shift: 982

OUTPUT

Urine: 550	Chest Tube #2:	Autologous Reinfuser:
# of Unmeasured Voids:	Chest Tube #3:	CSF:
# of Bowel Movements:	Bile Drain:	Ultrafiltrate:
Stool (liquid):	JP/Hemovac #1:	Other #1:
Emesis:	JP/Hemovac #2:	Other #2:
NG Tube:	JP/Hemovac #3:	
Chest Tube #1:	JP/Hemovac #4:	

Comments:

Total Ouput/8hr shift: 550

- Document 10/10/21 0600 MP 10/10/21 0600 MP

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:	TPN:	TF:
PO:	Lipids:	TF/NG Flush:
Supplement(s):	Packed RBC:	Cardiac Output flush:
Parenteral: 732.0	Fresh Frozen Plasma:	Other #1:
Propofol:	Albumin:	Other #2:
Cleviprex:	Platelets:	
Chemotherapy:		

Comments:

Total Intake/8hr shift: 732

OUTPUT

Urine: 500	Chest Tube #2:	Autologous Reinfuser:
# of Unmeasured Voids:	Chest Tube #3:	CSF:
# of Bowel Movements:	Bile Drain:	Ultrafiltrate:
Stool (liquid):	JP/Hemovac #1:	Other #1:
Emesis:	JP/Hemovac #2:	Other #2:
NG Tube:	JP/Hemovac #3:	
Chest Tube #1:	JP/Hemovac #4:	

Comments:

Total Ouput/8hr shift: 500

- Document 10/10/21 1511 KRH 10/10/21 1512 KRH

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO:	TPN:	TF:
PO: 75	Lipids:	TF/NG Flush:
Supplement(s):	Packed RBC:	Cardiac Output flush:
Parenteral: 980.0	Fresh Frozen Plasma:	Other #1:
Propofol:	Albumin:	Other #2:
Cleviprex:	Platelets:	
Chemotherapy:		

Comments:

Total Intake/8hr shift: 1055

OUTPUT

Urine: 2325	Chest Tube #2:	Autologous Reinfuser:
# of Unmeasured Voids: 0	Chest Tube #3:	CSF:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2520 Intake & Output ^ (continued)
# of Bowel Movements: 0 Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 2325
- Document 10/10/21 2200 MP 10/10/21 2207 MP
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: TPN: TF:
PO: Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 535.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 535
OUTPUT
Urine: 400 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 400
- Document 10/11/21 0556 MP 10/11/21 0557 MP
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: TPN: TF:
PO: Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 735.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 735
OUTPUT
Urine: 275 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 275

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

2520 Intake & Output ^ D SHIFT END PS
- Document 10/11/21 1350 ES 10/11/21 1351 ES
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: N TPN: TF:
PO: 160 Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 924.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 1084
OUTPUT
Urine: 375 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 375
- Document 10/11/21 2119 RS 10/11/21 2119 RS
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: TPN: TF:
PO: 120 Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 781.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:
Comments:
Total Intake/8hr shift: 901
OUTPUT
Urine: 475 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:
Comments:
Total Ouput/8hr shift: 475
- Document 10/12/21 0515 CGR 10/12/21 0517 CGR
INTAKE *View fluid volumes for PO intake by pressing shift F8*
NPO: TPN: TF:
PO: 25 Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 879.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

2520 Intake & Output ^ (continued)

Chemotherapy:

Comments:

Total Intake/8hr shift: 904

OUTPUT

Urine: 375 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:

Comments:

Total Ouput/8hr shift: 375

- Document 10/12/21 1400 HJM 10/12/21 1410 HJM

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO: TPN: TF:
PO: 100 Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 867.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:

Comments:

Total Intake/8hr shift: 967

OUTPUT

Urine: 550 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:

Comments:

Total Ouput/8hr shift: 550

- Document 10/12/21 2200 SH 10/12/21 2227 SH

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO: TPN: TF:
PO: 100 Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 925.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:

Comments:

Total Intake/8hr shift: 1025

OUTPUT

Urine: 400 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:

2520 Intake & Output ^ (continued)

Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:

Comments:

Total Ouput/8hr shift: 400

- Document 10/13/21 0600 SH 10/13/21 0628 SH

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO: TPN: TF:
PO: Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 923.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:

Comments:

Total Intake/8hr shift: 923

OUTPUT

Urine: 400 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:

Comments:

Total Ouput/8hr shift: 400

- Document 10/13/21 1400 HJM 10/13/21 1500 HJM

INTAKE *View fluid volumes for PO intake by pressing shift F8*

NPO: Y TPN: TF:
PO: Lipids: TF/NG Flush:
Supplement(s): Packed RBC: Cardiac Output flush:
Parenteral: 993.0 Fresh Frozen Plasma: Other #1:
Propofol: Albumin: Other #2:
Cleviprex: Platelets:
Chemotherapy:

Comments:

Total Intake/8hr shift: 993

OUTPUT

Urine: 300 Chest Tube #2: Autologous Reinfuser:
# of Unmeasured Voids: Chest Tube #3: CSF:
# of Bowel Movements: 1 Bile Drain: Ultrafiltrate:
Stool (liquid): JP/Hemovac #1: Other #1:
Emesis: JP/Hemovac #2: Other #2:
NG Tube: JP/Hemovac #3:
Chest Tube #1: JP/Hemovac #4:

Comments: PAD WET ALSO

Total Ouput/8hr shift: 300

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
60685 Sepsis Screening Tool Screening to be completed on: 1. All admitted patients 2. During rapid response 3. With change in condition 4. With transfer to new unit Notify provider of any positive screening results Provider determines the diagnosis and subsequent orders	^	D	PRN	PS									
- Create					10/07/21	2222	SH	10/07/21	2224	SH			
11145 RESP: BiPAP 10/9 15/12	^	C	Q2H	PS									
- Document					10/08/21	0000	LK	10/08/21	0114	LK			
Bipap On: Y Bipap Mask in use: Under Nose Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments* Intervention taken: Mask Repositioned Patient refused mask repositioning or assessment: N Cares: Offered Fluids Comments: PT REFUSED WATER. WILL TRY SWABBING WITH BIOTENE Education provided: Learners, if other than patient: Method: Learner Response/Outcome:													
- Create					10/08/21	0113	LK	10/08/21	0113	LK			
- Document					10/08/21	0400	LK	10/08/21	0436	LK			
Bipap On: Y Bipap Mask in use: Under Nose Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments* Intervention taken: Mask Repositioned Patient refused mask repositioning or assessment: N Cares: Offered Fluids Comments: Education provided: Learners, if other than patient: Method: Learner Response/Outcome:													
11145 RESP: BiPAP 10/9 15/12	^	C	Q2H	PS									
- Document					10/08/21	0600	LK	10/08/21	0606	LK			
Bipap On: Y Bipap Mask in use: Under Nose Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments* Intervention taken: Mask Repositioned Patient refused mask repositioning or assessment: N Cares: Offered Fluids Comments: Education provided: Learners, if other than patient: Method: Learner Response/Outcome:													
- Document					10/08/21	0815	AM	10/08/21	0950	AM			
Bipap On: Y Bipap Mask in use: Under Nose Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments* Intervention taken: Mask Repositioned Patient refused mask repositioning or assessment: Cares: Comments: Education provided: Learners, if other than patient: Method: Learner Response/Outcome:													
- Document					10/08/21	1010	AM	10/08/21	1012	AM			
Bipap On: Y Bipap Mask in use: Under Nose Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments* Intervention taken: Patient refused mask repositioning or assessment: Cares: Comments: Education provided: Learners, if other than patient: Method:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

11145 RESP: BiPAP ^ (continued)

Learner Response/Outcome:
- Document 10/08/21 1211 AM 10/08/21 1219 AM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/08/21 1418 AM 10/08/21 1422 AM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/08/21 1615 AM 10/08/21 1633 AM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

11145 RESP: BiPAP ^ (continued)
Method:

Learner Response/Outcome:
- Document 10/08/21 1821 AM 10/08/21 1822 AM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/08/21 2000 MP 10/08/21 2039 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/08/21 2200 MP 10/08/21 2246 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 0000 MP 10/09/21 0042 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 0200 MP 10/09/21 0210 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 0400 MP 10/09/21 0405 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 0600 MP 10/09/21 0617 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 0811 VW 10/09/21 0821 VW
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/09/21 1006 VW 10/09/21 1006 VW
Bipap On: Bipap Mask in use:
Skin Assessment: *If skin not WNL or `Other' options selected, document details in comments*

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Intervention taken:

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Ed Text 10/09/21 1006 VW 10/09/21 1006 VW
- Document 10/09/21 1153 VW 10/09/21 1155 VW
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/09/21 1411 VW 10/09/21 1434 VW
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:

11145 RESP: BiPAP ^ C Q2H PS
10/9 15/12
- Document 10/09/21 1611 VW 10/09/21 1624 VW
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/09/21 1800 VW 10/09/21 1801 VW
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/09/21 2000 MP 10/09/21 2128 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/09/21 2157 MP 10/09/21 2219 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0000 MP 10/10/21 0040 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0200 MP 10/10/21 0203 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0400 MP 10/10/21 0404 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0556 MP 10/10/21 0556 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Oral Care
Swabbed Mouth
Lip moisturizer
Comments: UNDER NOSE MASK BUT DUE TO SIZE OF FACE, COVERS NOSE

Education provided:
Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0800 KRH 10/10/21 0939 KRH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change
11145 RESP: BiPAP										^	(continued)	
Patient refused mask repositioning or assessment: N												
Cares:												
Comments:												
Education provided:												
Learners, if other than patient:												
Method:												
Learner Response/Outcome:												
- Document	10/10/21	1000	KRH	10/10/21	1124	KRH						
Bipap On: Y Bipap Mask in use: Under Nose												
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*												
Intervention taken:												
Patient refused mask repositioning or assessment:												
Cares:												
Comments:												
Education provided:												
Learners, if other than patient:												
Method:												
Learner Response/Outcome:												
- Document	10/10/21	1123	KRH	10/10/21	1124	KRH						
Bipap On: Y Bipap Mask in use: Under Nose												
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*												
Intervention taken: Mask Repositioned												
Patient refused mask repositioning or assessment:												
Cares:												
Comments:												
Education provided:												
Learners, if other than patient:												
Method:												
Learner Response/Outcome:												
- Ed Status	10/10/21	1330	KRH	10/10/21	1330	KRH						A => C

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Direction	From Change
15108 GU: Catheter, external										^	D PRN	PS
-May change direction to every 24 hrs for Male External Catheter												
- Create	10/08/21	0113	LK	10/08/21	0113	LK						
- Document	10/08/21	0113	LK	10/08/21	0113	LK						
External catheter type: Female (PureWick)												
Device placed: Y												
Device changed:												
-Change Male External Catheter every 24 hours												
-Change PureWick Female External Catheter every 8 hours with I&O or if soiled with feces or blood.												
Discontinued:												
Comments:												
- Document	10/08/21	0600	LK	10/08/21	0606	LK						
External catheter type: Female (PureWick)												
Device placed:												
Device changed: Y												
-Change Male External Catheter every 24 hours												
-Change PureWick Female External Catheter every 8 hours with I&O or if soiled with feces or blood.												
Discontinued:												
Comments:												
- Document	10/08/21	1418	AM	10/08/21	1422	AM						
External catheter type: Female (PureWick)												
Device placed:												
Device changed: Y												
-Change Male External Catheter every 24 hours												
-Change PureWick Female External Catheter every 8 hours with I&O or if soiled with feces or blood.												
Discontinued:												
Comments:												
- Document	10/08/21	2200	MP	10/08/21	2247	MP						
External catheter type: Female (PureWick)												
Device placed: Y												
Device changed: N												
-Change Male External Catheter every 24 hours												
-Change PureWick Female External Catheter every 8 hours with I&O or if soiled with feces or blood.												
Discontinued: Y												
Comments: ORDER FOR FOLEY												
- Document	10/09/21	0600	MP	10/09/21	0618	MP						
External catheter type:												
Device placed:												
Device changed:												
-Change Male External Catheter every 24 hours												
-Change PureWick Female External Catheter every 8 hours with I&O or if soiled with feces or blood.												

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

15108 GU: Catheter, external ^ (continued)

Discontinued: Y
Comments:
- Ed Directs 10/09/21 0622 EF 10/09/21 0623 EF
10/08 0113 06,14,22 ==> 10/08 0113 06,14,22
==> 10/09 0000 PRN
80015 Transfer patient D PRN OE
Transfer To: ICU
- Create 10/08/21 0126 JME 10/08/21 0126 JME
15107 GU: Cath, Indwelling Insertion ^ D PRN OE
Catheter type: Foley/indwelling **F9 To View Options**
For Male patient: Lidocaine 2% Urojet to lubricate urethra prior to insertion:
Must enter separate medication order for Urojet
Indication: Urn output measurements **F9 To View Options** . -
**Only patients meeting the insertion criteria should have an indwelling urinary cath.
**Alternatives to indwelling urinary caths (external caths, frequent toileting scheds, intermittent catheterization) should be considered and utilized as appropriate.
Removal per Nurse Driven Protocol: Y If 'NO': Reason:
Click Blue ? to view Nurse Driven Protocol
Discontinue catheter on (date/time):
Comments:
Date inserted:10/8/21
Time inserted:2300
Indication for Catheter:ACCURATE I/O,
SKIN BREAKDOWN
- Create 10/08/21 1802 AM 10/08/21 1802 AM
- Document 10/08/21 2300 NWK 10/08/21 2335 NWK
Catheter type: Foley/indwelling Size (Fr): 16
Amount instilled in balloon (ml): 10 Immediate urine return (ml): 300
Color: Yellow Clarity: Cloudy
Specimen sent to lab: Securement device present: Y Patient tolerated procedure: Y
Education provided: Y Foley insertion, signs & symptoms of infection, & CAUTIprevention.

LIP Order is required for catheter insertion

Indication for Foley Catheter Insertion: (check all that apply)

Patient has acute or chronic urinary retention or bladder outlet obstruction:
Need for accurate urine output measurements: Y
Use for selected surgical procedures:
To assist in healing of open sacral or perineal wounds:
Patient requires prolonged immobilization:
To improve comfort for end of life care:

Discontinued:
Comments:
- Ed Text 10/08/21 2329 JLJ 10/08/21 2329 JLJ
- Ed Text 10/09/21 0621 EF 10/09/21 0621 EF

17013 IV: PICC/Midline ^ D Q2H PS
Site Care due:10/19/2021
Type:PICC
Measurement:
Insertion date:10/8/2021

Solution:
Tubing change due:

*Change dressing every 7 days & PRN loose, soiled or drainage. If gauze dressing present, change 24hr post-insertion and remove gauze. No gauze under transparent dressing post initial dressing change. Change securement device with dressing change. Apply Biopatch. Label dressing with line type and date.
*No need to change extension tubing applied during insertion
*Obtain measurement with each dressing change & PRN.
*Measure arm circumference with each dressing change.

*Cap changes every 7 days all lumens with site care.

*RN to assess the need to continue central line. Contact physician for order to discontinue if central line not needed.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ D Q2H PS
- Create 10/08/21 2044 MP 10/08/21 2044 MP
- Document 10/08/21 2044 MP 10/08/21 2045 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Ed Text 10/08/21 2045 MP 10/08/21 2045 MP
- Document 10/09/21 0000 MP 10/09/21 0043 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 0200 MP 10/09/21 0210 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

17013 IV: PICC/Midline ^ (continued)
Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 0400 MP 10/09/21 0405 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 0600 MP 10/09/21 0618 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 0811 VW 10/09/21 0821 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 1011 VW 10/09/21 1013 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 1153 VW 10/09/21 1155 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

17013 IV: PICC/Midline ^ (continued)

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 1411 VW 10/09/21 1434 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 1611 VW 10/09/21 1624 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 1800 VW 10/09/21 1801 VW
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL:
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

17013 IV: PICC/Midline ^ (continued)
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 2000 MP 10/09/21 2128 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/09/21 2157 MP 10/09/21 2219 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:

17013 IV: PICC/Midline ^ D Q2H PS
Site Care due:10/19/2021
Type:PICC
Measurement:
Insertion date:10/8/2021

Solution:
Tubing change due:

*Change dressing every 7 days & PRN loose, soiled or drainage. If gauze dressing present, change 24hr post-insertion and remove gauze. No gauze under transparent dressing post initial dressing change. Change securement device with dressing change. Apply Biopatch. Label dressing with line type and date.
*No need to change extension tubing applied during insertion
*Obtain measurement with each dressing change & PRN.
*Measure arm circumference with each dressing change.

*Cap changes every 7 days all lumens with site care.

*RN to assess the need to continue central line. Contact physician for order to discontinue if central line not needed.
- Document 10/10/21 0000 MP 10/10/21 0041 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
Comments:
- Document 10/10/21 0200 MP 10/10/21 0203 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 0400 MP 10/10/21 0404 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 0556 MP 10/10/21 0556 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:

17013 IV: PICC/Midline ^ (continued)
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 0800 KRH 10/10/21 0939 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 1000 KRH 10/10/21 1024 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 1230 KRH 10/10/21 1320 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 1400 KRH 10/10/21 1418 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

17013 IV: PICC/Midline ^ (continued)
Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 1800 KRH 10/10/21 1809 KRH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 2000 MP 10/10/21 2049 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/10/21 2200 MP 10/10/21 2209 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change
17013 IV: PICC/Midline ^ (continued)													

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 0000 MP 10/11/21 0014 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments: PRECEDEX TUBING CHANGED
10/11/21 0000
- Document 10/11/21 0200 MP 10/11/21 0205 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change
17013 IV: PICC/Midline ^ D Q2H PS													

Site Care due:10/19/2021
Type:PICC
Measurement:
Insertion date:10/8/2021

Solution:
Tubing change due:

*Change dressing every 7 days & PRN loose, soiled or drainage. If gauze dressing present, change 24hr post-insertion and remove gauze. No gauze under transparent dressing post initial dressing change. Change securement device with dressing change. Apply Biopatch. Label dressing with line type and date.
*No need to change extension tubing applied during insertion
*Obtain measurement with each dressing change & PRN.
*Measure arm circumference with each dressing change.

*Cap changes every 7 days all lumens with site care.

*RN to assess the need to continue central line. Contact physician for order to discontinue if central line not needed.
- Document 10/11/21 0400 MP 10/11/21 0416 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
Comments:
- Document 10/11/21 0550 MP 10/11/21 0551 MP
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 0800 ES 10/11/21 0843 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1003 ES 10/11/21 1007 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1157 ES 10/11/21 1158 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1536 ES 10/11/21 1536 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1742 ES 10/11/21 1742 ES
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

17013 IV: PICC/Midline ^ (continued)
Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 0006 CGR 10/12/21 0101 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 0152 CGR 10/12/21 0153 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)

Type: PICC: Y Single-lumen: Double-lumen: Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 0551 CGR 10/12/21 0552 CGR
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 0800 HJM 10/12/21 0858 HJM
*Document what applies:

17013 IV: PICC/Midline ^ (continued)
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 1000 HJM 10/12/21 1013 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 1130 HJM 10/12/21 1131 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 1400 HJM 10/12/21 1410 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 1530 HJM 10/12/21 1530 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 1800 HJM 10/12/21 1832 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patient: Redness: Swelling: Phlebitis: Pain/tenderness:

17013 IV: PICC/Midline ^ (continued)
*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 2000 SH 10/12/21 2141 SH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patient: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments: INFUSING

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
17013 IV: PICC/Midline Site Care due:10/19/2021 Type:PICC Measurement: Insertion date:10/8/2021 Solution: Tubing change due: *Change dressing every 7 days & PRN loose, soiled or drainage. If gauze dressing present, change 24hr post-insertion and remove gauze. No gauze under transparent dressing post initial dressing change. Change securement device with dressing change. Apply Biopatch. Label dressing with line type and date. *No need to change extension tubing applied during insertion *Obtain measurement with each dressing change & PRN. *Measure arm circumference with each dressing change. *Cap changes every 7 days all lumens with site care. *RN to assess the need to continue central line. Contact physician for order to discontinue if central line not needed.	^ D	Q2H	PS										
- Document 10/13/21 0000 SH 10/13/21 0024 SH *Document what applies: Site Location: LEFT BRACHIAL IV Site WNL: Y (Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites) Patent: Redness: Swelling: Phlebitis: Pain/tenderness: *Document action taken for abnormal findings in comments. Comments: INFUSING Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter: External measurement (cm): PICC arm circumference (cm): *Measurement is midway between shoulder & elbow Site care: Biopatch changed: Tubing change: Cap change: Securement device: Discontinued: Tip sent to lab for culture:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
17013 IV: PICC/Midline ^ (continued) Comments: - Document 10/13/21 0200 SH 10/13/21 0239 SH *Document what applies: Site Location: LEFT BRACHIAL IV Site WNL: Y (Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites) Patent: Redness: Swelling: Phlebitis: Pain/tenderness: *Document action taken for abnormal findings in comments. Comments: INFUSING Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter: External measurement (cm): PICC arm circumference (cm): *Measurement is midway between shoulder & elbow Site care: Biopatch changed: Tubing change: Cap change: Securement device: Discontinued: Tip sent to lab for culture: Comments: - Document 10/13/21 0400 SH 10/13/21 0505 SH *Document what applies: Site Location: LEFT BRACHIAL IV Site WNL: Y (Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites) Patent: Redness: Swelling: Phlebitis: Pain/tenderness: *Document action taken for abnormal findings in comments. Comments: INFUSING Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter: External measurement (cm): PICC arm circumference (cm): *Measurement is midway between shoulder & elbow Site care: Biopatch changed: Tubing change: Cap change: Securement device: Discontinued: Tip sent to lab for culture: Comments: - Document 10/13/21 0600 SH 10/13/21 0630 SH *Document what applies: Site Location: LEFT BRACHIAL IV Site WNL: Y (Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites) Patent: Redness: Swelling: Phlebitis: Pain/tenderness: *Document action taken for abnormal findings in comments. Comments: INFUSING Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

17013 IV: PICC/Midline ^ (continued)
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/13/21 0802 HJM 10/13/21 0810 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Y Biopatch changed: Y Tubing change: Y Cap change: All
Securement device: Y

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency,

17013 IV: PICC/Midline ^ (continued)
absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Ed Text 10/13/21 1402 HJM 10/13/21 1402 HJM
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

17013 IV: PICC/Midline ^ (continued)

Discontinued: Tip sent to lab for culture:

Comments:

- Document 10/13/21 1805 HJM 10/13/21 1807 HJM

*Document what applies:
Site Location: LEFT BRACHIAL IV Site WNL: Y
(Includes verification of correct solution, flow rate, amount infused, site patency, absence of site problems for all sites)
Patent: Redness: Swelling: Phlebitis: Pain/tenderness:

*Document action taken for abnormal findings in comments.
Comments:

Type: PICC: Y Single-lumen: Double-lumen: Y Midline: Extended length catheter:
External measurement (cm):
PICC arm circumference (cm): *Measurement is midway between shoulder & elbow
Site care: Biopatch changed: Tubing change: Cap change:
Securement device:

Discontinued: Tip sent to lab for culture:

Comments:

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ D SHIFT PS
Location:INNER THIGHS/GROIN
Specify treatment type: HOME TOPICAL
MEDS
Dressing change due: N/A
Measurement due:

- Create 10/09/21 0137 MP 10/09/21 0138 MP
- Ed Text 10/09/21 0138 MP 10/09/21 0138 MP
- Document 10/09/21 0139 MP 10/09/21 0142 MP

Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: SOAP AND WATER
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue: Erythema

Comments: OPEN SORES/RASH/REDNESS/SCABS

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

- Document 10/09/21 0811 VW 10/09/21 0822 VW

Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Solution used:
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/09/21 1611 VW 10/09/21 1625 VW
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Solution used:
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/10/21 0053 MP 10/10/21 0053 MP
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments: OPEN SORES/RASH/REDNESS/SCABS

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Y Dressing: Risk for infection: Y
Other topics:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Learners, if other than patient: Family member

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/10/21 0800 KRH 10/10/21 0939 KRH
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue: Erythema

Comments: OPEN SORES/RASH/REDNESS/SCABS

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Learner Response/Outcome:
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: N Solution used:
Wound irrigated: N Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 0027 MP 10/11/21 0029 MP
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/GROIN
Dressing:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments: OPEN SORES/RASH/REDNESS/SCABS

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics: CLEANSING & PROPER SKIN CARE

Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0533 MP 10/11/21 0534 MP
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing:
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments: OPEN SORES/RASH/REDNESS/SCABS. OOZING OPEN SORE ON LEFT ABDOMINAL FOLD.

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1527 ES 10/11/21 1528 ES
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES
Wound irrigated: N Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue: Erythema

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Comments: OPEN SORES/RASH/REDNESS/SCABS.
INTERDRY TO ABDOMINAL FOLDS

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0006 CGR 10/12/21 0101 CGR
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: N
Dressing type: Dressing management:

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: PRE-PACKAGED WIPES
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0800 HJM 10/12/21 0859 HJM
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: Y
Dressing type: INTERDRY Dressing management:

Exudate: N Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: CLOTHS
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments: ABX CREAM IN PLACE

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 1530 HJM 10/12/21 1531 HJM
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: Y
Dressing type: INTERDRY Dressing management: Dry & intact

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Solution used:
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0100 SH 10/13/21 0237 SH
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: Y
Dressing type: INTERDRY Dressing management: Dry & intact

Exudate: N Color: Consistency:
Amount: Odor:

Wound cleansed: Y Solution used: CLOTHS
Wound irrigated: N Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue: Erythema

Comments: ABX CREAM IN PLACE

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Method:

Learner Response/Outcome:
- Document 10/13/21 0802 HJM 10/13/21 0810 HJM
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: Y
Dressing type: INTERDRY Dressing management: Dry & intact

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Solution used:
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
Definitions can be viewed clicking Blue ? key on toolbar OR by pressing shift <F8>

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

19130 WOUND: #01 Wound / Press Ulcer/Drs Mgmt^ (continued)
Wound OR Pressure Ulcer Location: INNER THIGHS/BUTTOCKS/BREASTS/FOLDS
Dressing: Y
Dressing type: INTERDRY Dressing management: Dry & intact

Exudate: Color: Consistency:
Amount: Odor:

Wound cleansed: Solution used:
Wound irrigated: Solution used:

WOUND BASE: Granulation tissue: Necrotic tissue: Slough:
Surrounding tissue:

Comments:

Wound OR Pressure Ulcer measurements & stage of ulcer on next page
Staging for pressure ulcer and measurement for wound or pressure ulcer are done on admission, every 7 days, and with change of condition

Stage of ulcer:
Size: Length (cm): Width (cm): Depth (cm):

Presence of Undermining: cm: From (o'clock position):
To (o'clock position):

Tunneling: cm: At (o'clock position):

Comments:

Education Topic: Wound care: Dressing: Risk for infection:
Other topics:

Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

135 PRI: Falls, risk for R/t: *129839007 C CONT OE
- Create 10/10/21 0938 KRH 10/10/21 0938 KRH
- Ed Status 10/10/21 1831 KRH 10/10/21 1831 KRH A => C
11145 RESP: BiPAP ^ D Q2H OE
Standard initial settings: Y Continuous: Y PRN: Y
Standard initial settings: IPAP 10, EPAP 5, RR 12. FiO2 to keep SpO2 > 90%, settings to be adjusted by RT PRN. If settings different than standard, indicate below:
IPAP: 15 EPAP: 12 RR: 14 FiO2 to keep SpO2 greater than: 90 %
Comments:
10/10: 15/12, RATE 14
- Create 10/10/21 1035 KRH 10/10/21 1035 KRH
- Document 10/10/21 1230 KRH 10/10/21 1320 KRH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: REFUSED

Comments: PT REFUSED TOOTHBRUSH AND SWAB. WILL REATTEMPT AT LATER TIME

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/10/21 1325 KRH 10/10/21 1330 KRH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken:

Patient refused mask repositioning or assessment:
Cares:

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Ed Text 10/10/21 1330 KRH 10/10/21 1331 KRH
- Document 10/10/21 1606 KRH 10/10/21 1616 KRH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*

11145 RESP: BiPAP ^ (continued)
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: REFUSED

Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/10/21 1800 KRH 10/10/21 1809 KRH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids
Comments: alternating between oxymask and bipap for drinking

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/10/21 2000 MP 10/10/21 2049 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ D Q2H OE
10/10: 15/12, RATE 14
- Document 10/10/21 2200 MP 10/10/21 2209 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0000 MP 10/11/21 0013 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0200 MP 10/11/21 0205 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:

11145 RESP: BiPAP ^ (continued)
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0400 MP 10/11/21 0416 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0548 MP 10/11/21 0548 MP
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method: Verbal

Learner Response/Outcome: Requires reinforcement
- Document 10/11/21 0800 ES 10/11/21 0843 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1003 ES 10/11/21 1004 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1200 ES 10/11/21 1225 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1353 ES 10/11/21 1354 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1600 ES 10/11/21 1634 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 1742 ES 10/11/21 1742 ES
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

11145 RESP: BiPAP ^ (continued)
Learner Response/Outcome:
- Document 10/11/21 1952 CGR 10/11/21 2000 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/11/21 2138 CGR 10/11/21 2138 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0006 CGR 10/12/21 0101 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Offered Fluids

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

11145 RESP: BiPAP ^ (continued)
Comments: ALTERNATING BETWEEN VAPOTHERM AND BIPAP FOR ORAL CARES

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0152 CGR 10/12/21 0153 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0351 CGR 10/12/21 0355 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0551 CGR 10/12/21 0552 CGR
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 0800 HJM 10/12/21 0858 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 1000 HJM 10/12/21 1013 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ensure offered

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 1130 HJM 10/12/21 1131 HJM
Bipap On: Y Bipap Mask in use: Under Nose

11145 RESP: BiPAP ^ (continued)
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ensure offered

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 1400 HJM 10/12/21 1410 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ensure offered

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 1530 HJM 10/12/21 1530 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken:

Patient refused mask repositioning or assessment:
Cares:

Comments: DEFERED MASK ADJUSTMENT D/T LOW SAT AND LONG RECOVERY LAST ADJUSTMENT

Education provided:
Learners, if other than patient:

Method:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Learner Response/Outcome:
- Document 10/12/21 1800 HJM 10/12/21 1832 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 2000 SH 10/12/21 2141 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: DEFERED MASK ADJUSTMENT D/T LOW SAT AND LONG RECOVERY LAST ADJUSTMENT

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/12/21 2200 SH 10/12/21 2229 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:

11145 RESP: BiPAP ^ (continued)
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0000 SH 10/13/21 0024 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0200 SH 10/13/21 0239 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0400 SH 10/13/21 0505 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

11145 RESP: BiPAP ^ (continued)
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0600 SH 10/13/21 0629 SH
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 0802 HJM 10/13/21 0809 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: LIQUIDS OFFERED

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 1000 HJM 10/13/21 1020 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

11145 RESP: BiPAP ^ (continued)

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ENSURE OFFERED

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 1143 HJM 10/13/21 1144 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments: ENSURE OFFERED

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 1405 HJM 10/13/21 1406 HJM
Bipap On: Y Bipap Mask in use:
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment:
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

11145 RESP: BiPAP ^ D Q2H OE
10/10: 15/12, RATE 14
- Document 10/13/21 1600 HJM 10/13/21 1613 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken: Mask Repositioned

Patient refused mask repositioning or assessment: N
Cares: Swabbed Mouth
Oral Care
Lip moisturizer
Comments:

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:
- Document 10/13/21 1805 HJM 10/13/21 1807 HJM
Bipap On: Y Bipap Mask in use: Under Nose
Skin Assessment: WNL *If skin not WNL or `Other' options selected, document details in comments*
Intervention taken:

Patient refused mask repositioning or assessment:
Cares:

Comments: DEFERED MASK REPO D/T O2 SAT 49%

Education provided:
Learners, if other than patient:

Method:

Learner Response/Outcome:

28440 NUT: Nutrition Standard Assessment ^ D PRN PS
- Create 10/11/21 1016 LR 10/11/21 1016 LR
- Document 10/11/21 1016 LR 10/11/21 1135 LR
Standard Assessment - Nutritional Service

Diagnosis: COVID POSITIVE
Past Medical Hx: HIGH FUNCTIONING DOWN SYNDROME, SLEEP APNEA ON CPAP, HEARING LOSS
OTHER PMH REVIEWED. POA ACTIVATED.
BROUGHT TO ER BY HER FAMILY SECONDARY TO SOB. COVID POSITIVE.
BIPAP DEPENDENT. INFECTIOUS DISEASE FOLLOWS. PICC PLACED 10/8.
FAMILY WISHES FOR NO INTUBATION AND NO FEEDING TUBE.

Allergies reviewed? Y
Comments: NKFA

28440 NUT: Nutrition Standard Assessment ^ (continued)

Diet Rx/Nutritional 10/7: NPO --> GENERAL
Supplements: ROOM SERVICE ASSIST

Appetite: NO REPORT OF POOR APPETITE PTA PER PART A. ORDERING OKAY.
TOOK 100% OF 3 MEALS ON 10/7, NO PO RECORDED FROM 10/8-10/10 AT
DINNER - TOOK 50% OF AN ENSURE CLEAR. STAFF ENCOURAGING PO.
GI: LBM 10/6. NO REPORT OF N/V.

LABS:

Alb:	3.0	Date: 10/11/21 0552	GFR:	> 60	Date: 10/11/21 0552
Glucose:	116	Date: 10/11/21 0552	Na+:	142	Date: 10/11/21 0552
BUN:	16	Date: 10/11/21 0552	K+:	3.8	Date: 10/11/21 0552
Creat:	0.74	Date: 10/11/21 0552	Hgb:	12.7	Date: 10/11/21 0535

Additional Labs: REVIEWED ALL LABS

Pertinent Meds:

Ht/Ft: Wt/lbs: 185.0 BMI: 41.5 Usual weight:
Inches: 56 IBW: 90 LB ADJ IBW for amputation:
CM: 142.24 KG: 83.910 %IBW:

Weight history: *DENIES UNPLANNED WT LOSS PTA PER PART A*
WT HX PER ATHENA:
9/7/18: 157 LB
9/19/19: 189 LB
9/8/20: 190 LB (APPEARS STABLE OVER PAST YEAR)

Nutritional Needs:

kcal:		Protein (gm):		Fluid (ml):	
Kcal/Kg:		gm/Kg:		ml/kg:	

Level of Nutritional Risk: At risk for malnutrition

Assessment Summary: CONSULTED FOR MINIMAL PO INTAKE, ACTIVATED POA IS
RESISTANT TO A FEEDING TUBE.
MST SCORE OF 0 (NOT AT RISK) & NUTRITION BRADEN SCORES
OF 3 NOTED. WT STABLE. MINIMAL PO INTAKE SINCE ADMIT.
INADEQUATE ORAL INTAKE R/T POOR APPETITE WITH COVID-19

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

28440 NUT: Nutrition Standard Assessment ^ (continued)

AND DEPENDENT ON BIPAP AS EVIDENCED BY MINIMAL PO
INTAKES SINCE ADMIT.
WILL FOLLOW PO/WT TRENDS, ANY NEED FOR ALTERNATE
NUTRITION SUPPORT - THOUGH NOTED FAMILY DOES NOT WISH
FOR FEEDING TUBE PLACEMENT.

Plan / Recommendation: RECOMMEND CONTINUE DIET AS ORDERED. ENCOURAGE PO INTAKES.
PO SUPPLEMENTS: ORDERING ON OWN & CAN RECEIVE FROM THE FLOOR PRN.

Goal: PO INTAKES OF AT LEAST 50% AVG OVER NEXT 2-3 DAYS.

Follow up date: 10/14/21

- Document 10/13/21 1405 LR 10/13/21 1426 LR
Standard Assessment - Nutritional Service

Diagnosis: COVID POSITIVE
Past Medical Hx: HIGH FUNCTIONING DOWN SYNDROME, SLEEP APNEA ON CPAP, HEARING LOSS
OTHER PMH REVIEWED. POA ACTIVATED.
BROUGHT TO ER BY HER FAMILY SECONDARY TO SOB. COVID POSITIVE.
BIPAP DEPENDENT. INFECTIOUS DISEASE FOLLOWS. PICC PLACED 10/8.
FAMILY WISHES FOR NO INTUBATION, CHANGED TO NO CODE TODAY.
TUBE FEEDINGS ORDERED TO START TODAY, SMALL BORE NG PLACED.

Allergies reviewed? Y
Comments: NKFA

Diet Rx/Nutritional Supplements: 10/13: NPO, TF ORDERED TO START (JEVITY 1.2, GOAL 65 ML/HR)

28440 NUT: Nutrition Standard Assessment ^ (continued)

Appetite: MINIMAL PO INTAKES SINCE ADMIT PER D/W HOLLEE, RN.
NO PO DOCUMENTED PER FLOWSHEET REVIEW. RN ADJUSTED PT TO NPO
TODAY. NG PLACED FOR TF TO START.
GI: LBM 10/14. NO REPORT OF N/V.

LABS:

Alb: 2.7	Date: 10/13/21 0437		GFR: > 60	Date: 10/13/21 0437	
Glucose: 101	Date: 10/13/21 0437		Na+: 140	Date: 10/13/21 0437	
BUN: 16	Date: 10/13/21 0437		K+: 4.2	Date: 10/13/21 0437	
Creat: 0.67	Date: 10/13/21 0437		Hgb: 12.7	Date: 10/13/21 0418	

Additional Labs: REVIEWED ALL LABS

Pertinent Meds: DEXAMETHASONE, PRN ZOFRAN, PRECEDEX, INSULIN, NS AT 100 ML/HR,
SEE EMAR FOR COMPLETE LIST

Ht/Ft:	Wt/lbs: 185.0	BMI: 41.5	Usual weight:
Inches: 56		IBW: 88LB/40KG	ADJ IBW for amputation:
CM: 142.24	KG: 83.910	%IBW:	

Weight history: *DENIES UNPLANNED WT LOSS PTA PER PART A*
WT HX PER ATHENA:
9/7/18: 157 LB
9/19/19: 189 LB
9/8/20: 190 LB (APPEARS STABLE OVER PAST YEAR)

Nutritional Needs:

kcal: 1770-2065	Protein (gm): 72-76	Fluid (ml): 2460
Kcal/Kg: 21-25(ABW)	gm/Kg: 1.8-1.9IBW	ml/kg: 29 (ABW)

Level of Nutritional Risk: At risk for malnutrition

Assessment Summary: NEEDS ASSESSED ABOVE USING MSJE = 1475 KCAL (X1.2-1.4)
AND PROTEIN & FLUID NEEDS FOR BMI >30.
MST SCORE OF 0 (NOT AT RISK) & NUTRITION BRADEN SCORES
OF 3 --> 2 NOTED. WT HX STABLE OVER PAST YEAR.
INADEQUATE ORAL INTAKE R/T POOR APPETITE WITH COVID-19
AND DEPENDENT ON BIPAP AS EVIDENCED BY MINIMAL PO
INTAKES SINCE ADMIT, NEED FOR TF TO MEET NEEDS.
WILL FOLLOW WITH NUTRITION SUPPORT MONITORING.

Plan / Recommendation: INITIATE ALTERNATE NUTRITION SUPPORT: TUBE FEEDINGS OF JEVITY 1.2
FOLLOWING SLOW ADVANCEMENT SCHEDULE TO GOAL RATE OF 65 ML/HR.
TO PROVIDE:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

28440 NUT: Nutrition Standard Assessment ^ (continued)
1872 KCAL (MEETING 100% EST. NEEDS)
87 G PROTEIN (MEETING OVER 100% EST. NEEDS - NO CONTRAINDICATION TO EXTRA PROTEIN, WILL MONITOR)
1259 ML TOTAL FREE WATER - PT ALSO ON IVFS, MAY WISH TO ADJUST AS PT GETS CLOSER TO GOAL TF RATE TO PREVENT FLUID OVERLOAD.

Goal: RECEIVE AT LEAST 80% OF ORDERED TF VOLUME OVER NEXT 7 DAYS.

Follow up date: 10/20/21

. |

- Edit Results 10/13/21 1405 LR 10/13/21 1429 LR
Assessment Summary: NEEDS ASSESSED ABOVE USING MSJE = 1475 KCAL (X1.2-1.4) AND PROTEIN & FLUID NEEDS FOR BMI >30. MST SCORE OF 0 (NOT AT RISK) & NUTRITION BRADEN SCORES OF 3 --> 2 NOTED. WT HX STABLE OVER PAST YEAR. INADEQUATE ORAL INTAKE R/T POOR APPETITE WITH COVID-19 AND DEPENDENT ON BIPAP AS EVIDENCED BY MINIMAL PO INTAKES SINCE ADMIT, NEED FOR TF TO MEET NEEDS. WILL FOLLOW WITH NUTRITION SUPPORT MONITORING. NUTRITION FOCUSED PHYSICAL EXAM NOT COMPLETED D/T [] COVID POSITIVE STATUS. []

26505 SPS: Spiritual Services Initial Assess D .first pt visit AS
Discipline: SPS
- Create 10/11/21 1329 RJR 10/11/21 1341 RJR
- Document 10/11/21 1329 RJR 10/11/21 1341 RJR
Spiritual Services Assessment
Religion:

Patient/Resident Population: Medical
Reason for visit: Chaplain Initiated Visit
If referral, list referral source:

Time spent on interventions is approximate and used for statistical purposes only.
Definitions can be viewed by using shift F8
Issue 1: Adjustment to Change
Spiritual Concerns: Coping well :
:
Intervention: Comfort & Support Time Spent: 5 minutes
: Explore Sources Mean/Hope Time Spent: 2 minutes

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

26505 SPS: Spiritual Services Initial Assess (continued)
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: Involvement in Care :
: :

Definitions can be viewed by using shift F8
Issue 2:
Spiritual Concerns: :
: :
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
: :

Issue 3:
Spiritual Concerns: :
: :
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
: :

Definitions can be viewed by using shift F8
Issue 4:
Spiritual Concerns: :
: :
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
: :

Press <Esc> to exit comment field.
Comments: PT GRACE, 19 YOA APPEARED TO BE ALERT AND SHE WAS RECEIVING BREATHING SUPPORT THROUGH BIPAP. GRACE IS A COVID PATIENT SO THIS VISIT WAS CONDUCTED THROUGH A SPECIAL INTERCOM SYSTEM. CONSULTED WITH GRACE'S DOCTOR WHO WAS ABOUT TO ENTER HER ROOM AND HE AGREED TO ASK IF SHE WOULD BE INTERESTED IN A INTERCOM VISIT WITH A CHAPLAIN. PT AGREED TO THE VISIT METHOD. BRIEFLY EXPLAINED WAYS CHAPLAINS VISIT WITH PEOPLE AND OFFER SUPPORT. GRACE DID NOT RESPOND VERBALLY DUE TO HER BIPAP TREATMENT. TALKED ABOUT A STUFFED ANIMAL PRESENT WITH HER AND ABOUT THE VALUE OF HAVING SOMETHING FUZZY, SOFT, AND FAMILIAR WITHIN REACH. WISHED GRACE STRENGTHENING AND A PLEASANT DAY.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Change
13563 GI: Insert Feeding Tube (FT)		D											OE
Tube Type: Nasogastric (NG) **F9 To View Options**													
- Create					10/13/21	1111	HJM	10/13/21	1111	HJM			
13555 GI: Use Tube in Place		D											OE
Tube Type: Nasogastric FT **F9 To View Options**													
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
1630 Glucose monitoring as ordered		^ C	Q6H										OE
SLIDING SCALE: See MAR													
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
- Ed Status					10/13/21	1344	HJM	10/13/21	1344	HJM			A => C
13570 GI: TF, Tube Feeding Management		^ D	Q4H*										OE
Product:JEVITY 1.2													
Ordered goal rate:65													
FLUSHES: Flush feeding tube with 30-60 ml warm tap water													
CONTINUOUS: Q4H													
INTERMITTENT: before & after feedings													
MEDS: Pre/post with 30cc water Between with 10cc water													
OPEN SYSTEM:													
-Fill bags with 8 hour volume of product for continuous feeding													
-Empty each bag - DO NOT add new TF to hanging TF													
-Rinse feeding bag with warm water every 8 hours before adding new TF formula to bag													
-Change bag every 24 hours													
-Open system daily bag change due at:													
CLOSED SYSTEM:													
-Label container & spike set with patient's name and date/time hung													
-Leave spike set intact for same duration as container for up to 48 hours per spiking													
-Use a new spike set with each new bag													
GRV CHECKS FOR NASOGASTRIC AND GASTROSTOMY TUBES (NO residual checks for jejunostomy tubes)													
- A GRV should be checked if there are symptoms of tube feeding intolerance (nausea, abdominal pain, distension, firmness, etc).													
- Do not perform routine GRVs for patients who are awake and alert and able to communicate, or who do not meet the follwing criteria:													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Documented Comment	Documented Units	Change
13570 (continued)													
nausea, regurgitation, vomiting, or abdominal bloating, distension or pain.													
RESIDUAL CHECKS:													
- If the GRV is 500 mL or less and the patient is tolerating tube feeding, continue feeding at prescribed rate.													
- If the GRV if 500 mL or less and the patient has intolerance:													
a-Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&O s.													
b-Reduce the tube feeding to half of the prior rate (but no less than 10 mL/hr).													
c-Recheck a GRV in 4 hours. If the second GRV is greater than 500 mL, ask attending provider about prokinetics and advancing the tube to the Jejunum.													
d-When symptoms resolve, advance tube feeding back to goal rate per original order.													
e-If the patient develops symptoms of intolerance again,													
i. Consult RD for further recommendations.													
ii. Notify attending provider													
iii. Follow the protocol under B above until new recommendations/orders are available													
-If the GRV is greater than 500 mL:													
a-Refeed up to 250 m: of residuals. Discard remaining residuals and document in I&O's.													
b-Hold the tube feeding for 4 hours then recheck another GRV													
c-If the second GRV is less than 500 mL, resume TF at half of the prior rate (but no less than 10 ml/hr) and advance to goal rate as originally ordered. Do not check routine GRVs unless the patient shows signs of intolerance.													
d-If the second GRV is greater than 500 mL:													
i.Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&O s.													
ii.Continue to hold TF and await further recommendations.													
A.Ask about starting a prokinetic agent.													

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change
13570 (continued) B.Ask about placing a Jejunal tube.													
13570 GI: TF, Tube Feeding Management	^	D	Q4H*										OE
				- Create	10/13/21	1303	TCC	10/13/21	1303	TCC			

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
13570 GI: TF, Tube Feeding Management	^	D	Q4H*										OE
- Ed Directs					10/13/21	1343	HJM	10/13/21	1343	HJM		10/13 1234 Q4H*	=> 10/13 1600 Q4H*

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
13570 GI: TF, Tube Feeding Management	^	D	Q4H*										OE
- Document					10/13/21	1343	HJM	10/13/21	1344	HJM			

Feeding tube type: Small-bore nasogastric
Current rate (ml): 10 Feeding tube measurement (cm): 50
Placement verified: Y Method: X-ray

Irritation or erosion of skin around device? N
Mucosal breakdown or ulceration? N
If not within normal limits, document interventions in comments box
Securement device present: Yes
Securement device changed:
Site care:
Oral care completed: Yes
(Required with every asessment while NG present)
Brush or swab teeth, gums and tongue. Lubricate lips

TF Residual (ml): Residual wasted (ml):
TF Flush: ml
TF Free water bolus (ml):
Rate change: If yes, rate changed to (ml):
TF turned off: Reason:
Closed system: Container/tubing changed:
Open system: Bag rinsed: Bag changed:
Syringe/graduated container changed:

Bolus feeding: Amount (ml):
Administered by (if other than staff):

Feeding tube inserted: Size (fr): Location:
Feeding tube measurement: cm to hub
Patient tolerated procedure: Education provided:
Discontinued:

Comments: INSERTED TO 50CM, UNABLE TO BRIDLE X2 D/T PT
SHAKING HEAD AND O2 DROPPING LOW, SO TAPED IN
PLACE

- Ed Text					10/13/21	1344	HJM	10/13/21	1344	HJM			
- Document					10/13/21	1600	HJM	10/13/21	1613	HJM			

Feeding tube type: Small-bore nasogastric
Current rate (ml): 10 Feeding tube measurement (cm): 50
Placement verified: Y Method: X-ray

Irritation or erosion of skin around device? N
Mucosal breakdown or ulceration? N
If not within normal limits, document interventions in comments box
Securement device present: Yes
Securement device changed:
Site care:

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change
13570 GI: TF, Tube Feeding Management	^ (continued)												
Oral care completed: Yes (Required with every asessment while NG present) Brush or swab teeth, gums and tongue. Lubricate lips													
TF Residual (ml): Residual wasted (ml): TF Flush: 30 ml TF Free water bolus (ml): Rate change: If yes, rate changed to (ml): TF turned off: Reason: Closed system: Container/tubing changed: Open system: Bag rinsed: Bag changed: Syringe/graduated container changed:													
Bolus feeding: Amount (ml): Administered by (if other than staff):													
Feeding tube inserted: Size (fr): Location: Feeding tube measurement: cm to hub Patient tolerated procedure: Education provided: Discontinued:													
Comments:													
1805 ADL: Elevate HOB Specify:		D	PER ORDERS										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
1960 Height Day TF started		D	PER ORDERS										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
2559 Weight Day TF started & every other day		^ C	Q2D										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
- Ed Status					10/13/21	1345	HJM	10/13/21	1345	HJM			A => C
2520 Intake & Output Strict I&O		^ C	SHIFT END										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
- Ed Status					10/13/21	1345	HJM	10/13/21	1345	HJM			A => C
13145 GI: Bowel Program Contact LIP for Bowel Program if no BM x 3 days.		D	PRN										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
27390 Notify MD -Contact LIP for Bowel Program if no BM in 3 days. -If feeding tube displacement is suspected or has occured, stop the feeding and notify LIP -Notify MD for signs/symptoms of tube feeding intolerance and for residual checks per feeding tube management orders.		D	PRN										OE
- Create					10/13/21	1303	TCC	10/13/21	1303	TCC			
60700 Nursing Order If patients vomits, alert LIP: a - Stop the tube feeding b - Verify proper tube placement c - Hold the tube feeding for 6 hours d - Restart tube feedings at half the prior rate (but no less than 10 mL/hr) if the patient is not displaying signs of intolerance (nausea, abdominal pain, distension, firmness, etc). e - Check a gastric residual volume (GRV) in 4 hours after restarting the tube feeding. i. If the GRV is less than 500 mL advance the tube feeding back to goal rate per original order. ii. If the GRV is greater than 500 mL, follow the steps in section C under GRV		D	PER ORDERS										OE

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

60700 Nursing Order D PER ORDERS OE
- Create 10/13/21 1303 TCC 10/13/21 1303 TCC
1630 Glucose monitoring as ordered ^ D Q6H OE
Sliding Scale:
- Create 10/13/21 1310 TCC 10/13/21 1310 TCC
- Ed Directs 10/13/21 1344 HJM 10/13/21 1344 HJM 10/13 1309 Q6H => 10/13 1600 Q6H
- Document 10/13/21 1656 HJM 10/13/21 1656 HJM
Glucose: 151 Critical High: Critical Low: Finger stick: Y Lab draw:
Nurse notified:
Symptoms:

Actions:

Comments:
26510 SPS: Spiritual Services Follow-up Assess D .every patient contact AS
Discipline: SPS
- Create 10/13/21 2118 CR 10/13/21 2121 CR
- Document 10/13/21 2118 CR 10/13/21 2121 CR
Spiritual Services Follow-up Assessment
Patient/Resident Population: Medical
Reason for visit: Referral
If referral, list referral source: Nurse

Time spent on interventions is approximate and used for statistical purposes only.
Definitions can be viewed by using shift F8
Issue 1: Death
Spiritual Concerns: None noted :
:
Intervention: Care Conference/Prep Time Spent: 35 minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: Involvement in Care :
:

Definitions can be viewed by using shift F8
Issue 2:
Spiritual Concerns: :
:
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

26510 SPS: Spiritual Services Follow-up Assess (continued)
Issue 3:
Spiritual Concerns: :
:
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
:
Definitions can be viewed by using shift F8
Issue 4:
Spiritual Concerns: :
:
Intervention: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
: Time Spent: minutes
Evaluation/Outcomes: :
:

Press <Esc> to exit comment field.
Comments: GRACE 19, PASSED AWAY PRIOR TO THE CHAPLIN ARRIVING AT THE HOSPITAL. THE PATIENT'S SISTER WAS IN THE ROOM WITH THE PATIENT. THE PATIENT'S MOTHER ARRIVED SHORTLY AFTERWARD WITH ANOTHER INDIVIDUAL. CHAPLAIN REMAINED AVAILABLE. DID NOT GO INTO ROOM AS THE PATIENT WAS COVID POSTIVE.
35050 DC: Discharge Care Plan ^ D AT DISCHARGE AS
- Create 10/13/21 2344 JC 10/13/21 2345 JC
- Document 10/13/21 2344 JC 10/13/21 2345 JC
DISCHARGE CARE PLAN N

Discharge problem(s): COVID-19

Outcome(s): EXPIRED

Instructions:

Additional Information:

Have Pt-specific education/DC instructions been provided: N

Was a Patient Health Summary printed for the patient: Y
(Patient Health Summary to be given to patient to bring to next appointment)

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Patient Notes: CASE MGMT/SOCIAL SERVICES
- Create 10/07/21 0857 LC 10/07/21 0858 LC
Abnormal? N Confidential? N
Initial Status Review
Order: Inpatient Date: 10/7/2021 Time: 0057

Payer: UHC WMA

MCG: PG-RF Respiratory Failure GRG

MCG criteria met: New (acute) need for mechanical invasive or noninvasive (eg, bilevel positive airway pressure (BPAP), volume-assured pressure support (VAPS), or volume control) ventilation

Additional supporting information: Acute hypoxic respiratory failure secondary to viral COVID-19 pneumonia, on BiPAP, FiO2 70. IV dexamethasone. ID consult.

Note Type Description
No Type None

Patient Notes: CASE MGMT/SOCIAL SERVICES
- Create 10/07/21 1155 GMH 10/07/21 1156 GMH
Abnormal? N Confidential? N
Admission Status:
Inpatient: Date 10/7/21 Time 0057
Observation: Date Time
SDC: Date Time

Milliman Guideline: See UR note

Living Situation: With Spouse/Family
Other: with parents

Equipment:

Durable Power of Attorney:

Guardian: Yes
Voluntary Behavioral Health Admission: No
Involuntary 72 hour Mental Health Hold: No
Self Pay: No
Discharge Needs: Case management following

Contact Information:

Note Type Description
No Type None

Patient Notes: CASE MGMT/SOCIAL SERVICES
- Create 10/09/21 1442 SMB 10/09/21 1506 SMB
Abnormal? N Confidential? N
Case Management: rec'd from manager of case management, Tara Crawford, pt's Advanced Directives document that Rachel, Fremont 2 Mgr had rec'd from pt's Dad, Scott Schara. Writer placed Advanced Directives on pt chart w/note for Medical Records to scan into system. Noted on pt chart Statement of INCAP

Patient Notes: CASE MGMT/SOCIAL SERVICES (continued)
completed by 2 MD's 10/8/2021 activating pt's Advanced Directives, per same document, #1 HCPOA is Cindy Schara, #2 HCPOA is Scott Schara, #3 HCPOA is Jessica Vander Heiden, #4 HCPOA is Levi Rocke. Noted on Advanced Directives "My agent's authority is effective immediately upon my signing this document, as permitted in WI statutes section 155.05(2). No determination of Incapacity is required", document signed on 9/23/2020 & is considered valid document. Carrie, HUC had checked on 10/8/2021 for Guardianship document in Meditech, Athena & EPIC w/no such document located. Rachel, RN Mgr assisted in getting Advanced Directives document from pt's father on 10/8/2021 as document was not present in Meditech, Athena or EPIC. Rachel had also forwarded to Tara Crawford documents pt's Dad sent to her un-signed (w/email from Hooper Law Office of Appleton stating Dad should have signed version) of "Supported Decision-Making Agreement" listing parents Cindy & Scott Schara as "Supporters", this un-signed document is attached to case management record as reference Dad should have signed copy per Law office. Rachel had also rec'd from pt's Dad "Authorization for Release of Grace Schara's PHI" document that was placed on pt chart which was sent from Hooper Law Office to pt's Dad. Case Management will continue to follow & assist in dc plan as pt gets closer to dc date.

Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/07/21 0054 BC 10/07/21 0055 BC
Abnormal? N Confidential? N
Patient admitted with diagnosis of COVID
at time of 0050 to room 2029 from ED via BED
accompanied by ED STAFF/FATHER.
Report received from ED RN. Patient ID band on/applied.

Patient currently resides at HOME.
Transported to Facility by PERSONAL VEHICLE.

Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/07/21 0346 BC 10/07/21 0351 BC
Abnormal? N Confidential? N
PTS FATHER GOT UPSET WITH US COMING IN TO DO VITALS Q4HRS. WANTS PT TO HAVE MORE TIME TO SLEEP.

Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/08/21 0110 LK 10/08/21 0129 LK
Abnormal? N Confidential? N
DR. BECK NOTIFIED OF ABG RESULT, VITALS, AND CLINICAL STATUS. ORDER OBTAINED TO CHANGE TYLENOL FROM PO TO PR AND TO INCREASE IVF TO 100 CC/HR. ORDERS PLACED.

Note Type Description
No Type None

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES
- Create 10/08/21 1200 AM 10/08/21 1209 AM
Abnormal? N Confidential? N
PT FATHER BEDSIDE. FATHER ASKING RN HOSPITAL STATISTICS/NATION WIDE STATISTICS ON COVID MEDICATONS/OUTCOMES. RN REDIRECTED FATHER TO GEAR ALL MEDICATION QUESTIONS TO MD.

DURING MORNING CARES RN GAVE UPDATE TO FATHER ON PATIENT STATUS. FATHER NEEDED MUCH EDUCATION ON PATIENT STATUS. BIPAP SETTINGS INCREASED, PT NEEDING PRECEDEX TO HELP KEEP CALM. ORAL CARES HAVE BEEN DIFFICULT. PT FATHER WANTED TO "PROVE" THAT PATIENT WAS GETTING BETTER AND DID NOT NEED BIPAP. RN REMOVED BIPAP AND PLACED VAPOTHERM 40L 100% AND PATIENT QUICKLY DESATURATED TO 85%. BIPAP REPLACED. FATHER BECAME FIXATED ON PATIENT ABG THINKING THEY LOOKED BETTER. RN EDUCATED THAT THEY WERE NOT.

FATHER CURRENTLY LOOKING INTO TAKING PATIENT HOME ON A HOME BIPAP MACHINE.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/08/21 1220 AM 10/08/21 1221 AM
Abnormal? N Confidential? N
DR MARADA UPDATED ON PATIENT BRAYCARDIA
DR MARADA OK WITH RATES 49-50'S
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/08/21 1706 EB 10/08/21 1706 EB
Abnormal? N Confidential? N
WRITER PULLED ATROPINE FOR AMANDA M, RN.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/08/21 2355 EF 10/08/21 2357 EF
Abnormal? N Confidential? N
UPDATE GIVEN TO DR BECK REGARDING PATIENT STATUS AND ELEVATED BLOOD PRESSURE DUE TO AGITATION. DR BECK ALSO SIGNED POA PAPERWORK TO ACTIVATE POA. NO NEW ORDERS AT THIS TIME. WILL CONTINUE TO MONITOR BLOOD PRESSURE BEFORE ADDING ANTIHYPERTENSIVES DUE TO PREVIOUS LOW BLOOD PRESSURES.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/09/21 0600 MP 10/09/21 0601 MP
Abnormal? N Confidential? N
********** UNDONE **********
CALL WITH DR BECK TO GIVE UPDATE ON PATIENT STATUS. DISCUSSED VITALS AND TACHYPNEA UP TO 40S. DISCUSSED DRIPS AND RESTARTING LEVOPHED. SEE ORDERS FOR MORNING LABS AND ABG TO BE COLLECTED.

Undone: 10/09/21 at 0603 by PAFFENROTH,MELINDA RN
Reason: CHARTED UNDER WRONG NURSE ACCOUNT

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES (continued)
Note Type Description
No Type None

Patient Notes: NURSING NOTES (continued)
- Create 10/09/21 0604 EF 10/09/21 0605 EF
Abnormal? N Confidential? N
CALL WITH DR BECK TO UPDATE ON PATIENT STATUS. DISCUSSED VITALS AND BIPAP SETTINGS. NOTIFIED OF TACHYPNEA UP TO 40S. DISCUSSED BLOOD PRESSURE AND RESTARTING LEVOPHED AT LOW DOSE. REVIEWED POA PAPER WORK. SEE ORDERS FOR LABS AND ABG.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/09/21 1000 VW 10/09/21 1132 VW
Abnormal? N Confidential? N
dr leonard here and able to speak w father at length. orders noted
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/09/21 2337 EF 10/09/21 2346 EF
Abnormal? N Confidential? N
PARENT SCOTT IN ROOM WITH PATIENT SINCE ADMISSION. HE HAS REPEATEDLY YELLED AT NURSES ON ALL SHIFTS AND TONIGHT HAS ACCUSED NURSES OF LYING ABOUT SEVERITY OF PATIENT STATUS. WHEN ATTEMPTS WERE MADE TO EDUCATE ON MEDICATIONS AND PATIENT CARE HE STATED "I'M NOT GOING TO TAKE ANY OF YOUR GUFF. YOU'RE HERE TO FOLLOW MY COMMANDS". PARENT SHOWS ONGOING,BLATANT DISRESPECT OF NURSES SUBVERSION OF MEDICAL CARE.
WHEN ENTERING ROOM TO ASSESS ALARMS FROM SPO2 MONITOR, BLOOD PRESSURE CUFF, AND IV PUMP PARENT ACCUSES NURSES OF NOT KNOWING HOW TO DO NURSING CARE, RUN EQUIPMENT,AND OF EQUIPMENT BEING FAULTY. PARENT DEMANDED THAT MONITOR ALARMS AND IV ALARMS BE COMPLETELY TURNED OFF AND SPO2 DEVICE BE REMOVED FROM PATIENT. FURTHER
ATTEMPTED TO PROVIDE EDUCATION AND EXPLANATIONS ABOUT THE ALARMS AND FUNCTION OF EQUIPMENT IN ROOM. ALL ATTEMPTS TO PROVIDE EDUCATION TO PARENT REFUSED.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/10/21 0605 EF 10/10/21 0614 EF
Abnormal? N Confidential? N
PARENT SCOTT CONTINUES TO BE DIFFICULT WITH STAFF WITH QUESTIONING AND RUDE STATEMENTS ABOUT CARE. ALSO NOTED TO BE INTERFERING WITH PUMP ALARMS. FREQUENT COMPLAINTS ABOUT MONITOR AND IV PUMP ALARMS. I HAVE REPEATEDLY ATTEMPTED TO PROVIDE EDUCATION ON THE REASON FOR THE ALARMS AND THE INTERVENTIONS TAKEN TO CORRECT ALARMS BUT PARENT IS NOT ACCEPTING OF EDUCATION. PARENT REQUESTS THAT ALL ALARMS BE TURNED OFF INSIDE OF ROOM. EXPLAINED THAT THIS IS NOT POSSIBLE AND NOT SAFE DUE TO AMOUNT OF TIME NURSING STAFF SPENDS AT THE BEDSIDE IN THE ROOM WITH PATIENT. PARENT REQUESTS DR BECK AND UNIT SUPERVISOR COME TO SPEAK WITH HIM. MESSAGE SENT TO DR BECK AND RACHEL TO NOTIFY OF REQUEST AND UPDATE ON CONCERNS ABOUT PARENT INTERFERENCE IN CARE. AT THIS TIME NO NEW CONCERNS ABOUT PATIENT STATUS.

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES (continued)
Note Type Description
No Type None
Patient Notes: NURSING NOTES (continued)
- Create 10/10/21 0614 EF 10/10/21 0617 EF
Abnormal? N Confidential? N
PHONE CALL WITH DR BECK TO UPDATE ON CONCERNS WITH PARENT INTERENCE AND DISRESPECT AND POOR TREATMENT OF STAFF.
DR BECK STATES HE WILL TALK WITH PARENT TO HEAR CONCERNS.
EXPLAINED TO DR BECK PARENT CONCERNS ABOUT ALARMS BEEPING AND INTERVENTIONS TAKEN TO FIX THEM.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/10/21 0830 AB 10/10/21 1040 AB
Abnormal? N Confidential? N
PATIENT'S MOTHER AND FATHER UPDATED VIA PHONE (FOR MOTHER) AND IN PERSON (FOR FATHER) ABOUT VISITATION POLICY. PATIENT'S FATHER ESCORTED OUT OF BUILDING CALMLY BY SECURITY. PATIENT'S MOTHER CURRENTLY RECOVERING FROM COVID HERSELF AND PER HER STATEMENT DOES NOT FEEL WELL ENOUGH YET. ENCOURAGED PATIENT'S MOTHER (WHO IS PRIMARY POA) TO STAY HOME AND THAT SIGNS/SYMPTOMS EXPRESSED BY ANYONE COMING TO THE HOSPITAL WOULD NOT BE GRANTED ENTRANCE INTO THE BUILDING TO HELP PREVENT THE SPREAD OF COVID. VIRTUAL VISITION OFFERED, AND PLAN SET UP FOR FACETIME WITH PATIENT'S IPAD WITH FAMILY. ALL OF THE ABOVE RELAYED TO PRIMARY RN KATIE CARING FOR PATIENT.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/10/21 0830 KRH 10/10/21 1423 KRH
Abnormal? N Confidential? N
Dr. LEONARD here to see patient. Update given. NEW ORDERS RECEIVED.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/10/21 0845 KRH 10/10/21 1424 KRH
Abnormal? N Confidential? N
Dr. BAUM here to see patient. Update given. PATIENT'S ACTIVATED POA (HER MOTHER) CALLED PER DR BAUM WITH UPDATE.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/10/21 1419 KRH 10/10/21 1422 KRH
Abnormal? N Confidential? N
FOCUS WORD- FAMILY UPDATED VIA PHONE
D- ATTEMPTED TO CONTACT FAMILY MULTIPLE TIMES VIA FACETIME PER IPAD IN ROOM AND PATIENT'S CELLPHONE. MOM/DAD CALLED WRITER BACK ON WORK PHONE
A- UPDATE GIVEN, INCLUDING RECENT LABS, RECENT VITAL SIGNS, NUTRITION ATTEMPTS, MD NOTES, AND CURRENT PRONE STATUS
R- MULTIPLE QUESTIONS ASKED AND ANSWERED. FATHER SCOTT ASKED TO SPEAK WITH DR. BAUM. WRITER GAVE DR BAUM THE MESSAGE. DR BAUM HAS ALREADY UPDATED THE MOTHER EXTENSIVELY THIS AM. FATHER SCOTT ALSO REQUESTED TO HAVE HOME PHONE

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES (continued)
NUMBER OF 788-5578 REMOVED FROM CONTACT LIST. WRITER CALLED ADMISSIONS WITH THIS REQUEST. 20 + MINUTES SPENT UPDATING FAMILY. WRITER STRESSED TO PATIENT'S PARENTS THAT ASPIRATING IS A VERY REAL RISK AT THIS TIME AND COULD BE DETRIMENTAL FOR THE PATIENT, AND THEREFORE IT IS WRITER'S OPINION TO PROCEED CAUTIOUSLY WITH NUTRITIONAL INTAKE.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/10/21 1815 KRH 10/10/21 1835 KRH
Abnormal? N Confidential? N
DAD UPDATED VIA FACEBOOK IN ROOM WITH PATIENT. MOM THEN UPDATED VIA FACETIME IN ROOM WITH PATIENT. DURING THIS TIME, WRITER SWITCHING PATIENT IN BETWEEN BIPAP AND OXYMASK FOR ATTEMPT AT PO INTAKE. PT DRANK 1/2 OF ENSURE CLEAR. MULTIPLE BREAKS NEEDED FOR BIPAP D/T SATS <90%
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/11/21 1503 JB 10/11/21 1510 JB
Abnormal? N Confidential? N
WOUND CONSULT
PATIENT WAS ADMITTED WITH COVID, ON BI-PAP. CURRENTLY NO PRESSURE INJURY TO NOSE, CHEEK IS RED BUT BLANCHABLE. PATIENT HAS CHRONIC WOUND THAT OCCUR, SCARS PRESENT INNER THIGHS. FIRST OPEN WOUND IS IN THE LEFT GROIN FOLD, APPROXIMATELY 1CM X 1CM. SECOND IS IN THE RIGHT ABDOMINAL FOLD, APPROXIMATELY 1CM X 1CM. WOUND BASES ARE RED/YELLOW. CLOTRIMAZOLE CREAM AND CLINDAMYCIN CREAM ARE ORDERED TO BOTH AREAS. ALSO RECOMMEND INTERDRY AG TO HELP WITH EXCESS MOISTURE IN FOLDS. PLACE IN A SINGLE LAYER WITH 2-3" EXCESS FOR MOISTURE WICKING. CONTINUE TO REPOSITION EVERY 2 HOURS, FLOAT HEELS. PATIENT IS ON AN OFFLOADING WAFFLE MATTRESS. EMMA RN ALSO REPORTS PATIENT HAS SOME REDNESS UNDER THE LEFT BREAST. INTERDRY AG CAN BE PLACED THERE AS WELL IN A SINGLE LAYER WITH 2-3" EXCESS. REPLACE INTERDRY AG EVERY 5 DAYS AND IF SOILED.
PATIENT HAS A FOLEY
EMMA RN PRESENT FOR ASSESSMENT
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/11/21 1630 ES 10/15/21 1238 ES
Abnormal? N Confidential? N
WRITER TALKING WITH PT SISTER AT BEDSIDE, WRITER SAID PT WAS TOLERATING PRONING BETTER TODAY AND THAT ABGs LOOKED SLIGHTLY BETTER. WRITER ALSO TOLD PT SISTER THAT PT IS STILL VERY SICK AND THINGS COULD GET BETTER OR WORSE AT THIS POINT. COMFORT PROVIDED FOR FAMILY AND PT.
Note Type Description
No Type None
Patient Notes: NURSING NOTES
- Create 10/12/21 1014 HJM 10/12/21 1014 HJM
Abnormal? N Confidential? N
PT'S MOTHER UPDATED BY DR SHOKAR ON POC. QUESTIONS ANSWERED.
Note Type Description
No Type None

Intervention Description	Sts	Direction	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES
- Create 10/12/21 1356 HJM 10/12/21 1402 HJM
Abnormal? N Confidential? N
PT TURNED FROM PRONE POSITION TO SUPINE WITH HOB 45 DEGREES. FIO2 INCREASED FROM 95% TO 100%. O2 SAT 78-85% AND NOT RECOVERING. DR SHOKAR INFORMED. STAT ABG, RT TO ADJUST BIPAP SETTINGS IF POSSIBLE AND MD WILL COME ASSESS PT AND TALK WITH FAMILY.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/12/21 1440 HJM 10/12/21 1442 HJM
Abnormal? N Confidential? N
PT'S MOTHER TO CONFIR WITH PT'S FATHER AND GIVE DECISION ON CODE STATUS AS PT IS CURRENTLY DO NOT INUBATE, BUT A FULL CODE. CLARIFICATION NEEDED PER DR SHOKAR'S CONVERSATION WITH MOTHER.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/12/21 1700 HJM 10/12/21 1829 HJM
Abnormal? N Confidential? N
PARENTS UPDATED BY DR SHOKAR OF PT'S LOW O2 SATURATION T/O THIS AFTERNOON. PARENTS DO NOT WANT INTUBATION AS PREVIOUSLY INDICATED.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 0941 HJM 10/13/21 0942 HJM
Abnormal? N Confidential? N
DR SHOKAR PAGED FOR SCOTT, TO RETURN CALL.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1134 HJM 10/13/21 1137 HJM
Abnormal? N Confidential? N
SMALL BORE NG TUBE PLACED LEFT NARE WITH PT ON 15L OXIMASK FOR PROCEEDURE, PLACED WITH EASE AND BIPAP REPLACED. O2 DESAT TO 61%, SLOW RECOVERY. CXR CALLED TO CONFIRM PLACEMENT. PT'S SISTER PRESENT FOR COMFORT. PT TOLERATED WELL. RR REMAINS IN THE 40'S.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1358 HJM 10/13/21 1359 HJM
Abnormal? N Confidential? N
FEEDING TUBE CONFIRMED IN PLACE, TUBE FEEDING STARTED. ATEMPTED BRIDLE X2, 2 RN'S, UNSUCESSFUL D/T PT SHAKING HEAD. TAPED IN PLACE.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1750 HJM 10/13/21 1751 HJM
Abnormal? N Confidential? N
PT O2 SAT 54 WITH PRONING. REVERSED WITH NO RECOVERY IN O2 SAT. PT'S SISTER AT BEDSIDE WHO FACETIMED PT'S FATHER TO UPDATE ON SITUATION. FAMILY PROVIDING

Patient Notes: NURSING NOTES (continued)
COMFORT.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1755 HJM 10/13/21 1756 HJM
Abnormal? N Confidential? N
PT SISTER AT BEDSIDE AND FATHER ON FACETIME UPDATED ON O2 SAT DROP TO 40'S. 2 DIFFERENT O2 PROBES TESTED AND O2 SAT CONFIRMED. STAT ABG ORDERED BY MD. OFFERING PT COMFORT.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1805 HJM 10/13/21 1805 HJM
Abnormal? N Confidential? N
DR SHOKAR AT BEDSIDE SPEAKING TO FAMILY.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1927 JC 10/13/21 2323 JC
Abnormal? N Confidential? N
No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye. Dr. Watton notified and pronouncement of death order and permission to release the body to the funeral home received.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1927 SP 10/13/21 2330 SP
Abnormal? N Confidential? N
DEATH NOTE:

No apical pulse, respirations, or blood pressure. Breath sounds absent. No pupil reaction in either eye.
Dr. WATTON notified and pronouncement of death order and permission to release the body to the funeral home received.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 1927 JC 10/13/21 2331 JC
Abnormal? N Confidential? N
Pt went asystole, No Code order in the computer. Day nurse with me at the bedside, team lead in the unit as well. No Pulse or respiration observed. Sister was on the phone with the family. No CPR done due to No Code status, MD informed by the changes.
Note Type Description
No Type None

Patient Notes: NURSING NOTES
- Create 10/13/21 2320 JC 10/14/21 0116 JC
Abnormal? N Confidential? N
Pt picked up by the funeral home from room 2029. All of pt's belongings given to the pt's mom and sister.

Intervention Description	Sts	Direction	From

Activity Type	Occurred Date	Occurred Time	Recorded by	Recorded Date	Recorded Time	Documented by	Comment	Documented Units	Change

Patient Notes: NURSING NOTES (continued)

Note Type	Description
No Type	None

Monogram	Initials	Name	Nurse Type
	INTERFACE		None
AB	ASCHNELL	BARKHOLTZ,ALISON	RN
AM	AMIDD011	MIDDLETON, AMANDA	RN
BB	BBURGHAR	BURGHARDT,BRYNN	RN
BC	BCHRI039	CHRISTENSON,BRITTANY	RN
BV	BVOSTERS	VOSTERS-BUCKLIN,BRIT	CNA
CGR	CORISKA	RISKA,COURTNEY	RN
CR	CREYBURN	REYBURN,CALVIN	SPS
CT	CTURCO	TURCO,CASSANDRA	CNA
DB	DBECK034	BECK,DAVID	MD
DW	DWADE	WADE,DEREK	RN
EB	EBRAATZ	BRAATZ,EMILY	RN
EF	EMFISHER1	FISHER,EMILY	RN
ES	ESTAR006	STARK,EMMA	NE
FD	FDONOVAN	DONOVAN-BROZEWSKI,FA	CNA
GMH	GHINTZ	HINTZ,GINA M	SS
HJM	HMCINNIS	MCINNIS,HOLLEE	RN
JB	JBAUE024	BAUER,JEANEAN	RN
JC	JCAST126	#CASTRO,JORIZZA	RN
JLJ	JJOHANEK	JOHANEK,JOSEPH	RN
JME	JEVERS	EVERS,JILL	RN
KM	KMAKEEVE	MAKEEVER,KATHRYN	CNA
KRH	KHALE	HALE,KATHARINE	RN
KS	KSIEKERT	SIEKERT,KAYLEE	CNA
LC	LCHAN062	#CHANG,LA	RN3
LK	LKEMP025	KEMPS,LAUREN	RN
LR	LREYN026	REYNEBEAU RD CD,LAUR	RD
MM	MMACHURI	MACHURICK,MICHAELA	RN
MMG	MGEHRT	GEHRT,MAKENZIE	RN
MP	MPAFF001	PAFFENROTH,MELINDA	RN
NWK	NKRIZENE	KRIZENESKY,NANETTE	RN
RJR	RREIHL	REIHL,RON	SPS
RS	RSCHU014	SCHULTZ,RAQUEL	RN
SH	SHAIN002	HAINES,SAMUEL	RN
SMB	SBREU001	BREU,SANDI M	RN3
SP	SPAGELS	PAGELS,SARAH	RN
TCC	TCARLSON	CARLSON,TRINA C	CNA
VW	VWILLS	WILLS,VICKI	RN

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order Date: 10/06/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CT	ANGCHE	20211006-0078	10/06/21	1434	S			CMP	BARLA

Other Provider : **Sig Lvl Provider :**

TRANSPORTATION?	CT (CART)
CLINICAL HISTORY?	84Kg
CAMPUS?	ST. ELIZABETH HOSPITAL
REASON FOR EXAM?	covid, pos ddimer, ?PE
COMMENTS:	E12
CREATININE NEEDED	**YES**

Order's Audit Trail of Events

1 10/06/21 1434 MIATRIC Order ENTER in OE
2 10/06/21 1434 MIATRIC Ordering Doctor: BARLOW MD,LAUREN K
3 10/06/21 1434 interface order's status changed from TRANS to LOGGED by RAD
4 10/06/21 1606 interface order's status changed from LOGGED to IN PRO by RAD
5 10/06/21 1631 interface order's status changed from IN PRO to COMP by RAD

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211006-2147	10/06/21	1458	R	1		CMP	ESCAL

Other Provider : **Sig Lvl Provider :**

RX: E10021477 **Start:** 10/06/21 1458 PRN CMP
Stop:

Ibuprofen (Motrin equiv)
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1 10/06/21 1458 JLIETZAN Order ENTER in PHA
2 10/06/21 1458 JLIETZAN Ordering Doctor: ESCH DO,ALLY E
3 10/07/21 1508 AUTO-DC DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211006-2150	10/06/21	1500	R	1		CMP	ESCAL

Other Provider : **Sig Lvl Provider :**

RX: E10021478 **Start:** 10/06/21 1500 PRN CMP
Stop:

Albuterol HFA (Ventolin HFA)
Dose: 0 GM
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1 10/06/21 1500 JLIETZAN Order ENTER in PHA
2 10/06/21 1500 JLIETZAN Ordering Doctor: ESCH DO,ALLY E
3 10/07/21 1508 AUTO-DC DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0079467	20211006-0222	10/06/21		R	1		CMP	BARLA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/06/21 1606 JNEVINSK order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	00767780	20211006-0223	10/06/21		R	81		CMP	BARLA

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/06/21 1606 JNEVINSK order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211006-2490	10/06/21	1701	R	1		CMP	ESCAL

Other Provider : **Sig Lvl Provider :**

RX: E10021681 **Start:** 10/06/21 1701 PRN CMP
Stop:

Dexamethasone (Decadron equiv)
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1 10/06/21 1702 KRHINO Order ENTER in PHA
2 10/06/21 1702 KRHINO Ordering Doctor: ESCH DO,ALLY E
3 10/07/21 1709 AUTO-DC DISCONTINUE in PHA

Order Date: 10/07/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
ADM	INP	20211007-0003	10/07/21		R		POM	TRN	BECD

Other Provider : **Sig Lvl Provider :**

Inpatient Admission:
-Expected length of stay at least two midnights

-Extensive clinical treatment, care and med/surg services

-Inpatient Only Procedure
Admit to unit: covid
CMC only:
I anticipate this patient will require a hospital stay

not to exceed 96 hours:
(if anticipated hospital stay expected to exceed 96 hours,

consider transfer)
Anticipated discharge plan: Home
F9 To View Options
Anticipated length of stay in midnights:
2 MIDNIGHTS
(midnights must include time spent in the Emergency Room)

MEDICAL NECESSITY: I believe this patient should be admitted

as an inpatient because:
(Check ALL that apply)
Surgical procedure is on inpatient only list:
N
Intensive service required:
Specify:
Severe illnes:
Specify:
Complex treatment:
Specify:
Co-morbid condition:
Specify:

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Patient safety concern:
Specify:
Risk of mortality:
Specify:
Advanced age:
Specify:
Acute need for mechanical vent:

Specify:
Other:
Specify:
:
See H&P:

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0156	BCHRI039	order acknowledged
7	10/07/21 1109	SBANGART	order viewed
8	10/07/21 1154	GHINTZ	order viewed
9	10/08/21 0728	LBULSON	order viewed
10	10/08/21 0748	SBREU001	order viewed
11	10/15/21 1320	MIMCCORM	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CODE	CODE	20211007-0003	10/07/21	0057	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**
CODE STATUS: Full Code

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0156	BCHRI039	order acknowledged
7	10/07/21 2308	LKEMP025	order viewed from Order Management
8	10/08/21 1603	JFRIT207	order viewed from Order Management
9	10/10/21 0800	KHALE	order viewed from Order Management
10	10/13/21 1056	GSHOK003	Order DC in POM
11	10/13/21 1056	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
12	10/13/21 1056	GSHOK003	Order Source: POM
13	10/13/21 1056	GSHOK003	order's status changed to Comp.
14	10/13/21 1108	HMCINNIS	order acknowledged
15	01/19/22 1023	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CONS	C	20211007-0001	10/07/21	0057	R		POM	TRN	BECD

Other Provider : **Sig Lvl Provider :**
N\First 3 letters of last name and do F9 Lookup

PHYSICIAN TO CONSULT/REFERRAL: ZEIMET DO,ANTHONY P
Phone: 920-730-5495
Provider Group To Consult:

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

F9 Lookup
Name:
Phone:
F9 or Free Text
Provider Notified: N
Notify Provider: In AM
Date:
Time:
Reason For Consult: covid
:

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	DBECK034	This procedure has reflexed the following order(s)
7	10/07/21 0057	DBECK034	Notify Provider To Consult (NUR)
8	10/07/21 0156	BCHRI039	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DIET	NPO	20211007-0028	10/07/21	B			POM	CNC	BECD

Other Provider : **Sig Lvl Provider :**
After midnight: Y
With Meds: Y
(Y = NPO but able to take Meds with sips of water)

Ice Chips:
(Y = NPO but able to have Ice Chips)

Comments:

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0156	BCHRI039	order acknowledged
7	10/07/21 0809	0	order cancelled: OVERWRITTEN BY NEW DIET ORDER

Cancel comment: OVERWRITTEN BY NEW DIET ORDER

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	BR	20211007-0038	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PRN	PRN

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

7 10/07/21 0156 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	PRONE	20211007-0039	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: -Trial 1 hour of awake prone positioning
-If tolerated, encourage prone
positioning 12-16 hours per day
-If patient intubated, has a decline in
condition, or cannot prone
independently, contact LIP for patient
specific proning orders
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PRN	PRN

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/14/21 1228 RJANZEN order viewed from Order Management
9 01/19/22 1025 ABUSHMAN order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	CHAIR	20211007-0040	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
Provider order: -Up to chair for all meals
NURSING TEXT: -Up to chair for all meals
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PRN	PRN

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	ISO	20211007-0041	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
Isolation? CON (CONTACT)
Reason for Isolation:
NURSING TEXT: Type:Contact
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	SHIFT	EVERY SHIFT: 01, 08, 16 (NUR)

Order's Audit Trail of Events

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
1    10/07/21 0057 DBECK034   Order ENTER in POM
2    10/07/21 0057 DBECK034   Order from set: HS ADMIT COVID 19
3    10/07/21 0057 DBECK034   Ordering Doctor: BECK MD,DAVID
4    10/07/21 0057 DBECK034   Order Source: POM
5    10/07/21 0057 DBECK034   Signed by BECK MD,DAVID
6    10/07/21 0057 interface  order's status changed from TRANS to ACTIVE by NUR
7    10/07/21 0158 BCHRI039   order acknowledged
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	ISO	20211007-0042	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
Isolation? DRO (DROPLET)
Reason for Isolation:
NURSING TEXT: Type:Airborne
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	SHIFT	EVERY SHIFT: 01, 08, 16 (NUR)

Order's Audit Trail of Events

```
1    10/07/21 0057 DBECK034   Order ENTER in POM
2    10/07/21 0057 DBECK034   Order from set: HS ADMIT COVID 19
3    10/07/21 0057 DBECK034   Ordering Doctor: BECK MD,DAVID
4    10/07/21 0057 DBECK034   Order Source: POM
5    10/07/21 0057 DBECK034   Signed by BECK MD,DAVID
6    10/07/21 0057 interface  order's status changed from TRANS to ACTIVE by NUR
7    10/07/21 0158 BCHRI039   order acknowledged
8    10/08/21 0250 LKEMP025   Supplemental Text edited:
9    10/08/21 0250 LKEMP025   From:
10   10/08/21 0250 LKEMP025      Type:Droplet
11   10/08/21 0250 LKEMP025   To:
12   10/08/21 0250 LKEMP025      Type:Airborne
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	VS	20211007-0043	10/07/21	0057			POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	Q4H*	Q 4 HRS - 00-04-08-12-16-20

Order's Audit Trail of Events

```
1    10/07/21 0057 DBECK034   Order ENTER in POM
2    10/07/21 0057 DBECK034   Order from set: HS ADMIT COVID 19
3    10/07/21 0057 DBECK034   Ordering Doctor: BECK MD,DAVID
4    10/07/21 0057 DBECK034   Order Source: POM
5    10/07/21 0057 DBECK034   Signed by BECK MD,DAVID
6    10/07/21 0057 interface  order's status changed from TRANS to ACTIVE by NUR
7    10/07/21 0158 BCHRI039   order acknowledged
8    10/07/21 2224 interface  order's status changed from COMP to COMP by NUR
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	TEL	20211007-0044	10/07/21	0057			POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Change patches daily with bath.
RN to document at end of shift.

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

NUR DIRECTIONS: ----START----
DATE TIME DIRECTIONS
1 10/07/21 0052 SHIFT END END OF EVERY SHIFT: 06,14,22

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged
8 10/07/21 2224 interface order's status changed from COMP to COMP by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	OXPULSE	20211007-0045	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Oximetry:

Document on vital sign intervention
NUR DIRECTIONS: ----START----
DATE TIME DIRECTIONS
1 10/07/21 0052 CONT CONTINUOUSLY

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	OXPULSE	20211007-0046	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
Provider order: Maintain SaO2 above 92%
NURSING TEXT: Oximetry: Maintain SaO2 above 92%

Document on vital sign intervention
NUR DIRECTIONS: ----START----
DATE TIME DIRECTIONS
1 10/07/21 0052 PER ORDERS PER ORDERS

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	C&DB	20211007-0047	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	Q2HWA	EVERY 2 HOURS WHILE AWAKE

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
7	10/07/21 0158	BCHRI039	order acknowledged
8	10/12/21 1132	interface	order's status changed from HOLD to HOLD by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	IS	20211007-0048	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: Incentive Spirometry Date/Goal:

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	Q1HWA	EVERY HOUR WHILE AWAKE

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
7	10/07/21 0158	BCHRI039	order acknowledged
8	10/12/21 0900	interface	order's status changed from HOLD to HOLD by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	WEIGHT	20211007-0049	10/07/21	0057			POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	ON ADMISSION	COMPLETE ON ADM OR PER POLICY

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
7	10/07/21 0158	BCHRI039	order acknowledged
8	10/07/21 2224	interface	order's status changed from COMP to COMP by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	PRECAUTION	20211007-0050	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

Provider order: Follow protocol for Airborne Respiratory Precautions during and after any Aerosol Generating Procedure

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

NURSING TEXT: Follow protocol for Airborne Respiratory
Precautions during and after any Aerosol
Generating Procedure
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PER ORDERS	PER ORDERS

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
7	10/07/21 0158	BCHRI039	order acknowledged
8	01/19/22 1025	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	NMD	20211007-0051	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: Notify LIP:
-T > 38 or < 36
-HR > 120 or < 55
-SBP > 170 or < 100
-DBP > 120 or < 60
-MAP < 60
-RR > 25 or < 12
-O2 sat < 92
-UO < 240
-If oxygen requirements above 6 liters
per minute required to maintain goal
SpO2
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PRN	PRN

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
7	10/07/21 0158	BCHRI039	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	DCCOMM	20211007-0052	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: Specify: Patient education COVID+
Discharge Home. If patient positive AND
after patient informed of positive
diagnosis by provider.
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0052	PRN	PRN

Order's Audit Trail of Events

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	AP	20211007-0053	10/07/21	0057			POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**
Placement:
F9 To View Options
NURSING TEXT: When not ambulating

Remove and inspect skin surfaces twice
daily. Check tubing position & skin
irritation every 2hrs.
Type:
NUR DIRECTIONS: ----START----
DATE TIME DIRECTIONS
1 10/07/21 0052 Q2H EVERY 2 HOURS

Order's Audit Trail of Events
1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface order's status changed from TRANS to ACTIVE by NUR
7 10/07/21 0158 BCHRI039 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211008-0252	10/08/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/08/21 0001 interface cc'd doctors edited in LAB
9 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
10 10/08/21 0001 interface order's status changed from LOGGED to IN PRO by LAB
11 10/08/21 1302 interface order's status changed from IN PRO to COMP by LAB
12 10/08/21 1303 interface order's status changed from COMP to IN PRO by LAB
13 10/08/21 1320 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211010-0142	10/10/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/10/21 0000 interface cc'd doctors edited in LAB
9 10/10/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/10/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/10/21 0620 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211012-0169	10/12/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/12/21 0000 interface cc'd doctors edited in LAB
9 10/12/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/12/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/12/21 0454 interface order's status changed from IN PRO to COMP by LAB
12 10/12/21 0454 interface order's status changed from COMP to IN PRO by LAB
13 10/12/21 0657 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211008-0253	10/08/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/08/21 0001 interface cc'd doctors edited in LAB
9 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
10 10/08/21 0001 interface order's status changed from LOGGED to IN PRO by LAB
11 10/08/21 1327 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211010-0143	10/10/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/10/21 0000 interface cc'd doctors edited in LAB
9 10/10/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/10/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/10/21 0636 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211012-0170	10/12/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/12/21 0000 interface cc'd doctors edited in LAB
9 10/12/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/12/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/12/21 0511 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BTNP	20211007-0373	10/07/21	0057	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**
Order Comment: add

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 interface cc'd doctors edited in LAB
7 10/07/21 0057 interface order's status changed from TRANS to LOGGED by LAB
8 10/07/21 0102 interface order's status changed from LOGGED to IN PRO by LAB
9 10/07/21 0156 BCHRI039 order acknowledged
10 10/07/21 0709 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CK	20211008-0254	10/08/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/08/21 0001 interface cc'd doctors edited in LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

9 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
10 10/08/21 0001 interface order's status changed from LOGGED to IN PRO by LAB
11 10/08/21 1327 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CK	20211010-0144	10/10/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/10/21 0000 interface cc'd doctors edited in LAB
9 10/10/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/10/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/10/21 0636 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CK	20211012-0171	10/12/21	0600	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Order created as part of series
6 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 0156 BCHRI039 order acknowledged
8 10/12/21 0000 interface cc'd doctors edited in LAB
9 10/12/21 0000 interface order's status changed from TRANS to LOGGED by LAB
10 10/12/21 0000 interface order's status changed from LOGGED to IN PRO by LAB
11 10/12/21 0511 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211007-0376	10/07/21	0100	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021952 **Start:** 10/07/21 0100 SCH CMP
Route: IV **Stop:**
0.9% NaCl **Volume:** 1,000 ML
Premixed at 1,000 ML (1,000 ML)
Total Volume: 1,000 mls
Rate: 30 MLS/HR **Direction:** CONT
Infusion Site: IV
Bag Duration: 33 HR 20 MIN
Rx Duration: No Stop Date/Time
Special Instructions: Please add extension tubing to all continuous infusions so pump can sit in hallway

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0104 MLONDO EDIT in PHA
7 10/07/21 0104 MLONDO EDIT
8 10/07/21 0104 MLONDO Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
9 10/07/21 0104 MLONDO VERIFIED in PHA
10 10/07/21 0104 MLONDO VERIFIED
11 10/07/21 0104 MLONDO Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
12 10/07/21 0153 BCHRI039 order acknowledged
13 10/07/21 0808 KBAUM Order DC in POM
14 10/07/21 0808 KBAUM Ordering Doctor: BAUM MD,KARL E
15 10/07/21 0808 KBAUM Order Source: POM
16 10/07/21 0808 KBAUM Order's Rx has been discontinued.
17 10/07/21 0808 KBAUM Signed by BAUM MD,KARL E
18 10/07/21 0811 BBURGHAR order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0377	10/07/21	0100	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021950 **Start:** 10/07/21 0100 PRN CMP
Stop:

Guaifenesin Oral Liquid (Robitussin)
Dose: 5 ML
Route: PO **Direction:** PRNQ4H
PRN Reason: COUGH

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0104 MLONDO VERIFIED in PHA
7 10/07/21 0136 BCHRI039 order acknowledged
8 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0378	10/07/21	1600	R		POM	CNC	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021968 **Start:** 10/07/21 1600 SCH CNC
Stop:

Enoxaparin (Lovenox equiv)
Dose: 40 MG
Route: SUBCUT **Direction:** 1600

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0057 DBECK034 VIEWED LAB TEST RESULTS
7 10/07/21 0057 DBECK034 Test Group CR/INR/PLT
8 10/07/21 0057 DBECK034 LABORATORY
9 10/07/21 0057 DBECK034 Date Time Test Result Flag Normal Range
10 10/07/21 0057 DBECK034 10/06/21 1147 PLT 149 L 160-475 x1000

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
11  10/07/21 0057 DBECK034  10/06/21 1147 CREATININE      1.40  H                        0.60-1.30 mg/d
12  10/07/21 0057 DBECK034                Hydroxyurea also known as Hydroxycarbamide (Hydrea or
13  10/07/21 0057 DBECK034                Droxia) may cause significant errors in the measurement of
14  10/07/21 0057 DBECK034                creatinine and glucose with the i-STAT system.  Use an
15  10/07/21 0057 DBECK034                alternative method to test the glucose or creatinine when
16  10/07/21 0057 DBECK034                patients have been administered hydroxyurea and results are
17  10/07/21 0057 DBECK034                suspect.
18  10/07/21 0057 DBECK034  10/06/21 1147 GFR CALCULATED  51  L                          >60 mL/min
19  10/07/21 0057 DBECK034                Units: mL/min/1.73 sq.m
20  10/07/21 0057 DBECK034                Assume Caucasian.  For Af Amer, multiply GFRe by 1.21
21  10/07/21 0136 BCHRI039  order acknowledged
22  10/07/21 0156 MLONDO    RULES AT VERIFY in PHA
23  10/07/21 0156 MLONDO    RULES AT VERIFY
24  10/07/21 0156 MLONDO    ENOX40INJ:  Ensure baseline Hgb, Hct, & Plt have been checked in the past 3
25  10/07/21 0156 MLONDO                days.
26  10/07/21 0156 MLONDO    ENOX40INJ:  BMI=  41.5
27  10/07/21 0156 MLONDO    ENOX40INJ:  Renal dosing required for this drug.
28  10/07/21 0156 MLONDO    ENOX40INJ:  IBW =  36.7  ABW = 84 (228.0 %)  SCR = 1.40
29  10/07/21 0156 MLONDO    ENOX40INJ:  CRCL = 37.4 (IBW), 85.0 (ABW), 56.1 (BWadj40)
30  10/07/21 0156 MLONDO    VERIFIED in PHA
31  10/07/21 0156 MLONDO    VIEWED LAB TEST RESULTS in PHA
32  10/07/21 0156 MLONDO    VIEWED LAB TEST RESULTS
33  10/07/21 0156 MLONDO    Test Group CR/INR/PLT
34  10/07/21 0156 MLONDO                                      LABORATORY
35  10/07/21 0156 MLONDO    Date     Time Test            Result   Flag                  Normal Range
36  10/07/21 0156 MLONDO    10/06/21 1147 PLT             149  L                         160-475 x1000
37  10/07/21 0156 MLONDO    10/07/21 UNK  INR             PENDING RECEIPT                0.86-1.13
38  10/07/21 0156 MLONDO    10/06/21 1147 CREATININE      1.40  H                        0.60-1.30 mg/dL
39  10/07/21 0156 MLONDO                Hydroxyurea also known as Hydroxycarbamide (Hydrea or
40  10/07/21 0156 MLONDO                Droxia) may cause significant errors in the measurement of
41  10/07/21 0156 MLONDO                creatinine and glucose with the i-STAT system.  Use an
42  10/07/21 0156 MLONDO                alternative method to test the glucose or creatinine when
43  10/07/21 0156 MLONDO                patients have been administered hydroxyurea and results are
44  10/07/21 0156 MLONDO                suspect.
45  10/07/21 0156 MLONDO    10/06/21 1147 GFR CALCULATED  51  L                          >60 mL/min
46  10/07/21 0156 MLONDO                Units: mL/min/1.73 sq.m
47  10/07/21 0156 MLONDO                Assume Caucasian.  For Af Amer, multiply GFRe by 1.21
48  10/07/21 0302 DBECK034  Order DC in POM
49  10/07/21 0302 DBECK034  Ordering Doctor: BECK MD,DAVID
50  10/07/21 0302 DBECK034  Order Source: POM
51  10/07/21 0302 DBECK034  Order's Rx has been cancelled.
52  10/07/21 0302 DBECK034  Signed by BECK MD,DAVID
53  10/07/21 0302 interface Order cancelled by PHA
54  10/07/21 0314 BCHRI039  Cancelled order acknowledged

  Cancel comment: Cancelled by Pharmacy
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0379	10/07/21	0100	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021946 **Start:** 10/07/21 0100 PRN CMP
Stop:

Acetaminophen (Tylenol equiv)
Dose: 650 MG
Route: PO **Direction:** PRNQ6H
PRN Reason: TEMP >= 38.3 C (101 F)
Special Instructions: MAX ADULT ACETAMINOPHEN DOSE 4 GM/DAY
may change to liquid for intubated patients

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0058	MLONDO	VERIFIED in PHA
7	10/07/21 0153	BCHRI039	order acknowledged
8	10/08/21 0104	LKEMP025	DISCONTINUE in PHA
9	10/08/21 0104	LKEMP025	DISCONTINUE
10	10/08/21 0104	LKEMP025	Edit Dr: BECK MD,DAVID Edit Source: Telephone/Read Back
11	10/08/21 0105	LKEMP025	order acknowledged
12	10/08/21 0200	DBECK034	Signed by BECK MD,DAVID

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0380	10/07/21	0100	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021951 **Start:** 10/07/21 0100 PRN CMP
Stop:

Ondansetron (Zofran equiv)
Dose: 4 MG
Route: IV **Direction:** PRNQ6H
PRN Reason: NAUSEA/VOMITING
Special Instructions: If both PO and Injectable (IV or IM) are ordered and if the prescriber does not provide criteria or instructions, administer the PO medication UNLESS the following criteria are met for Injectable (IV or IM) administration: 1) Patient is unable to tolerate PO 2) Patient is NPO 3) PO medication does not relieve symptoms as indicated per order. Transition between PO and Injectable (IV or IM) medications must be no sooner than the interval of the last PO Injectable (IV or IM) medication administered.

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0104	MLONDO	VERIFIED in PHA
7	10/07/21 0153	BCHRI039	order acknowledged
8	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	M	20211007-0381	10/07/21	0100	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10021953 **Start:** 10/07/21 0100 PRN CMP
Stop:
Albuterol HFA (Ventolin HFA)
Dose: 0 GM
Route: INH **Direction:** PRNQ4H
PRN Reason: SHORTNESS OF BREATH
Dose Instructions: 2 PUFFS
Special Instructions: No common canisters

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM	
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19	
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID	
4	10/07/21 0057	DBECK034	Order Source: POM	
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID	
6	10/07/21 0104	MLONDO	EDIT in PHA	
7	10/07/21 0104	MLONDO	EDIT	
8	10/07/21 0104	MLONDO	Edit Dr: BECK MD,DAVID	Edit Source: Pharmacy change only
9	10/07/21 0104	MLONDO	FROM:	
10	10/07/21 0104	MLONDO	DISPENSE: 1	
11	10/07/21 0104	MLONDO	TO:	
12	10/07/21 0104	MLONDO	DISPENSE: 0	
13	10/07/21 0104	MLONDO	VERIFIED in PHA	
14	10/07/21 0104	MLONDO	VERIFIED	
15	10/07/21 0104	MLONDO	Edit Dr: BECK MD,DAVID	Edit Source: Pharmacy change only
16	10/07/21 0135	BCHRI039	order acknowledged	
17	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA	
18	10/14/21 1229	RJANZEN	order viewed from Order Management	
19	10/14/21 1238	RJANZEN	order viewed from Order Management	

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0382	10/07/21	0900	R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021948 **Start:** 10/07/21 0900 SCH CMP
Stop: 10/16/21 0901 **Total Doses:** 10
Dexamethasone (Decadron equiv)
Dose: 6 MG
Route: IV **Direction:** DAILY

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM	
2	10/07/21 0057	DBECK034	Order from set: HS ADMIT COVID 19	
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID	
4	10/07/21 0057	DBECK034	Order Source: POM	
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID	
6	10/07/21 0102	MLONDO	VERIFIED in PHA	
7	10/07/21 0153	BCHRI039	order acknowledged	
8	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA	

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	NMDC	20211007-0054	10/07/21				POM	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS
1	10/07/21	0053	PRN PRN

Order's Audit Trail of Events

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Order from set: NOTIFY PROVIDER TO CONSULT
3	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
4	10/07/21 0057	DBECK034	Order Source: POM
5	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
6	10/07/21 0057	DBECK034	This Procedure was triggered by :
7	10/07/21 0057	DBECK034	PHYSICIAN CONSULT ORDER (CONS)
8	10/07/21 0057	interface	order's status changed from TRANS to ACTIVE by NUR
9	10/07/21 0158	BCHRI039	order acknowledged
10	10/10/21 1637	KHALE	order viewed from Order Management

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211007-0374	10/07/21		R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0057	DBECK034	Order Source: POM
4	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
5	10/07/21 0058	interface	cc'd doctors edited in LAB
6	10/07/21 0058	interface	order's status changed from TRANS to LOGGED by LAB
7	10/07/21 0102	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/07/21 0156	BCHRI039	order acknowledged
9	10/07/21 0643	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211007-0375	10/07/21		R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0057	DBECK034	Order Source: POM
4	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
5	10/07/21 0058	interface	cc'd doctors edited in LAB
6	10/07/21 0058	interface	order's status changed from TRANS to LOGGED by LAB
7	10/07/21 0102	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/07/21 0156	BCHRI039	order acknowledged
9	10/07/21 0717	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PT	20211007-0376	10/07/21		R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0057	DBECK034	Order ENTER in POM
2	10/07/21 0057	DBECK034	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0057	DBECK034	Order Source: POM
4	10/07/21 0057	DBECK034	Signed by BECK MD,DAVID
5	10/07/21 0058	interface	cc'd doctors edited in LAB
6	10/07/21 0058	interface	order's status changed from TRANS to LOGGED by LAB
7	10/07/21 0102	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/07/21 0156	BCHRI039	order acknowledged
9	10/07/21 0713	interface	order's status changed from IN PRO to COMP by LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-0386	10/07/21	0115	R	1	WO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10021949 **Start:** 10/07/21 0115 SCH CMP
Stop:

Pharmacy To Rn Communication (Note (Covid Pui Or Positive))
Dose: 1 EACH
Route: PO **Direction:** AD

Order's Audit Trail of Events

1	10/07/21 0103	MLONDO	Order ENTER in PHA
2	10/07/21 0103	MLONDO	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0103	MLONDO	Order Source: Written/Fax/Electron
4	10/07/21 0157	BCHRI039	order acknowledged
5	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5098	20211006-0296	10/06/21		R	1		CMP	UNK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0115	DWOELFEL	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9068	20211006-0297	10/06/21		R	1		CMP	UNK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0115	DWOELFEL	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5014	20211006-0298	10/06/21		R	1		CMP	UNK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0115	DWOELFEL	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
REH	ADMASBRADN	20211007-0008	10/07/21	0127	R		NUR	TRN	BECD

Other Provider : **Sig Lvl Provider :**

ACTIVITY
Degree of physical activity: 3 - WALKS OCCASIONALLY
MOBILITY
Ability to change and control body position:
3 - SLIGHTLY LIMITED

Order's Audit Trail of Events

1	10/07/21 0127	BCHRI039	Order ENTER in OM
2	10/07/21 0127	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0127	BCHRI039	Order Source: Nursing Routine Ord
4	10/07/21 0158	BCHRI039	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

MEDS F 20211007-0421 10/07/21 0900 R POM CMP BECD
Other Provider : **Sig Lvl Provider :**
RX: E10021988 **Start:** 10/07/21 0900 SCH CMP
Stop:

Heparin (USE FOR DVT PROPH)
Dose: 5,000 UNITS
Route: SUBCUT **Direction:** Q12H

Order's Audit Trail of Events

1	10/07/21 0303	DBECK034	Order ENTER in POM
2	10/07/21 0303	DBECK034	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0303	DBECK034	Order Source: POM
4	10/07/21 0303	DBECK034	Signed by BECK MD,DAVID
5	10/07/21 0303	DBECK034	VIEWED LAB TEST RESULTS
6	10/07/21 0303	DBECK034	Test Group COAG
7	10/07/21 0303	DBECK034	LABORATORY
8	10/07/21 0303	DBECK034	Date Time Test Result Flag Normal Range
9	10/07/21 0303	DBECK034	10/06/21 1147 PLT 149 L 160-475 x1000
10	10/07/21 0303	DBECK034	10/07/21 UNK PROTIME PENDING RECEIPT 9.4-12.5 SECON
11	10/07/21 0303	DBECK034	10/07/21 UNK INR PENDING RECEIPT 0.86-1.13
12	10/07/21 0306	MLONDO	RULES AT VERIFY in PHA
13	10/07/21 0306	MLONDO	RULES AT VERIFY
14	10/07/21 0306	MLONDO	HEP5000SDV: Ensure baseline Hgb, Hct, & Plt have been checked in the past 3
15	10/07/21 0306	MLONDO	days.
16	10/07/21 0306	MLONDO	VERIFIED in PHA
17	10/07/21 0306	MLONDO	VIEWED LAB TEST RESULTS in PHA
18	10/07/21 0306	MLONDO	VIEWED LAB TEST RESULTS
19	10/07/21 0306	MLONDO	Test Group COAG
20	10/07/21 0306	MLONDO	LABORATORY
21	10/07/21 0306	MLONDO	Date Time Test Result Flag Normal Range
22	10/07/21 0306	MLONDO	10/06/21 1147 PLT 149 L 160-475 x1000
23	10/07/21 0306	MLONDO	10/07/21 UNK PROTIME PENDING RECEIPT 9.4-12.5 SECONDS
24	10/07/21 0306	MLONDO	10/07/21 UNK INR PENDING RECEIPT 0.86-1.13
25	10/07/21 0315	BCHRI039	order acknowledged
26	10/08/21 1838	RMARADA	Order DC in POM
27	10/08/21 1838	RMARADA	Ordering Doctor: MARADA MD,RAMANA R
28	10/08/21 1838	RMARADA	Order Source: POM
29	10/08/21 1838	RMARADA	Order's Rx has been discontinued.
30	10/08/21 1838	RMARADA	Signed by MARADA MD,RAMANA R
31	10/08/21 1838	AMIDD011	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	FALLPREC	20211007-0078	10/07/21	0304			NUR	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: *Offer toileting to patient regularly.
*Do not leave unattended in restroom, shower or tub.
*Communicate to transport staff if patient is a Fall Risk.
*Inform and educate patients and/or family members regarding a plan of care to prevent falls and document on Education Record.
*Place clear text fall risk sign outside of patient room, & patient in yellow gown to alert all staff that patient is a fall risk.

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0304	CONT	CONTINUOUSLY

Order's Audit Trail of Events

1	10/07/21 0304	BCHRI039	Order ENTER in OM
2	10/07/21 0304	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0304	BCHRI039	Order Source: Nursing Routine Ord
4	10/07/21 0304	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/07/21 0315	BCHRI039	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	FALLPRI	20211007-0079	10/07/21	0304			NUR	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: R/t: HOSPITALIZATION

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0304	CONT	CONTINUOUSLY

Order's Audit Trail of Events

1	10/07/21 0304	BCHRI039	Order ENTER in OM
2	10/07/21 0304	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0304	BCHRI039	Order Source: Nursing Routine Ord
4	10/07/21 0304	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/07/21 0315	BCHRI039	order acknowledged
6	10/09/21 0957	VWILLS	Supplemental Text edited:
7	10/09/21 0957	VWILLS	From:
8	10/09/21 0957	VWILLS	R/t:
9	10/09/21 0957	VWILLS	To:
10	10/09/21 0957	VWILLS	R/t: HOSPITALIZATION

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
REH	ADMASFALL	20211007-0012	10/07/21	0304	R		NUR	TRN	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/07/21 0304	BCHRI039	Order ENTER in OM
2	10/07/21 0304	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0304	BCHRI039	Order Source: Nursing Routine Ord
4	10/07/21 0315	BCHRI039	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	FALLPRI	20211007-0083	10/07/21	0313			NUR	CMP	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: R/t: HOSPITALIZATION

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0313	CONT	CONTINUOUSLY

Order's Audit Trail of Events

1	10/07/21 0314	BCHRI039	Order ENTER in OM
2	10/07/21 0314	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0314	BCHRI039	Order Source: Nursing Routine Ord
4	10/07/21 0314	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/07/21 0315	BCHRI039	order acknowledged
6	10/09/21 0957	VWILLS	Supplemental Text edited:

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

7 10/09/21 0957 VWILLS From:
8 10/09/21 0957 VWILLS R/t:
9 10/09/21 0957 VWILLS To:
10 10/09/21 0957 VWILLS R/t: HOSPITALIZATION
11 10/10/21 1831 interface order's status changed from COMP to COMP by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PROCAL	20211007-0424	10/07/21		R		POM	CMP	BECD

Other Provider : **Sig Lvl Provider :**
Order Comment: add

Order's Audit Trail of Events
1 10/07/21 0329 DBECK034 Order ENTER in POM
2 10/07/21 0329 DBECK034 Ordering Doctor: BECK MD,DAVID
3 10/07/21 0329 DBECK034 Order Source: POM
4 10/07/21 0329 DBECK034 Signed by BECK MD,DAVID
5 10/07/21 0329 interface cc'd doctors edited in LAB
6 10/07/21 0329 interface order's status changed from TRANS to LOGGED by LAB
7 10/07/21 0333 interface order's status changed from LOGGED to IN PRO by LAB
8 10/07/21 0351 BCHRI039 order acknowledged
9 10/07/21 0823 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	VS	20211007-0090	10/07/21				VO	IPR	BECD

Other Provider : **Sig Lvl Provider :**
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	0423	SHIFT	EVERY SHIFT: 01, 08, 16 (NUR)
2	10/08/21	0000	Q1H	EVERY HOUR
3	10/10/21	0800	Q2H	EVERY 2 HOURS

Order's Audit Trail of Events
1 10/07/21 0425 MMACHURI Order ENTER in OM
2 10/07/21 0425 MMACHURI Ordering Doctor: BECK MD,DAVID
3 10/07/21 0425 MMACHURI Order Source: Verbal Ord/Read Back
4 10/07/21 0426 interface order's status changed from TRANS to ACTIVE by NUR
5 10/07/21 0426 MMACHURI order acknowledged
6 10/07/21 0434 DBECK034 Signed by BECK MD,DAVID
7 10/10/21 0940 KHALE Supplemental Text edited:
8 10/10/21 0940 KHALE From:
9 10/10/21 0940 KHALE MD ORDERS FOR Q8H VITALS. PATIENT'S
10 10/10/21 0940 KHALE FATHER WOULD LIKE TO LIMIT NIGHTTIME
11 10/10/21 0940 KHALE INTERACTIONS TO ALLOW FOR SLEEP.
12 10/10/21 0940 KHALE To:

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	POM	20211007-0526	10/07/21	0900	R	1	VO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
RX: E10022981 **Start:** 10/07/21 0900 SCH CMP
Stop:
Clindamycin 1% Top Soln (Cleocin-T 1% Topical soln)
Dose: 0 ML
Route: TOP **Direction:** BID
Dose Instructions: 1 application
Special Instructions: APPLY TO GROIN

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/07/21 0618	BCHRI039	Order ENTER in OM
2	10/07/21 0618	BCHRI039	Ordering Doctor: BECK MD,DAVID
3	10/07/21 0618	BCHRI039	Order Source: Verbal Ord/Read Back
4	10/07/21 0628	interface	Order copied from: 1007-0504
5	10/07/21 0628	MLONDO	Order EDIT in PHA
6	10/07/21 0628	MLONDO	Ordering Doctor: BECK MD,DAVID
7	10/07/21 0628	MLONDO	Order Source: Pharmacy change only
8	10/07/21 0628	MLONDO	EDIT in PHA
9	10/07/21 0628	MLONDO	EDIT
10	10/07/21 0628	MLONDO	Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
11	10/07/21 0628	MLONDO	FROM:
12	10/07/21 0628	MLONDO	ORDER TYPE: M - BULK MED
13	10/07/21 0628	MLONDO	DISPENSE: 1
14	10/07/21 0628	MLONDO	CHARGE TYPE: BULK - BULK/MULTIDOSE
15	10/07/21 0628	MLONDO	CHARGE: $108.07
16	10/07/21 0628	MLONDO	LABEL COMMENTS:
17	10/07/21 0628	MLONDO	Disposal - black container w/green dot
18	10/07/21 0628	MLONDO	PENDING COMMENTS:
19	10/07/21 0628	MLONDO	TO:
20	10/07/21 0628	MLONDO	ORDER TYPE: POM - PATIENT'S OWN NF MED
21	10/07/21 0628	MLONDO	DISPENSE: 0
22	10/07/21 0628	MLONDO	CHARGE TYPE: NOCALC - NO CHARGE
23	10/07/21 0628	MLONDO	CHARGE: $0.00
24	10/07/21 0628	MLONDO	CHARGE ON ADMIN: N
25	10/07/21 0628	MLONDO	LABEL COMMENTS:
26	10/07/21 0628	MLONDO	*** PATIENT'S OWN MED ***
27	10/07/21 0628	MLONDO	PHARMACY TO VERIFY PRIOR TO ADMINISTRATION
28	10/07/21 0628	MLONDO	NURSING TO CALL RX IF DOSE NOT AVAILABLE
29	10/07/21 0628	MLONDO	PENDING COMMENTS:
30	10/07/21 0628	MLONDO	PLEASE VERIFY WITH 2 RNS AND NOTIFY
31	10/07/21 0628	MLONDO	PHARMACY
32	10/07/21 0628	MLONDO	PENDING FLAG SET in PHA
33	10/07/21 0656	DWADE	order acknowledged
34	10/07/21 1422	HRIHA	EDIT in PHA
35	10/07/21 1422	HRIHA	EDIT
36	10/07/21 1422	HRIHA	Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
37	10/07/21 1422	HRIHA	FROM:
38	10/07/21 1422	HRIHA	LABEL COMMENTS:
39	10/07/21 1422	HRIHA	*** PATIENT'S OWN MED ***
40	10/07/21 1422	HRIHA	PHARMACY TO VERIFY PRIOR TO ADMINISTRATION
41	10/07/21 1422	HRIHA	NURSING TO CALL RX IF DOSE NOT AVAILABLE
42	10/07/21 1422	HRIHA	PENDING COMMENTS:
43	10/07/21 1422	HRIHA	PLEASE VERIFY WITH 2 RNS AND NOTIFY
44	10/07/21 1422	HRIHA	PHARMACY
45	10/07/21 1422	HRIHA	TO:
46	10/07/21 1422	HRIHA	LABEL COMMENTS:
47	10/07/21 1422	HRIHA	*** PATIENT'S OWN MED ***
48	10/07/21 1422	HRIHA	VERIFIED BY 2 RNS
49	10/07/21 1422	HRIHA	PENDING COMMENTS:
50	10/07/21 1422	HRIHA	OK
51	10/07/21 1422	HRIHA	PENDING FLAG REMOVED in PHA
52	10/07/21 1422	HRIHA	VERIFIED in PHA
53	10/07/21 1422	HRIHA	VERIFIED
54	10/07/21 1422	HRIHA	Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
55	10/07/21 1433	BBURGHAR	order acknowledged
56	10/07/21 1837	DBECK034	Signed by BECK MD,DAVID
57	10/10/21 1142	AGLOD001	EDIT in PHA
58	10/10/21 1142	AGLOD001	EDIT

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

59 10/10/21 1142 AGLOD001 Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
60 10/10/21 1142 AGLOD001 FROM:
61 10/10/21 1142 AGLOD001 SPECIAL INSTRUCTIONS:
62 10/10/21 1142 AGLOD001 TO:
63 10/10/21 1142 AGLOD001 SPECIAL INSTRUCTIONS:
64 10/10/21 1142 AGLOD001 APPLY TO GROIN
65 10/10/21 1322 KHALE order acknowledged
66 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	POM	20211007-0527	10/07/21	1400	R	1	VO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10022982 **Start:** 10/07/21 1400 SCH CMP
Stop:

Clotrimazole 1% Cream
Dose: 0 GM
Route: TOP **Direction:** TID
Dose Instructions: 1 application
Special Instructions: APPLY TO GROIN

Order's Audit Trail of Events

1 10/07/21 0618 BCHRI039 Order ENTER in OM
2 10/07/21 0618 BCHRI039 Ordering Doctor: BECK MD,DAVID
3 10/07/21 0618 BCHRI039 Order Source: Verbal Ord/Read Back
4 10/07/21 0629 interface Order copied from: 1007-0505
5 10/07/21 0629 MLONDO Order EDIT in PHA
6 10/07/21 0629 MLONDO Ordering Doctor: BECK MD,DAVID
7 10/07/21 0629 MLONDO Order Source: Pharmacy change only
8 10/07/21 0629 MLONDO EDIT in PHA
9 10/07/21 0629 MLONDO EDIT
10 10/07/21 0629 MLONDO Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
11 10/07/21 0629 MLONDO FROM:
12 10/07/21 0629 MLONDO ORDER TYPE: M - BULK MED
13 10/07/21 0629 MLONDO DISPENSE: 1
14 10/07/21 0629 MLONDO CHARGE TYPE: BULK - BULK/MULTIDOSE
15 10/07/21 0629 MLONDO CHARGE: $42.88
16 10/07/21 0629 MLONDO LABEL COMMENTS:
17 10/07/21 0629 MLONDO PENDING COMMENTS:
18 10/07/21 0629 MLONDO TO:
19 10/07/21 0629 MLONDO ORDER TYPE: POM - PATIENT'S OWN NF MED
20 10/07/21 0629 MLONDO DISPENSE: 0
21 10/07/21 0629 MLONDO CHARGE TYPE: NOCALC - NO CHARGE
22 10/07/21 0629 MLONDO CHARGE: $0.00
23 10/07/21 0629 MLONDO CHARGE ON ADMIN: N
24 10/07/21 0629 MLONDO LABEL COMMENTS:
25 10/07/21 0629 MLONDO *** PATIENT'S OWN MED ***
26 10/07/21 0629 MLONDO PHARMACY TO VERIFY PRIOR TO ADMINISTRATION
27 10/07/21 0629 MLONDO NURSING TO CALL RX IF DOSE NOT AVAILABLE
28 10/07/21 0629 MLONDO PENDING COMMENTS:
29 10/07/21 0629 MLONDO PLEASE VERIFY WITH 2 RNS AND LET
30 10/07/21 0629 MLONDO PHARMACY KNOW WHEN COMPLETE
31 10/07/21 0629 MLONDO PENDING FLAG SET in PHA
32 10/07/21 0656 DWADE order acknowledged
33 10/07/21 1422 HRIHA EDIT in PHA
34 10/07/21 1422 HRIHA EDIT
35 10/07/21 1422 HRIHA Edit Dr: BECK MD,DAVID Edit Source: Pharmacy change only
36 10/07/21 1422 HRIHA FROM:
37 10/07/21 1422 HRIHA START: 10/07/21-0900 STOP: None SOFT STOP:

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

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38   10/07/21 1422 HRIHA        LABEL COMMENTS:
39   10/07/21 1422 HRIHA          *** PATIENT'S OWN MED ***
40   10/07/21 1422 HRIHA          PHARMACY TO VERIFY PRIOR TO ADMINISTRATION
41   10/07/21 1422 HRIHA          NURSING TO CALL RX IF DOSE NOT AVAILABLE
42   10/07/21 1422 HRIHA        PENDING COMMENTS:
43   10/07/21 1422 HRIHA          PLEASE VERIFY WITH 2 RNS AND LET
44   10/07/21 1422 HRIHA          PHARMACY KNOW WHEN COMPLETE
45   10/07/21 1422 HRIHA      TO:
46   10/07/21 1422 HRIHA        START: 10/07/21-1400   STOP: None   SOFT STOP:
47   10/07/21 1422 HRIHA        LABEL COMMENTS:
48   10/07/21 1422 HRIHA          *** PATIENT'S OWN MED ***
49   10/07/21 1422 HRIHA          VERIFIED BY 2 RNS
50   10/07/21 1422 HRIHA        PENDING COMMENTS:
51   10/07/21 1422 HRIHA          OK
52   10/07/21 1422 HRIHA      PENDING FLAG REMOVED in PHA
53   10/07/21 1422 HRIHA      VERIFIED in PHA
54   10/07/21 1422 HRIHA      VERIFIED
55   10/07/21 1422 HRIHA      Edit Dr: BECK MD,DAVID                Edit Source: Pharmacy change only
56   10/07/21 1433 BBURGHAR   order acknowledged
57   10/07/21 1837 DBECK034   Signed by BECK MD,DAVID
58   10/10/21 1142 AGLOD001   EDIT in PHA
59   10/10/21 1142 AGLOD001   EDIT
60   10/10/21 1142 AGLOD001   Edit Dr: BECK MD,DAVID                Edit Source: Pharmacy change only
61   10/10/21 1142 AGLOD001   FROM:
62   10/10/21 1142 AGLOD001     SPECIAL INSTRUCTIONS:
63   10/10/21 1142 AGLOD001   TO:
64   10/10/21 1142 AGLOD001     SPECIAL INSTRUCTIONS:
65   10/10/21 1142 AGLOD001       APPLY TO GROIN
66   10/10/21 1322 KHALE      order acknowledged
67   10/14/21 0128 DISCHARGE  DISCONTINUE in PHA
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211008-0303	10/08/21		R		POM	CNC	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

```
1    10/07/21 0700 KBAUM      Order ENTER in POM
2    10/07/21 0700 KBAUM      Ordering Doctor: BAUM MD,KARL E
3    10/07/21 0700 KBAUM      Order Source: POM
4    10/07/21 0700 KBAUM      Signed by BAUM MD,KARL E
5    10/07/21 0717 BCHRI039   order acknowledged
6    10/08/21 0001 interface  cc'd doctors edited in LAB
7    10/08/21 0001 interface  order's status changed from TRANS to LOGGED by LAB
8    10/08/21 0005 interface  order's status changed from LOGGED to IN PRO by LAB
9    10/08/21 0322 interface  order's status changed from IN PRO to CANCEL by LAB
```

Cancel comment: DUPLICATE ORDER.

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBC	20211008-0304	10/08/21		R		POM	CNC	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

```
1    10/07/21 0700 KBAUM      Order ENTER in POM
2    10/07/21 0700 KBAUM      Ordering Doctor: BAUM MD,KARL E
3    10/07/21 0700 KBAUM      Order Source: POM
4    10/07/21 0700 KBAUM      Signed by BAUM MD,KARL E
5    10/07/21 0717 BCHRI039   order acknowledged
```

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

6 10/08/21 0001 interface cc'd doctors edited in LAB
7 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/08/21 0005 interface order's status changed from LOGGED to IN PRO by LAB
9 10/08/21 0321 interface order's status changed from IN PRO to CANCEL by LAB

Cancel comment: IN CBC

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	DDIM	20211008-0305	10/08/21		R		POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0700 KBAUM Order ENTER in POM
2 10/07/21 0700 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/07/21 0700 KBAUM Order Source: POM
4 10/07/21 0700 KBAUM Signed by BAUM MD,KARL E
5 10/07/21 0717 BCHRI039 order acknowledged
6 10/08/21 0001 interface cc'd doctors edited in LAB
7 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/08/21 0005 interface order's status changed from LOGGED to IN PRO by LAB
9 10/08/21 1352 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CRP	20211008-0306	10/08/21		R		POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/07/21 0700 KBAUM Order ENTER in POM
2 10/07/21 0700 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/07/21 0700 KBAUM Order Source: POM
4 10/07/21 0700 KBAUM Signed by BAUM MD,KARL E
5 10/07/21 0717 BCHRI039 order acknowledged
6 10/08/21 0001 interface cc'd doctors edited in LAB
7 10/08/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/08/21 0005 interface order's status changed from LOGGED to IN PRO by LAB
9 10/08/21 1343 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DIET	GEN	20211007-0042	10/07/21	B			POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**
Caffeine: Y
Fluid restriction:
F9 Lookup
Neutropenic:
High protein/high calorie:

Order's Audit Trail of Events

1 10/07/21 0809 KBAUM Order ENTER in POM
2 10/07/21 0809 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/07/21 0809 KBAUM Order Source: POM
4 10/07/21 0809 KBAUM Signed by BAUM MD,KARL E
5 10/07/21 0811 BBURGHAR order acknowledged
6 10/09/21 0957 System order's status changed from TRANS to COMP
7 10/09/21 0957 System Order Replaced with New Diet
8 10/11/21 0929 LREYN026 order viewed

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DISCHARGE	DISCHARGE	20211007-0028	10/07/21		R		VO	TRN	BAUK

Other Provider : **Sig Lvl Provider :**

Diet/Consistancy/Fluid Restrictions: GENERAL DIET
Discharge Weight (LB)
Activity: Activity as tolerated
F9 To View Options
Additional Activity & Weight Bearing Status:
Lifting restriction:
May return to work:
May return to school:
Notify your physician for elevated temp of: 100.4
Follow-up APPOINTMENT: DR. MARY NORDSTROM 730-4950
OCT 19,2021 AT 9:30 AM
Diagnosis:
Diagnosis:
Diagnosis:
Visiting Nurse referral:
If yes, select the following that are applicable:

Skilled RN:
PT:
OT:
ST:
Telemonitoring:
Lab draw:
Hospice:
Anticoagulation Clinic:
Diagnosis:
Physician to monitor INR's:
INR Range:
INR Date:
Duration of therapy:
Diagnosis:
Diagnosis:
Diagnosis:
Additional Orders if Applicable:

Code Status for SNF: No CPR:
CPR:
Treatment Goals: Short Term:
Long Term:
Rehab Potential: Good:
Fair:
Poor:
Rehab Therapy:
Evaluate and treat as indicated: PT/OT

Speech Therapy:
Oxygen per NC/Trach Mask LPM:
PRN:
Continuous:
Keep sat % >
Additional comments for Oxygen:
Foley catheter care per facility policy:

Foley catheter inserted:

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Central Line care per facility protocol:

Dressing change due:
Additional Discharge Instructions:

Order's Audit Trail of Events

1	10/07/21 0839	ALOETHER	Order ENTER in OM
2	10/07/21 0839	ALOETHER	Ordering Doctor: BAUM MD,KARL E
3	10/07/21 0839	ALOETHER	Order Source: Verbal Ord/Read Back
4	10/07/21 0844	BBURGHAR	order acknowledged
5	10/07/21 0919	CACKER	Order EDIT in OM
6	10/07/21 0919	CACKER	Ordering Doctor: BAUM MD,KARL E
7	10/07/21 0919	CACKER	Order Source: Written/Fax/Electron
8	10/07/21 0919	CACKER	Query: Follow-up APPOINTMENT:
9	10/07/21 0919	CACKER	old response set: DR. MARY NORDSTROM IN 1 WEEK 730-4950
10	10/07/21 0919	CACKER	new response set: DR. MARY NORDSTROM 730-4950
11	10/07/21 0919	CACKER	OCT 19,2021 AT 9:30 AM
12	10/07/21 0946	BBURGHAR	order acknowledged
13	10/10/21 1600	KBAUM	Signed by BAUM MD,KARL E
14	10/11/21 0809	EWEGAND	order viewed from Order Management
15	10/12/21 0845	EWEGAND	order viewed from Order Management
16	10/15/21 1320	MIMCCORM	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RAD	CHEP	20211008-0016	10/08/21		R		POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**

REASON FOR EXAM? COVID POSITIVE, HYPOXIA
COMMENTS:

Order's Audit Trail of Events

1	10/07/21 1706	KBAUM	Order ENTER in POM
2	10/07/21 1706	KBAUM	Ordering Doctor: BAUM MD,KARL E
3	10/07/21 1706	KBAUM	Order Source: POM
4	10/07/21 1706	KBAUM	Signed by BAUM MD,KARL E
5	10/07/21 1706	interface	order's status changed from TRANS to LOGGED by RAD
6	10/07/21 1709	BBURGHAR	order acknowledged
7	10/08/21 0541	LKEMP025	order viewed from Order Management
8	10/08/21 0556	interface	order's status changed from LOGGED to IN PRO by RAD
9	10/08/21 0736	interface	order's status changed from IN PRO to COMP by RAD
10	10/08/21 1431	AMIDD011	order viewed from Order Management
11	10/08/21 1431	AMIDD011	order viewed from Order Management

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-2525	10/07/21	1930	R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023368 **Start:** 10/07/21 1930 PRN CMP
Stop:

LORazepam (Ativan Equiv)
Dose: 0.5 MG
Route: IV **Direction:** PRNQ6H
PRN Reason: ANXIETY/AGITATION

Order's Audit Trail of Events

1	10/07/21 1927	BBURGHAR	Order ENTER in OM
2	10/07/21 1927	BBURGHAR	Ordering Doctor: BECK MD,DAVID
3	10/07/21 1927	BBURGHAR	Order Source: Telephone/Read Back
4	10/07/21 1929	AGLOD001	VERIFIED in PHA

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

5 10/07/21 1954 BBURGHAR order acknowledged
6 10/07/21 2007 DBECK034 Signed by BECK MD,DAVID
7 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	RESINIT	20211007-0930	10/07/21				TO	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: Date/Time family notified of restraint initiation:10/7 1940

NUR DIRECTIONS:

	DATE	TIME	DIRECTIONS	
1	10/07/21	1928	ONCE	ONE TIME ONLY

Order's Audit Trail of Events

1 10/07/21 1928 BBURGHAR Order ENTER in OM
2 10/07/21 1928 BBURGHAR Ordering Doctor: BECK MD,DAVID
3 10/07/21 1928 BBURGHAR Order Source: Telephone/Read Back
4 10/07/21 1929 interface order's status changed from TRANS to ACTIVE by NUR
5 10/07/21 1929 MMACHURI order acknowledged
6 10/07/21 2007 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 2348 LKEMP025 Supplemental Text edited:
8 10/07/21 2348 LKEMP025 From:
9 10/07/21 2348 LKEMP025 Date/Time family notified of restraint
10 10/07/21 2348 LKEMP025 initiation:
11 10/07/21 2348 LKEMP025 To:
12 10/07/21 2348 LKEMP025 Date/Time family notified of restraint
13 10/07/21 2348 LKEMP025 initiation:10/7 1940
14 01/19/22 1026 ABUSHMAN order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	RES	20211007-0931	10/07/21				TO	IPR	BECD

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: RN to obtain TO/VO ASAP with restraint initiation. Obtain renewal order from LIP for restraint at least once every calendar day.

NUR DIRECTIONS:

	DATE	TIME	DIRECTIONS	
1	10/07/21	1928	Q2H	EVERY 2 HOURS
2	10/08/21	2330	PRN	PRN

Order's Audit Trail of Events

1 10/07/21 1928 BBURGHAR Order ENTER in OM
2 10/07/21 1928 BBURGHAR Ordering Doctor: BECK MD,DAVID
3 10/07/21 1928 BBURGHAR Order Source: Telephone/Read Back
4 10/07/21 1929 interface order's status changed from TRANS to ACTIVE by NUR
5 10/07/21 1929 MMACHURI order acknowledged
6 10/07/21 2007 DBECK034 Signed by BECK MD,DAVID
7 01/19/22 1026 ABUSHMAN order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211007-2535	10/07/21	1937	R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10023372 **Start:** 10/07/21 1937 PRN CMP
Stop:
Key For Med Lock Boxes (*Key Lorazepam)
Dose: 0 EACH
Route: FS **Direction:** .DISP

Order's Audit Trail of Events

1	10/07/21 1937	MMACHURI	Order ENTER in PHA
2	10/07/21 1937	MMACHURI	Ordering Doctor: BECK MD,DAVID
3	10/08/21 2025	AUTO-DC	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-2651	10/07/21	2100	R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023475 **Start:** 10/07/21 2100 ONE CMP
Stop: 10/07/21 2101
Metoprolol Tartrate
Dose: 2.5 MG
Route: IV **Direction:** ONCE

Order's Audit Trail of Events

1	10/07/21 2056	SHAIN002	Order ENTER in OM
2	10/07/21 2056	SHAIN002	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2056	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2056	AGLOD001	VERIFIED in PHA
5	10/07/21 2101	SCHEDULER	DISCONTINUE in PHA
6	10/07/21 2109	DBECK034	Signed by BECK MD,DAVID
7	10/07/21 2113	MMACHURI	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211007-2652	10/07/21	2100	R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023474 **Start:** 10/07/21 2100 ONE CMP
Stop: 10/07/21 2101
LORazepam (Ativan Equiv)
Dose: 0.5 MG
Route: IV **Direction:** ONCE

Order's Audit Trail of Events

1	10/07/21 2056	SHAIN002	Order ENTER in OM
2	10/07/21 2056	SHAIN002	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2056	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2056	AGLOD001	VERIFIED in PHA
5	10/07/21 2101	SCHEDULER	DISCONTINUE in PHA
6	10/07/21 2109	DBECK034	Signed by BECK MD,DAVID
7	10/07/21 2113	MMACHURI	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211007-2654	10/07/21	2100	R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023476 **Start:** 10/07/21 2100 PRN CMP
Stop:
LORazepam (Ativan Equiv)
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1 10/07/21 2100 SHAIN002 Order ENTER in PHA
2 10/07/21 2100 SHAIN002 Ordering Doctor: BECK MD,DAVID
3 10/08/21 2126 AUTO-DC DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211007-2655	10/07/21	2115	R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023479 **Start:** 10/07/21 2115 SCH CMP
Route: IV **Stop:**
0.9% NaCl **Volume:** 1,000 ML
Premixed at 1,000 ML (1,000 ML)
Total Volume: 1,000 mls
Rate: 100 MLS/HR **Direction:** CONT
Bag Duration: 10 HR
Rx Duration: No Stop Date/Time

Order's Audit Trail of Events

1 10/07/21 2102 SHAIN002 Order ENTER in OM
2 10/07/21 2102 SHAIN002 Ordering Doctor: BECK MD,DAVID
3 10/07/21 2102 SHAIN002 Order Source: Telephone/Read Back
4 10/07/21 2109 AGLOD001 VERIFIED in PHA
5 10/07/21 2109 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 2134 SHAIN002 order acknowledged
7 10/07/21 2159 SHAIN002 Order's Rx has been edited.
8 10/07/21 2159 SHAIN002 EDIT IV RATE
9 10/07/21 2159 SHAIN002 FROM:
10 10/07/21 2159 SHAIN002 RATE: 40 MLS/HR
11 10/07/21 2159 SHAIN002 DURATION: 25 HR
12 10/07/21 2159 SHAIN002 TO:
13 10/07/21 2159 SHAIN002 RATE: 75 MLS/HR
14 10/07/21 2159 SHAIN002 DURATION: 13 HR 20 MIN
15 10/07/21 2208 DBECK034 Signed by BECK MD,DAVID
16 10/07/21 2213 MMACHURI order acknowledged
17 10/08/21 0128 LKEMP025 Order's Rx has been edited.
18 10/08/21 0128 LKEMP025 EDIT IV RATE
19 10/08/21 0128 LKEMP025 FROM:
20 10/08/21 0128 LKEMP025 RATE: 75 MLS/HR
21 10/08/21 0128 LKEMP025 DURATION: 13 HR 20 MIN
22 10/08/21 0128 LKEMP025 TO:
23 10/08/21 0128 LKEMP025 RATE: 100 MLS/HR
24 10/08/21 0128 LKEMP025 DURATION: 10 HR
25 10/08/21 0129 LKEMP025 order acknowledged
26 10/08/21 0200 DBECK034 Signed by BECK MD,DAVID
27 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211007-1394	10/07/21		R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
* * * * CONTAINS NA,K,CL,CO2,GLU,BUN,CREAT,CALCIUM * * * *

COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/07/21 2129	SHAIN002	Order ENTER in OM
2	10/07/21 2129	SHAIN002	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2129	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2129	interface	cc'd doctors edited in LAB
5	10/07/21 2129	interface	order's status changed from TRANS to LOGGED by LAB
6	10/07/21 2134	SHAIN002	order acknowledged
7	10/07/21 2140	DBECK034	Signed by BECK MD,DAVID
8	10/07/21 2148	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/07/21 2346	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BTNP	20211007-1395	10/07/21		R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/07/21 2129	SHAIN002	Order ENTER in OM
2	10/07/21 2129	SHAIN002	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2129	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2129	interface	cc'd doctors edited in LAB
5	10/07/21 2129	interface	order's status changed from TRANS to LOGGED by LAB
6	10/07/21 2134	SHAIN002	order acknowledged
7	10/07/21 2140	DBECK034	Signed by BECK MD,DAVID
8	10/07/21 2148	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/07/21 2356	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211007-1396	10/07/21		R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
* * LEAVE PHLEBOTOMY COMMENTS BLANK - ENTER O2 INFO BELOW !!

* IF ALSO NEED Na, K, Cl, THEN ORDER `ABGS' INSTEAD *

OXYGEN STATUS(Rm.Air, L/Min, or %)?
BIPAP
DOES PT HAVE AN ART LINE? N
ARE OTHER LAB TESTS ORDERED WITH ABG(s)?
Y
* * * * * PAGE RT IF NEEDED STAT OR WITHIN THE HOUR* * * * *

COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/07/21 2129	SHAIN002	Order ENTER in OM
2	10/07/21 2129	SHAIN002	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2129	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2129	interface	cc'd doctors edited in LAB
5	10/07/21 2129	interface	order's status changed from TRANS to LOGGED by LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

6 10/07/21 2134 SHAIN002 order acknowledged
7 10/07/21 2140 DBECK034 Signed by BECK MD,DAVID
8 10/07/21 2148 interface order's status changed from LOGGED to IN PRO by LAB
9 10/07/21 2323 interface order's status changed from IN PRO to COMP by LAB
10 10/08/21 0043 LKEMP025 order viewed from Order Management

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RAD	CHE1	20211007-0170	10/07/21		R		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
TRANSPORTATION? P (PORTABLE)
CLINICAL HISTORY? COVID
CAMPUS? ST. ELIZABETH HOSPITAL
REASON FOR EXAM? SOB
COMMENTS:
Does the patient have an Insulin or other med infusion Pump?

Insulin/med infusion pump must be disconnected prior to exam

Order's Audit Trail of Events
1 10/07/21 2129 SHAIN002 Order ENTER in OM
2 10/07/21 2129 SHAIN002 Ordering Doctor: BECK MD,DAVID
3 10/07/21 2129 SHAIN002 Order Source: Telephone/Read Back
4 10/07/21 2129 interface order's status changed from TRANS to LOGGED by RAD
5 10/07/21 2134 SHAIN002 order acknowledged
6 10/07/21 2140 DBECK034 Signed by BECK MD,DAVID
7 10/07/21 2150 interface order's status changed from LOGGED to IN PRO by RAD
8 10/07/21 2229 interface order's status changed from IN PRO to COMP by RAD
9 10/08/21 0510 LKEMP025 order viewed from Order Management

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	NMDC	20211007-0990	10/07/21				TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/07/21	2131	PRN	PRN

Order's Audit Trail of Events
1 10/07/21 2131 SHAIN002 Order ENTER in OM
2 10/07/21 2131 SHAIN002 Ordering Doctor: BECK MD,DAVID
3 10/07/21 2131 SHAIN002 Order Source: Telephone/Read Back
4 10/07/21 2131 interface order's status changed from TRANS to ACTIVE by NUR
5 10/07/21 2134 SHAIN002 order acknowledged
6 10/07/21 2140 DBECK034 Signed by BECK MD,DAVID
7 10/09/21 1000 interface order's status changed from COMP to COMP by NUR
8 10/10/21 1637 KHALE order viewed from Order Management

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	I	20211007-2686	10/07/21	2145	R		TO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**
RX: E10023498 **Start:** 10/07/21 2145 SCH CMP
Route: IV **Stop:**

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

0.9% NaCl **Volume:** 100 ML
dexmedeTOMIDine **Dose:** 400 MCG
Total Volume: 104 mls
Rate: TITRATE **Direction:** TITRATE
Bag Duration: TITRATE
Rx Duration: No Stop Date/Time
Special Instructions: CONCENTRATION = 4 MCG/ML
DOSING RANGE- 0.2 MCG/KG/HR TO 1.5 MCG/KG/HR

Administration Criteria Queries
Initial Rate of mcg/kg/hr? 1 Titrate mcg/kg/hr? 0.1 Every ? minutes: 30
Max Rate of mcg/kg/hr? 1.5 Goal of? RASS of (-1)
DC Comments: CHANGING TO BIGGER BAG

Order's Audit Trail of Events

1	10/07/21 2132	SHAIN002	Order ENTER in OM
2	10/07/21 2132	SHAIN002	Ordering Doctor: MARADA MD,RAMANA R
3	10/07/21 2132	SHAIN002	Order Source: Telephone/Read Back
4	10/07/21 2133	AGLOD001	EDIT in PHA
5	10/07/21 2133	AGLOD001	EDIT
6	10/07/21 2133	AGLOD001	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
7	10/07/21 2133	AGLOD001	FROM:
8	10/07/21 2133	AGLOD001	DISPENSE: 0
9	10/07/21 2133	AGLOD001	LAST BAG: 0
10	10/07/21 2133	AGLOD001	TO:
11	10/07/21 2133	AGLOD001	DISPENSE: 1
12	10/07/21 2133	AGLOD001	LAST BAG: 1
13	10/07/21 2133	AGLOD001	Items Dispensed: 1 Doses Dispensed: 1
14	10/07/21 2133	AGLOD001	For: 10/07/21 - 2145
15	10/07/21 2133	AGLOD001	VERIFIED in PHA
16	10/07/21 2133	AGLOD001	VERIFIED
17	10/07/21 2133	AGLOD001	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
18	10/07/21 2134	SHAIN002	order acknowledged
19	10/13/21 0813	KRRAU	DISCONTINUE in PHA
20	10/13/21 0813	KRRAU	DISCONTINUE
21	10/13/21 0813	KRRAU	Edit Source: Pharmacy change only
22	10/13/21 0813	KRRAU	DC COMMENTS:
23	10/13/21 0813	KRRAU	CHANGING TO BIGGER BAG
24	10/13/21 0824	HMCINNIS	order acknowledged
25	11/01/21 0934	RMARADA	Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211007-1426	10/07/21	2224	R		VO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/07/21 2224	MMACHURI	Order ENTER in OM
2	10/07/21 2224	MMACHURI	Ordering Doctor: BECK MD,DAVID
3	10/07/21 2224	MMACHURI	Order Source: Verbal Ord/Read Back
4	10/07/21 2225	interface	cc'd doctors edited in LAB
5	10/07/21 2225	interface	order's status changed from TRANS to LOGGED by LAB
6	10/07/21 2231	DBECK034	Signed by BECK MD,DAVID
7	10/07/21 2235	interface	order's status changed from LOGGED to IN PRO by LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

8 10/07/21 2246 SHAIN002 order acknowledged
9 10/07/21 2346 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MIC	BC	20211007-0032	10/07/21		R	2	TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
Does Patient have central line? N
SOURCE? BLP (BLOOD, PERIPHERAL)
Use Source 'BLC' for blood culture drawn from catheter/line

SOURCE 2? BLP (BLOOD, PERIPHERAL)
Add'l Blood Culture (Source) Information:
COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1 10/07/21 2243 SHAIN002 Order ENTER in OM
2 10/07/21 2243 SHAIN002 Ordering Doctor: BECK MD,DAVID
3 10/07/21 2243 SHAIN002 Order Source: Telephone/Read Back
4 10/07/21 2243 interface cc'd doctors edited in LAB
5 10/07/21 2243 interface cc'd doctors edited in LAB
6 10/07/21 2243 interface order's status changed from TRANS to LOGGED by LAB
7 10/07/21 2246 SHAIN002 order acknowledged
8 10/07/21 2257 interface order's status changed from LOGGED to IN PRO by LAB
9 10/07/21 2258 DBECK034 Signed by BECK MD,DAVID
10 10/13/21 0643 interface order's status changed from IN PRO to COMP by LAB

Order Date: 10/08/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211008-0265	10/08/21	0115	R	1	TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

RX: E10023614 **Start:** 10/08/21 0115 PRN CMP
Stop:

Acetaminophen (Tylenol equiv)
Dose: 650 MG
Route: PR **Direction:** PRNQ6H
PRN Reason: TEMP >= 38.3 C (101 F)
Special Instructions: MAX ADULT ACETAMINOPHEN DOSE 4 GM/DAY
may change to liquid for intubated patients

Order's Audit Trail of Events

1 10/07/21 0057 DBECK034 Order ENTER in POM
2 10/07/21 0057 DBECK034 Order from set: HS ADMIT COVID 19
3 10/07/21 0057 DBECK034 Ordering Doctor: BECK MD,DAVID
4 10/07/21 0057 DBECK034 Order Source: POM
5 10/07/21 0057 DBECK034 Signed by BECK MD,DAVID
6 10/07/21 0058 MLONDO VERIFIED in PHA
7 10/07/21 0153 BCHRI039 order acknowledged
8 10/08/21 0104 LKEMP025 Order's Rx has been edited.
9 10/08/21 0104 interface Order copied from: 1007-2840
10 10/08/21 0104 LKEMP025 Order EDIT in PHA
11 10/08/21 0104 LKEMP025 Ordering Doctor: BECK MD,DAVID
12 10/08/21 0104 LKEMP025 Order Source: Telephone/Read Back

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

13 10/08/21 0105 LKEMP025 order acknowledged
14 10/08/21 0108 MLONDO VERIFIED in PHA
15 10/08/21 0200 DBECK034 Signed by BECK MD,DAVID
16 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	TRAN	20211008-0084	10/08/21	0000			VO	IPR	MARRA

Other Provider : **Sig Lvl Provider :**
Transfer To: ICU
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS
1	10/08/21	0125	PRN PRN

Order's Audit Trail of Events
1 10/08/21 0126 JEVERS Order ENTER in OM
2 10/08/21 0126 JEVERS Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 0126 JEVERS Order Source: Verbal Ord/Read Back
4 10/08/21 0126 interface order's status changed from TRANS to ACTIVE by NUR
5 10/08/21 0126 JEVERS order viewed from Order Management
6 10/08/21 0127 LKEMP025 order acknowledged
7 10/10/21 1833 KHALE order viewed from Order Management
8 11/01/21 0934 RMARADA Signed by MARADA MD,RAMANA R
9 01/19/22 1026 ABUSHMAN order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211007-0292	10/07/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 0350 MMCKE043 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211007-0293	10/07/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 0350 MMCKE043 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211007-0294	10/07/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 0350 MMCKE043 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5044	20211007-0295	10/07/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 0350 MMCKE043 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RESP 5134 20211007-0296 10/07/21 R 1 CMP BECD
Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 0350 MMCKE043 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
PHA	DN	20211008-0006	10/08/21	0800	U		NUR	TRN	BECD

Other Provider : **Sig Lvl Provider :**
DRUG NEEDED? PRECEDEX AT 0800
REASON?
DRUG NEEDED?
REASON?
Comment:

Order's Audit Trail of Events
1 10/08/21 0434 LKEMP025 Order ENTER in OM
2 10/08/21 0434 LKEMP025 Ordering Doctor: BECK MD,DAVID
3 10/08/21 0434 LKEMP025 Order Source: Nursing Routine Ord
4 10/08/21 0442 LKEMP025 order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
ART	PICC	20211008-0009	10/08/21	0952	U		VO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**
TRANSPORTATION? P (PORTABLE)
CLINICAL HISTORY? COVID
CAMPUS? ST. ELIZABETH HOSPITAL
REASON FOR EXAM? TPN
Lumen: Double Lumen
PICC Line Use:
TPN: Y
IV: Y
Antibiotics:
Other:
Pacemaker/Defibrillator: N
Side:
COMMENTS:
Does the patient have an Insulin or other med infusion Pump?
Y
Insulin/med infusion pump must be disconnected prior to exam

Order's Audit Trail of Events
1 10/08/21 0952 AMIDD011 Order ENTER in OM
2 10/08/21 0952 AMIDD011 Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 0952 AMIDD011 Order Source: Verbal Ord/Read Back
4 10/08/21 0952 interface order's status changed from TRANS to LOGGED by RAD
5 10/08/21 0955 AMIDD011 order acknowledged
6 10/08/21 1453 interface order's status changed from LOGGED to IN PRO by RAD
7 10/08/21 1546 interface order's status changed from IN PRO to COMP by RAD
8 11/01/21 0934 RMARADA Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211008-1034	10/08/21	1015	R		VO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10024085 **Start:** 10/08/21 1015 SCH CMP
Route: IV **Stop:**
Norepinephrine IV drip
0.9 % Sodium Chloride **Volume:** 250 ML
Norepinephrine **Dose:** 4 MG
Total Volume: 254 mls
Rate: TITRATE **Direction:** CONT
Bag Duration: TITRATE
Rx Duration: No Stop Date/Time

Administration Criteria Queries
Initial Rate of mcg/kg/min? 0.01 Titrate mcg/kg/min? 0.03 Every ? minutes: 5
Max Rate of mcg/kg/min? 1 MAP Goal of? >65

Order's Audit Trail of Events

1	10/08/21 1002	AMIDD011	Order ENTER in OM
2	10/08/21 1002	AMIDD011	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1002	AMIDD011	Order Source: Verbal Ord/Read Back
4	10/08/21 1003	AMIDD011	order acknowledged
5	10/08/21 1003	SANACKER	EDIT in PHA
6	10/08/21 1003	SANACKER	EDIT
7	10/08/21 1003	SANACKER	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
8	10/08/21 1003	SANACKER	FROM:
9	10/08/21 1003	SANACKER	DISPENSE: 0
10	10/08/21 1003	SANACKER	LAST BAG: 0
11	10/08/21 1003	SANACKER	TO:
12	10/08/21 1003	SANACKER	DISPENSE: 1
13	10/08/21 1003	SANACKER	LAST BAG: 1
14	10/08/21 1003	SANACKER	Items Dispensed: 1 Doses Dispensed: 1
15	10/08/21 1003	SANACKER	For: 10/08/21 - 1015
16	10/08/21 1003	SANACKER	VERIFIED in PHA
17	10/08/21 1003	SANACKER	VERIFIED
18	10/08/21 1003	SANACKER	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
19	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA
20	11/01/21 0934	RMARADA	Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211008-1356	10/08/21	1145	R		POM	CNC	MARRA

Other Provider : **Sig Lvl Provider :**
RX: U02553433 **Start:** 10/08/21 1145 SCH CNC
Route: IV **Stop:**
Fentanyl **Volume:** 30 ML
Premixed at 1,500 MCG/30 ML (1,500 MCG)
Total Volume: 30 mls
Rate: **Direction:** CONT
Bag Duration:
Rx Duration: No Stop Date/Time

Administration Criteria Queries
Initial Rate of mcg/hr? 50 Titrate mcg/hr? 50 Every ? minutes: 15
Max Rate of mcg/hr? 400 Goal of? See Patient Pain Goal
Cancel Comments: WRONG PATIENT

Order's Audit Trail of Events

1	10/08/21 1134	RMARADA	Order ENTER in POM
2	10/08/21 1134	RMARADA	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1134	RMARADA	Order Source: POM
4	10/08/21 1134	RMARADA	Signed by MARADA MD,RAMANA R

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

5 10/08/21 1141 AMIDD011 order acknowledged
6 10/08/21 1145 interface Order cancelled by PHA

Cancel comment: Cancelled by Pharmacy

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211008-1416	10/08/21	1200	R		TO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**

RX: E10024359 **Start:** 10/08/21 1200 ONE CMP
Route: IV **Stop:** 10/08/21 1259
0.9% NaCl **Volume:** 500 ML
Premixed at 1,000 ML (500 ML)
Total Volume: 500 mls
Rate: 500 ML/HR **Direction:** ONCE
Bag Duration: 1 HR
Rx Duration: 0.98 Hrs

Order's Audit Trail of Events

1 10/08/21 1152 AMIDD011 Order ENTER in OM
2 10/08/21 1152 AMIDD011 Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 1152 AMIDD011 Order Source: Telephone/Read Back
4 10/08/21 1152 AMIDD011 order acknowledged
5 10/08/21 1211 HRIHA EDIT in PHA
6 10/08/21 1211 HRIHA EDIT
7 10/08/21 1211 HRIHA Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
8 10/08/21 1211 HRIHA FROM:
9 10/08/21 1211 HRIHA DISPENSE: 1
10 10/08/21 1211 HRIHA LAST BAG: 1
11 10/08/21 1211 HRIHA TO:
12 10/08/21 1211 HRIHA DISPENSE: 0
13 10/08/21 1211 HRIHA LAST BAG: 0
14 10/08/21 1211 HRIHA VERIFIED in PHA
15 10/08/21 1211 HRIHA VERIFIED
16 10/08/21 1211 HRIHA Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
17 10/08/21 1259 SCHEDULER DISCONTINUE in PHA
18 11/01/21 0934 RMARADA Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211008-0958	10/08/21	1216	S		NUR	CMP	MARRA

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
* * LEAVE PHLEBOTOMY COMMENTS BLANK - ENTER O2 INFO BELOW !!

* IF ALSO NEED Na, K, Cl, THEN ORDER `ABGS' INSTEAD *

OXYGEN STATUS(Rm.Air, L/Min, or %)?
100
DOES PT HAVE AN ART LINE? N
ARE OTHER LAB TESTS ORDERED WITH ABG(s)?
Y
* * * * * PAGE RT IF NEEDED STAT OR WITHIN THE HOUR* * * * *

COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

1 10/08/21 1216 AMIDD011 Order ENTER in OM
2 10/08/21 1216 AMIDD011 Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 1216 AMIDD011 Order Source: Nursing Routine Ord
4 10/08/21 1216 interface cc'd doctors edited in LAB
5 10/08/21 1216 interface order's status changed from TRANS to LOGGED by LAB
6 10/08/21 1216 interface order's status changed from LOGGED to IN PRO by LAB
7 10/08/21 1216 AMIDD011 order acknowledged
8 10/08/21 1259 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211008-1573	10/08/21	1238	R	1		CMP	MARRA

Other Provider : **Sig Lvl Provider :**
RX: E10024434 **Start:** 10/08/21 1238 PRN CMP
Stop:
Lidocaine 1% Inj 20 ml
Dose: 0 ML
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events
1 10/08/21 1239 STHURBER Order ENTER in PHA
2 10/08/21 1239 STHURBER Ordering Doctor: MARADA MD,RAMANA R
3 10/09/21 1337 AUTO-DC DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RAD	CHEP	20211008-0106	10/08/21	1424	S		NUR	CNC	MARRA

Other Provider : **Sig Lvl Provider :**
TRANSPORTATION? P (PORTABLE)
CLINICAL HISTORY? COVID
CAMPUS? ST. ELIZABETH HOSPITAL
REASON FOR EXAM? PICC PLACEMENT
COMMENTS:
Does the patient have an Insulin or other med infusion Pump?
N
Insulin/med infusion pump must be disconnected prior to exam

Order's Audit Trail of Events
1 10/08/21 1424 AMIDD011 Order ENTER in OM
2 10/08/21 1424 AMIDD011 Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 1424 AMIDD011 Order Source: Nursing Routine Ord
4 10/08/21 1424 AMIDD011 order acknowledged
5 10/08/21 1425 interface order's status changed from TRANS to LOGGED by RAD
6 10/08/21 1429 interface order cancelled, RAD exam changed with no active match in OE

Cancel comment: RAD exam changed by Radiology : No defined a

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	10251371	20211008-0173	10/08/21		R	1		CMP	KRAJON

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1454 LSCHW012 order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211008-2011	10/08/21	1600	R		TO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10024751 **Start:** 10/08/21 1600 ONE CMP
Stop: 10/08/21 1601

Atropine
Dose: 0.5 MG
Route: IV **Direction:** ONCE

Order's Audit Trail of Events

1	10/08/21 1600	AMIDD011	Order ENTER in OM
2	10/08/21 1600	AMIDD011	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1600	AMIDD011	Order Source: Telephone/Read Back
4	10/08/21 1601	AMIDD011	order acknowledged
5	10/08/21 1601	AGLOD001	VERIFIED in PHA
6	10/08/21 1601	SCHEDULER	DISCONTINUE in PHA
7	11/01/21 0934	RMARADA	Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211008-2013	10/08/21	1601	R	1		CMP	MARRA

Other Provider : **Sig Lvl Provider :**

RX: E10024752 **Start:** 10/08/21 1601 PRN CMP
Stop:

Atropine
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1	10/08/21 1601	EBRAATZ	Order ENTER in PHA
2	10/08/21 1601	EBRAATZ	Ordering Doctor: MARADA MD,RAMANA R
3	10/09/21 1639	AUTO-DC	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	L	20211008-2078	10/08/21	1700	R		VO	CMP	MARRA

Other Provider : **Sig Lvl Provider :**

RX: E10024814 **Start:** 10/08/21 1700 SCH CMP
Route: IV **Stop:**
DoPAmine IV drip
DoPAmine **Volume:** 250 ML
Premixed at 400 MG/250 ML (400 MG)
Total Volume: 250 mls
Rate: TITRATE **Direction:** CONT
Bag Duration: TITRATE
Rx Duration: No Stop Date/Time

Administration Criteria Queries
Initial Rate of mcg/kg/min? 2 Titrate mcg/kg/min? 2 Every ? minutes: 2
Max Rate of mcg/kg/min? 20 Max rate on stepdown unit= 5 mcg/kg/min
MAP Goal of? >65

Order's Audit Trail of Events

1	10/08/21 1649	AMIDD011	Order ENTER in OM
2	10/08/21 1649	AMIDD011	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1649	AMIDD011	Order Source: Verbal Ord/Read Back
4	10/08/21 1652	AMIDD011	order acknowledged
5	10/08/21 1652	HRIHA	VERIFIED in PHA
6	10/08/21 1708	AMIDD011	order acknowledged
7	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA
8	11/01/21 0934	RMARADA	Signed by MARADA MD,RAMANA R

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211008-0202	10/08/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1755 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211008-0203	10/08/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1755 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211008-0204	10/08/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1755 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5044	20211008-0205	10/08/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1755 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5134	20211008-0206	10/08/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/08/21 1755 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	CATHINS	20211008-1086	10/08/21			TO		IPR	MARRA

Other Provider : **Sig Lvl Provider :**
Catheter type: Foley/indwelling
F9 To View Options
For Male patient:
Lidocaine 2% Urojet to lubricate urethra prior to insertion:

Must enter separate medication order for Urojet

Indication: Urn output measurements
F9 To View Options
. -
**Only patients meeting the insertion criteria should

have an indwelling urinary
cath.
**Alternatives to indwelling urinary caths

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

(external caths, frequent toileting scheds,

intermittent catheterization) should be

considered and utilized as appropriate.

Removal per Nurse Driven Protocol:
Y
If 'NO': Reason:
Click Blue ? to view Nurse Driven Protocol

Discontinue catheter on (date/time):

Comments:
NURSING TEXT: Date inserted:10/8/21
Time inserted:2300
Indication for Catheter:ACCURATE I/O,
SKIN BREAKDOWN
NUR DIRECTIONS: ----START----
DATE TIME DIRECTIONS
1 10/08/21 1801 PRN PRN

Order's Audit Trail of Events

1	10/08/21 1802	AMIDD011	Order ENTER in OM
2	10/08/21 1802	AMIDD011	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1802	AMIDD011	Order Source: Telephone/Read Back
4	10/08/21 1802	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/08/21 1816	AMIDD011	order acknowledged
6	10/08/21 2329	JJOHANEK	Supplemental Text edited:
7	10/08/21 2329	JJOHANEK	From:
8	10/08/21 2329	JJOHANEK	Date inserted:
9	10/08/21 2329	JJOHANEK	Time inserted:
10	10/08/21 2329	JJOHANEK	Indication for Catheter:
11	10/08/21 2329	JJOHANEK	To:
12	10/08/21 2329	JJOHANEK	Date inserted:10/8/21
13	10/08/21 2329	JJOHANEK	Time inserted:2300
14	10/08/21 2329	JJOHANEK	Indication for Catheter:TEMP PROBE
15	10/09/21 0621	EMFISHER1	Supplemental Text edited:
16	10/09/21 0621	EMFISHER1	From:
17	10/09/21 0621	EMFISHER1	Date inserted:10/8/21
18	10/09/21 0621	EMFISHER1	Time inserted:2300
19	10/09/21 0621	EMFISHER1	Indication for Catheter:TEMP PROBE
20	10/09/21 0621	EMFISHER1	To:
21	10/09/21 0621	EMFISHER1	Date inserted:10/8/21
22	10/09/21 0621	EMFISHER1	Time inserted:2300
23	10/09/21 0621	EMFISHER1	Indication for Catheter:ACCURATE I/O,
24	10/09/21 0621	EMFISHER1	SKIN BREAKDOWN
25	11/01/21 0934	RMARADA	Signed by MARADA MD,RAMANA R

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211008-2223	10/08/21	2100	R	1	POM	CMP	MARRA

Other Provider : **Sig Lvl Provider :**
RX: E10024932 **Start:** 10/08/21 2100 SCH CMP
Stop:
Enoxaparin (Lovenox equiv)
Dose: 40 MG
Route: SUBCUT **Direction:** Q12H

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/08/21 1838	RMARADA	Order ENTER in POM
2	10/08/21 1838	RMARADA	Ordering Doctor: MARADA MD,RAMANA R
3	10/08/21 1838	RMARADA	Order Source: POM
4	10/08/21 1838	RMARADA	Signed by MARADA MD,RAMANA R
5	10/08/21 1838	RMARADA	VIEWED LAB TEST RESULTS
6	10/08/21 1838	RMARADA	Test Group CR/INR/PLT
7	10/08/21 1838	RMARADA	LABORATORY
8	10/08/21 1838	RMARADA	Date Time Test Result Flag Normal Range
9	10/08/21 1838	RMARADA	10/08/21 1229 PLT 181 160-475 x1000
10	10/08/21 1838	RMARADA	10/08/21 1229 CREATININE 0.95 0.57-1.11 mg/d
11	10/08/21 1838	RMARADA	10/08/21 1229 GFR CALCULATED > 60 >60 mL/min
12	10/08/21 1838	RMARADA	Units: mL/min/1.73 sq.m
13	10/08/21 1838	RMARADA	Assume Caucasian. For Af Amer, multiply GFRe by 1.21
14	10/08/21 1838	interface	Order copied from: 1008-2222
15	10/08/21 1838	AGLOD001	Order EDIT in PHA
16	10/08/21 1838	AGLOD001	Ordering Doctor: MARADA MD,RAMANA R
17	10/08/21 1838	AGLOD001	Order Source: Pharmacy change only
18	10/08/21 1838	AGLOD001	EDIT in PHA
19	10/08/21 1838	AGLOD001	EDIT
20	10/08/21 1838	AGLOD001	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
21	10/08/21 1838	AGLOD001	FROM:
22	10/08/21 1838	AGLOD001	ORDER TYPE: D - UD CART FILL DRUG
23	10/08/21 1838	AGLOD001	TO:
24	10/08/21 1838	AGLOD001	ORDER TYPE: F - FLOOR STOCK MED
25	10/08/21 1838	AGLOD001	RULES AT EDIT in PHA
26	10/08/21 1838	AGLOD001	RULES AT EDIT
27	10/08/21 1838	AGLOD001	ENOX40INJ: Ensure baseline Hgb, Hct, & Plt have been checked in the past 3
28	10/08/21 1838	AGLOD001	days.
29	10/08/21 1838	AGLOD001	ENOX40INJ: BMI= 39.7
30	10/08/21 1838	AGLOD001	ENOX40INJ: Renal dosing required for this drug.
31	10/08/21 1838	AGLOD001	ENOX40INJ: IBW = 36.7 ABW = 80.24 (218.6 %) SCR = 0.95
32	10/08/21 1838	AGLOD001	ENOX40INJ: CRCL = 54.4 (IBW), 119.9 (ABW), 81.3 (BWadj40)
33	10/08/21 1838	AGLOD001	VERIFIED in PHA
34	10/08/21 1838	AGLOD001	VERIFIED
35	10/08/21 1838	AGLOD001	Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
36	10/08/21 1838	AGLOD001	VIEWED LAB TEST RESULTS in PHA
37	10/08/21 1838	AGLOD001	VIEWED LAB TEST RESULTS
38	10/08/21 1838	AGLOD001	Test Group CR/INR/PLT
39	10/08/21 1838	AGLOD001	LABORATORY
40	10/08/21 1838	AGLOD001	Date Time Test Result Flag Normal Range
41	10/08/21 1838	AGLOD001	10/08/21 1229 PLT 181 160-475 x1000
42	10/08/21 1838	AGLOD001	10/08/21 1229 CREATININE 0.95 0.57-1.11 mg/dl
43	10/08/21 1838	AGLOD001	10/08/21 1229 GFR CALCULATED > 60 >60 mL/min
44	10/08/21 1838	AGLOD001	Units: mL/min/1.73 sq.m
45	10/08/21 1838	AGLOD001	Assume Caucasian. For Af Amer, multiply GFRe by 1.21
46	10/08/21 1838	AMIDD011	order acknowledged
47	10/13/21 1303	GSHOK003	Signed by SHOKAR MD,GAVIN
48	10/13/21 1346	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211008-2507	10/08/21	2335	R	1		CMP	MARRA

Other Provider : **Sig Lvl Provider :**

PERMANENT MEDICAL RECORD COPY

<Continued>

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10025123 **Start:** 10/08/21 2335 PRN CMP
Stop:
Key For Med Lock Boxes (*Key Lorazepam)
Dose: 0 EACH
Route: FS **Direction:** .DISP

Order's Audit Trail of Events

1	10/08/21 2335	PHA ORDER	Order ENTER in PHA
2	10/08/21 2335	PHA ORDER	Ordering Doctor: MARADA MD,RAMANA R
3	10/09/21 2342	AUTO-DC	DISCONTINUE in PHA

Order Date: 10/09/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
ET	R	20211009-0001	10/09/21		R		NUR	TRN	MARRA

Other Provider : **Sig Lvl Provider :**

CAMPUS?	ST. ELIZABETH HOSPITAL
Reason for Referral:	OPEN WOUNDS BETWEEN THIGHS AND GROIN CREASES
:	
Braden Total Score:	
Notify ET Nurse:	Y

Order's Audit Trail of Events

1	10/09/21 0137	MPAFF001	Order ENTER in OM
2	10/09/21 0137	MPAFF001	Ordering Doctor: MARADA MD,RAMANA R
3	10/09/21 0137	MPAFF001	Order Source: Nursing Routine Ord
4	10/09/21 0142	MPAFF001	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211009-0378	10/09/21	0559	S		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**

CAMPUS?	ST. ELIZABETH HOSPITAL
* * LEAVE PHLEBOTOMY COMMENTS BLANK - ENTER O2 INFO BELOW !!	
* IF ALSO NEED Na, K, Cl, THEN ORDER `ABGS' INSTEAD *	
OXYGEN STATUS(Rm.Air, L/Min, or %)?	100
DOES PT HAVE AN ART LINE?	N
ARE OTHER LAB TESTS ORDERED WITH ABG(s)?	Y
* * * * * PAGE RT IF NEEDED STAT OR WITHIN THE HOUR* * * * *	
COLL BY NURSE?	N
LINE DRAW?	N
PHLEB CMNTS?	
COMMENTS:	

Order's Audit Trail of Events

1	10/09/21 0559	MPAFF001	Order ENTER in OM
2	10/09/21 0559	MPAFF001	Ordering Doctor: BECK MD,DAVID
3	10/09/21 0559	MPAFF001	Order Source: Telephone/Read Back
4	10/09/21 0600	interface	cc'd doctors edited in LAB
5	10/09/21 0600	interface	order's status changed from TRANS to LOGGED by LAB
6	10/09/21 0600	interface	order's status changed from LOGGED to IN PRO by LAB
7	10/09/21 0601	MPAFF001	order acknowledged
8	10/09/21 0903	interface	order's status changed from IN PRO to COMP by LAB
9	10/09/21 1807	DBECK034	Signed by BECK MD,DAVID

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211009-0379	10/09/21	0559	S		TO	CNC	BECD

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* * * * CONTAINS NA,K,CL,CO2,GLU,BUN,CREAT,CALCIUM * * * *

COLL BY NURSE? Y
LINE DRAW? Y
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/09/21 0559	MPAFF001	Order ENTER in OM
2	10/09/21 0559	MPAFF001	Ordering Doctor: BECK MD,DAVID
3	10/09/21 0559	MPAFF001	Order Source: Telephone/Read Back
4	10/09/21 0600	interface	cc'd doctors edited in LAB
5	10/09/21 0600	interface	order's status changed from TRANS to LOGGED by LAB
6	10/09/21 0600	interface	order's status changed from LOGGED to IN PRO by LAB
7	10/09/21 0601	MPAFF001	order acknowledged
8	10/09/21 0607	EMFISHER1	Order DC in OM
9	10/09/21 0607	EMFISHER1	Ordering Doctor: BECK MD,DAVID
10	10/09/21 0607	EMFISHER1	Order Source: Telephone/Read Back
11	10/09/21 0607	EMFISHER1	order cancel requested by Provider BECD
12	10/09/21 0607	EMFISHER1	order acknowledged
13	10/09/21 0624	interface	order cancelled - signature requirement removed for BECD
14	10/09/21 0624	interface	order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: CHANGE TO CMP
Cancel comment: OE Requested Cancellation of this order (100

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211009-0380	10/09/21	0559	S		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COMMENT:
COLL BY NURSE? Y
LINE DRAW? Y
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/09/21 0559	MPAFF001	Order ENTER in OM
2	10/09/21 0559	MPAFF001	Ordering Doctor: BECK MD,DAVID
3	10/09/21 0559	MPAFF001	Order Source: Telephone/Read Back
4	10/09/21 0600	interface	cc'd doctors edited in LAB
5	10/09/21 0600	interface	order's status changed from TRANS to LOGGED by LAB
6	10/09/21 0600	interface	order's status changed from LOGGED to IN PRO by LAB
7	10/09/21 0601	MPAFF001	order acknowledged
8	10/09/21 0700	interface	order's status changed from IN PRO to COMP by LAB
9	10/09/21 1807	DBECK034	Signed by BECK MD,DAVID

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211009-0381	10/09/21	0607	S		TO	CMP	BECD

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* CONTAINS ALL BMP TESTS + PROTEIN,ALB,ALT,AST,ALKP,T.BIL *

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

COLL BY NURSE? Y
LINE DRAW? Y
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/09/21 0607	EMFISHER1	Order ENTER in OM
2	10/09/21 0607	EMFISHER1	Ordering Doctor: BECK MD,DAVID
3	10/09/21 0607	EMFISHER1	Order Source: Telephone/Read Back
4	10/09/21 0607	EMFISHER1	order acknowledged
5	10/09/21 0607	interface	cc'd doctors edited in LAB
6	10/09/21 0607	interface	order's status changed from TRANS to LOGGED by LAB
7	10/09/21 0607	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/09/21 0722	interface	order's status changed from IN PRO to COMP by LAB
9	10/09/21 1807	DBECK034	Signed by BECK MD,DAVID

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DIET	GEN	20211009-0044	10/09/21	B			VO	CMP	LEODA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
Caffeine:
Fluid restriction:
F9 Lookup
Neutropenic:
High protein/high calorie:

Order's Audit Trail of Events

1	10/09/21 0957	VWILLS	Order ENTER in OM
2	10/09/21 0957	VWILLS	Ordering Doctor: LEONARD DO,DANIEL P
3	10/09/21 0957	VWILLS	Order Source: Verbal Ord/Read Back
4	10/09/21 0957	VWILLS	order acknowledged
5	10/09/21 1045	DLEON008	Signed by LEONARD DO,DANIEL P
6	10/10/21 1856	KGARV006	order viewed from Nursing Status Board
7	10/11/21 0929	LREYN026	order viewed
8	10/13/21 1213	HMCINNIS	order viewed from Order Management
9	10/13/21 1213	System	order's status changed from TRANS to COMP
10	10/13/21 1213	System	Order Replaced with New Diet

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	I	20211009-0601	10/09/21	1009	R		POM	CNC	LEODA

Other Provider : **Sig Lvl Provider :**
RX: U02554379 **Start:** 10/09/21 1009 SCH CNC
Route: IV **Stop:**
Famotidine **Volume:** 50 ML
Premixed at 20 MG/50 ML (20 MG)
Total Volume: 50 mls
Rate: 150 MLS/HR **Direction:** Q12H
Bag Duration: 20 MIN
Rx Duration: No Stop Date/Time
Cancel Comments: CHANGED TO VIAL

Order's Audit Trail of Events

1	10/09/21 1009	DLEON008	Order ENTER in POM
2	10/09/21 1009	DLEON008	Ordering Doctor: LEONARD DO,DANIEL P
3	10/09/21 1009	DLEON008	Order Source: POM
4	10/09/21 1009	DLEON008	Signed by LEONARD DO,DANIEL P
5	10/09/21 1009	DLEON008	VIEWED LAB TEST RESULTS

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

6 10/09/21 1009 DLEON008 Test Group CR
7 10/09/21 1009 DLEON008 LABORATORY
8 10/09/21 1009 DLEON008 Date Time Test Result Flag Normal Range
9 10/09/21 1009 DLEON008 10/09/21 0630 CREATININE 0.77 0.57-1.11 mg/d
10 10/09/21 1009 DLEON008 10/08/21 1229 CREATININE 0.95 0.57-1.11 mg/d
11 10/09/21 1009 DLEON008 10/09/21 0630 GFR CALCULATED > 60 >60 mL/min
12 10/09/21 1009 DLEON008 Units: mL/min/1.73 sq.m
13 10/09/21 1009 DLEON008 Assume Caucasian. For Af Amer, multiply GFRe by 1.21
14 10/09/21 1009 DLEON008 10/08/21 1229 GFR CALCULATED > 60 >60 mL/min
15 10/09/21 1009 DLEON008 Units: mL/min/1.73 sq.m
16 10/09/21 1009 DLEON008 Assume Caucasian. For Af Amer, multiply GFRe by 1.21
17 10/09/21 1013 interface Order cancelled by PHA
18 10/09/21 1014 VWILLS Cancelled order acknowledged

Cancel comment: Cancelled by Pharmacy

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211010-0161	10/10/21	0600	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1010 DLEON008 Order ENTER in POM
2 10/09/21 1010 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P
3 10/09/21 1010 DLEON008 Order Source: POM
4 10/09/21 1010 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/09/21 1011 VWILLS order acknowledged
6 10/10/21 0000 interface cc'd doctors edited in LAB
7 10/10/21 0000 interface order's status changed from TRANS to LOGGED by LAB
8 10/10/21 0024 interface order's status changed from LOGGED to IN PRO by LAB
9 10/10/21 0832 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211009-0605	10/09/21	0900	R	1	PHA CHG	CMP	LEODA

Other Provider : **Sig Lvl Provider :**
RX: E10025396 **Start:** 10/09/21 0900 SCH CMP
Stop:
Famotidine (Pepcid Equiv)
Dose: 20 MG
Route: IV **Direction:** BID

Order's Audit Trail of Events
1 10/09/21 1013 AGLOD001 Order ENTER in PHA
2 10/09/21 1013 AGLOD001 Ordering Doctor: LEONARD DO,DANIEL P
3 10/09/21 1013 AGLOD001 Order Source: Pharmacy change only
4 10/09/21 1013 VWILLS order acknowledged
5 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211009-0240	10/09/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1803 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211009-0241	10/09/21		R	1		CMP	BECD

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1803 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211009-0242	10/09/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1803 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5044	20211009-0243	10/09/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1803 RVANDRIE order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5134	20211009-0244	10/09/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/09/21 1803 RVANDRIE order entered

Order Date: 10/10/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CRP	20211010-0481	10/10/21		R		POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**
Order Comment: ADD TO LABS DRAWN TODAY

Order's Audit Trail of Events
1 10/10/21 0714 KBAUM Order ENTER in POM
2 10/10/21 0714 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/10/21 0714 KBAUM Order Source: POM
4 10/10/21 0714 KBAUM Signed by BAUM MD,KARL E
5 10/10/21 0714 interface cc'd doctors edited in LAB
6 10/10/21 0714 interface order's status changed from TRANS to LOGGED by LAB
7 10/10/21 0729 interface order's status changed from LOGGED to IN PRO by LAB
8 10/10/21 0745 KHALE order acknowledged
9 10/10/21 0802 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PROCAL	20211010-0482	10/10/21		R		POM	CMP	BAUK

Other Provider : **Sig Lvl Provider :**
Order Comment: ADD TO LABS DRAWN TODAY

Order's Audit Trail of Events
1 10/10/21 0714 KBAUM Order ENTER in POM
2 10/10/21 0714 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/10/21 0714 KBAUM Order Source: POM
4 10/10/21 0714 KBAUM Signed by BAUM MD,KARL E
5 10/10/21 0714 interface cc'd doctors edited in LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

6 10/10/21 0714 interface order's status changed from TRANS to LOGGED by LAB
7 10/10/21 0729 interface order's status changed from LOGGED to IN PRO by LAB
8 10/10/21 0745 KHALE order acknowledged
9 10/10/21 0821 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZIV	20211010-0361	10/10/21	0824	R	1		CMP	LEODA

Other Provider : **Sig Lvl Provider :**
RX: E10026077 **Start:** 10/10/21 0824 PRN CMP
Route: IV **Stop:**
Sodium chloride **Volume:** 10 ML
Premixed at 10 ML (10 ML)
Total Volume: 10 mls
Rate: ASDIRECTED **Direction:** .DISP
Bag Duration: ASDIRECTED
Rx Duration: No Stop Date/Time

Order's Audit Trail of Events
1 10/10/21 0824 KHALE Order ENTER in PHA
2 10/10/21 0824 KHALE Ordering Doctor: LEONARD DO,DANIEL P
3 10/11/21 0855 AUTO-DC DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	FALLPRI	20211010-0179	10/10/21	0938			NUR	CMP	BAUK

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: R/t:
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/10/21	0938	CONT	CONTINUOUSLY

Order's Audit Trail of Events
1 10/10/21 0938 KHALE Order ENTER in OM
2 10/10/21 0938 KHALE Ordering Doctor: BAUM MD,KARL E
3 10/10/21 0938 KHALE Order Source: Nursing Routine Ord
4 10/10/21 0938 interface order's status changed from TRANS to ACTIVE by NUR
5 10/10/21 0940 KHALE order acknowledged
6 10/10/21 1831 interface order's status changed from COMP to COMP by NUR

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RAD	CHEP	20211011-0004	10/11/21	0600	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**
REASON FOR EXAM? covid
COMMENTS:

Order's Audit Trail of Events
1 10/10/21 1023 DLEON008 Order ENTER in POM
2 10/10/21 1023 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P
3 10/10/21 1023 DLEON008 Order Source: POM
4 10/10/21 1023 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/10/21 1023 interface order's status changed from TRANS to LOGGED by RAD
6 10/10/21 1025 KHALE order acknowledged
7 10/11/21 0534 interface order's status changed from LOGGED to IN PRO by RAD
8 10/11/21 0552 interface order's status changed from IN PRO to COMP by RAD

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211011-0208	10/11/21	0600	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/10/21 1023 DLEON008 Order ENTER in POM
2 10/10/21 1023 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P
3 10/10/21 1023 DLEON008 Order Source: POM
4 10/10/21 1023 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/10/21 1025 KHALE order acknowledged
6 10/11/21 0001 interface cc'd doctors edited in LAB
7 10/11/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/11/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/11/21 0535 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211011-0209	10/11/21	0600	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/10/21 1023 DLEON008 Order ENTER in POM
2 10/10/21 1023 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P
3 10/10/21 1023 DLEON008 Order Source: POM
4 10/10/21 1023 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/10/21 1025 KHALE order acknowledged
6 10/11/21 0001 interface cc'd doctors edited in LAB
7 10/11/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/11/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/11/21 0552 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211011-0210	10/11/21	0600	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/10/21 1023 DLEON008 Order ENTER in POM
2 10/10/21 1023 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P
3 10/10/21 1023 DLEON008 Order Source: POM
4 10/10/21 1023 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/10/21 1025 KHALE order acknowledged
6 10/11/21 0001 interface cc'd doctors edited in LAB
7 10/11/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/11/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/11/21 1015 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211010-0514	10/10/21	1030	R		POM	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

RX: E10026175 **Start:** 10/10/21 1030 ONE CMP
Stop: 10/10/21 1031

Furosemide (Lasix equiv)
Dose: 40 MG
Route: IV **Direction:** ONCE

Order's Audit Trail of Events

1 10/10/21 1023 DLEON008 Order ENTER in POM
2 10/10/21 1023 DLEON008 Ordering Doctor: LEONARD DO,DANIEL P

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

3 10/10/21 1023 DLEON008 Order Source: POM
4 10/10/21 1023 DLEON008 Signed by LEONARD DO,DANIEL P
5 10/10/21 1023 AGLOD001 VERIFIED in PHA
6 10/10/21 1025 KHALE order acknowledged
7 10/10/21 1031 SCHEDULER DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	BIPAP	20211010-0189	10/10/21				TO	IPR	LEODA

Other Provider : **Sig Lvl Provider :**
Standard initial settings: Y
Continuous: Y
PRN: Y
Standard initial settings: IPAP 10, EPAP 5, RR 12. FiO2 to

keep SpO2 > 90%, settings to
be adjusted by RT PRN. If settings different than standard,

indicate below:
IPAP: 15
EPAP: 12
RR: 14
FiO2 to keep SpO2 greater than:
90
%
Comments:
NURSING TEXT: 10/10: 15/12, RATE 14
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/10/21	1033	Q2H	EVERY 2 HOURS

Order's Audit Trail of Events
1 10/10/21 1035 KHALE Order ENTER in OM
2 10/10/21 1035 KHALE Ordering Doctor: LEONARD DO,DANIEL P
3 10/10/21 1035 KHALE Order Source: Telephone/Read Back
4 10/10/21 1035 interface order's status changed from TRANS to ACTIVE by NUR
5 10/10/21 1109 KHALE order acknowledged
6 10/10/21 1329 KHALE Order EDIT in OM
7 10/10/21 1329 KHALE Ordering Doctor: LEONARD DO,DANIEL P
8 10/10/21 1329 KHALE Order Source: Telephone/Read Back
9 10/10/21 1329 KHALE Query: Comments:
10 10/10/21 1329 KHALE old response - PEEP 14
11 10/10/21 1329 KHALE new response -
12 10/10/21 1331 KHALE Supplemental Text edited:
13 10/10/21 1331 KHALE From:
14 10/10/21 1331 KHALE To:
15 10/10/21 1331 KHALE 10/10: 15/12, RATE 14
16 10/10/21 1332 KHALE order acknowledged
17 10/12/21 0820 DLEON008 Signed by LEONARD DO,DANIEL P

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
PHA	DN	20211010-0010	10/10/21		R		NUR	TRN	BAUK

Other Provider : **Sig Lvl Provider :**
DRUG NEEDED? PLEASE SPECIFY THAT CLINDAMYCIN & CLOTRIMAZOLE CREAM
REASON? ARE APPLIED TO GROIN
DRUG NEEDED?
REASON?
Comment: THANKS, KATIE 831-8661

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/10/21 1125	KHALE	Order ENTER in OM
2	10/10/21 1125	KHALE	Ordering Doctor: BAUM MD,KARL E
3	10/10/21 1125	KHALE	Order Source: Nursing Routine Ord
4	10/10/21 1127	KHALE	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
E.U2	1602	20211008-0003	10/08/21		R	1		CMP	CHEAR

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/10/21 1543	AKOSTELL	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
E.U2	0032	20211008-0004	10/08/21		R	1		CMP	CHEAR

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/10/21 1543	AKOSTELL	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211010-0097	10/10/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/10/21 1734	RVANDRIE	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211010-0098	10/10/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/10/21 1734	RVANDRIE	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211010-0099	10/10/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/10/21 1734	RVANDRIE	order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NS	CA	20211010-0008	10/10/21		R		VO	TRN	LEODA

Other Provider : **Sig Lvl Provider :**

Reason for Referral: PATIENT ESSENTIALLY BIPAP DEPENDENT W/ MINIMAL PO INTAKE
Comment: ALSO ASPIRATION RISK
Comment: ACTIVATED POA IS RESISTANT TO A FEEDING TUBE

Order's Audit Trail of Events

1	10/10/21 1833	KHALE	Order ENTER in OM
2	10/10/21 1833	KHALE	Ordering Doctor: LEONARD DO,DANIEL P
3	10/10/21 1833	KHALE	Order Source: Verbal Ord/Read Back

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

4 10/10/21 1833 KHALE order acknowledged
5 10/11/21 0928 LREYN026 order viewed
6 10/12/21 0820 DLEON008 Signed by LEONARD DO,DANIEL P

Order Date: 10/11/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	11025215	20211008-0324	10/08/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 0655 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0038980	20211008-0325	10/08/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 0655 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0003051	20211008-0326	10/08/21		R	3		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 0655 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0067875	20211008-0327	10/08/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 0655 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	10443275	20211008-0328	10/08/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 0655 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211012-0255	10/12/21		R		POM	CNC	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/11/21 1225 KBAUM Order ENTER in POM
2 10/11/21 1225 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/11/21 1225 KBAUM Order Source: POM
4 10/11/21 1225 KBAUM Signed by BAUM MD,KARL E
5 10/11/21 1236 ESTAR006 order acknowledged
6 10/12/21 0001 interface cc'd doctors edited in LAB
7 10/12/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/12/21 0009 interface order's status changed from LOGGED to IN PRO by LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

9 10/12/21 0057 interface order's status changed from IN PRO to CANCEL by LAB

Cancel comment: IN CMP

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBC	20211012-0256	10/12/21		R		POM	CNC	BAUK

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/11/21 1225 KBAUM Order ENTER in POM
2 10/11/21 1225 KBAUM Ordering Doctor: BAUM MD,KARL E
3 10/11/21 1225 KBAUM Order Source: POM
4 10/11/21 1225 KBAUM Signed by BAUM MD,KARL E
5 10/11/21 1236 ESTAR006 order acknowledged
6 10/12/21 0001 interface cc'd doctors edited in LAB
7 10/12/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/12/21 0009 interface order's status changed from LOGGED to IN PRO by LAB
9 10/12/21 0057 interface order's status changed from IN PRO to CANCEL by LAB

Cancel comment: IN CBC

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211011-0253	10/11/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/11/21 2232 ANWIED order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211011-0254	10/11/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/11/21 2232 ANWIED order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211011-0255	10/11/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/11/21 2232 ANWIED order entered

Order Date: 10/12/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211012-1059	10/12/21	1408	S		TO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
* * LEAVE PHLEBOTOMY COMMENTS BLANK - ENTER O2 INFO BELOW !!

* IF ALSO NEED Na, K, Cl, THEN ORDER `ABGS' INSTEAD *

OXYGEN STATUS(Rm.Air, L/Min, or %)?
100
DOES PT HAVE AN ART LINE? N
ARE OTHER LAB TESTS ORDERED WITH ABG(s)?
N

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

* * * * * PAGE RT IF NEEDED STAT OR WITHIN THE HOUR* * * * *

COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/12/21 1408	HMCINNIS	Order ENTER in OM
2	10/12/21 1408	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/12/21 1408	HMCINNIS	Order Source: Telephone/Read Back
4	10/12/21 1408	interface	cc'd doctors edited in LAB
5	10/12/21 1408	interface	order's status changed from TRANS to LOGGED by LAB
6	10/12/21 1408	interface	order's status changed from LOGGED to IN PRO by LAB
7	10/12/21 1413	HMCINNIS	order acknowledged
8	10/12/21 1536	interface	order's status changed from IN PRO to COMP by LAB
9	10/17/21 2302	GSHOK003	Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	LDH	20211013-0293	10/13/21		R		POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/12/21 1814	GSHOK003	Order ENTER in POM
2	10/12/21 1814	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
3	10/12/21 1814	GSHOK003	Order Source: POM
4	10/12/21 1814	GSHOK003	Signed by SHOKAR MD,GAVIN
5	10/12/21 1826	HMCINNIS	order acknowledged
6	10/13/21 0001	interface	cc'd doctors edited in LAB
7	10/13/21 0001	interface	order's status changed from TRANS to LOGGED by LAB
8	10/13/21 0012	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/13/21 0438	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	DDIM	20211013-0294	10/13/21		R		POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/12/21 1814	GSHOK003	Order ENTER in POM
2	10/12/21 1814	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
3	10/12/21 1814	GSHOK003	Order Source: POM
4	10/12/21 1814	GSHOK003	Signed by SHOKAR MD,GAVIN
5	10/12/21 1826	HMCINNIS	order acknowledged
6	10/13/21 0001	interface	cc'd doctors edited in LAB
7	10/13/21 0001	interface	order's status changed from TRANS to LOGGED by LAB
8	10/13/21 0012	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/13/21 0438	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211013-0295	10/13/21		R		POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/12/21 1814	GSHOK003	Order ENTER in POM
2	10/12/21 1814	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
3	10/12/21 1814	GSHOK003	Order Source: POM

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

4 10/12/21 1814 GSHOK003 Signed by SHOKAR MD,GAVIN
5 10/12/21 1826 HMCINNIS order acknowledged
6 10/13/21 0001 interface cc'd doctors edited in LAB
7 10/13/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/13/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/13/21 0437 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211013-0296	10/13/21		R		POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/12/21 1814 GSHOK003 Order ENTER in POM
2 10/12/21 1814 GSHOK003 Ordering Doctor: SHOKAR MD,GAVIN
3 10/12/21 1814 GSHOK003 Order Source: POM
4 10/12/21 1814 GSHOK003 Signed by SHOKAR MD,GAVIN
5 10/12/21 1826 HMCINNIS order acknowledged
6 10/13/21 0001 interface cc'd doctors edited in LAB
7 10/13/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/13/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/13/21 0419 interface order's status changed from IN PRO to COMP by LAB
10 10/13/21 0420 interface order's status changed from COMP to IN PRO by LAB
11 10/13/21 0520 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CRP	20211013-0297	10/13/21		R		POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/12/21 1814 GSHOK003 Order ENTER in POM
2 10/12/21 1814 GSHOK003 Ordering Doctor: SHOKAR MD,GAVIN
3 10/12/21 1814 GSHOK003 Order Source: POM
4 10/12/21 1814 GSHOK003 Signed by SHOKAR MD,GAVIN
5 10/12/21 1826 HMCINNIS order acknowledged
6 10/13/21 0001 interface cc'd doctors edited in LAB
7 10/13/21 0001 interface order's status changed from TRANS to LOGGED by LAB
8 10/13/21 0012 interface order's status changed from LOGGED to IN PRO by LAB
9 10/13/21 0438 interface order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211012-0189	10/12/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/12/21 1922 DWOELFEL order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211012-0190	10/12/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/12/21 1922 DWOELFEL order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211012-0191	10/12/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/12/21 1922 DWOELFEL order entered

Order Date: 10/13/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	I	20211013-0662	10/13/21	0815	R	1	PHA CHG	CMP	LEODA

Other Provider : **Sig Lvl Provider :**

RX: E10030001 **Start:** 10/13/21 0815 SCH CMP
Route: IV **Stop:**
0.9 % Sodium Chloride **Volume:** 250 ML
dexmedeTOMIDine **Dose:** 1,000 MCG
Total Volume: 260 mls
Rate: TITRATE **Direction:** CONT
Bag Duration: TITRATE
Rx Duration: No Stop Date/Time

Administration Criteria Queries

Initial Rate of mcg/kg/hr? 0.2 Titrate mcg/kg/hr? 0.1 Every ? minutes: 30
Max Rate of mcg/kg/hr? 1.5 Goal of? RASS of (-1)

Order's Audit Trail of Events

1 10/13/21 0813 KRRAU Order ENTER in PHA
2 10/13/21 0813 KRRAU Ordering Doctor: LEONARD DO,DANIEL P
3 10/13/21 0813 KRRAU Order Source: Pharmacy change only
4 10/13/21 0824 HMCINNIS order acknowledged
5 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0003051	20211010-0092	10/10/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/13/21 0830 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0067875	20211011-0313	10/11/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/13/21 0838 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0038980	20211011-0314	10/11/21		R	1		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 10/13/21 0838 KAMEYER order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CODE	CODE	20211013-0017	10/13/21	1056	R		POM	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

CODE STATUS: No Code

Order's Audit Trail of Events

1	10/13/21 1056	GSHOK003	Order ENTER in POM
2	10/13/21 1056	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1056	GSHOK003	Order Source: POM
4	10/13/21 1056	GSHOK003	Signed by SHOKAR MD,GAVIN
5	10/13/21 1108	HMCINNIS	order acknowledged
6	10/13/21 1137	LREYN026	order viewed
7	10/13/21 1946	LRITTMEY	order viewed from Order Management
8	10/14/21 0129	JCAST126	order viewed from Order Management
9	10/14/21 1142	RJANZEN	order viewed from Order Management
10	01/19/22 1024	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	INSFT	20211013-0458	10/13/21				VO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**
Tube Type: Nasogastric (NG)
F9 To View Options

Order's Audit Trail of Events

1	10/13/21 1111	HMCINNIS	Order ENTER in OM
2	10/13/21 1111	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1111	HMCINNIS	Order Source: Verbal Ord/Read Back
4	10/13/21 1111	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/13/21 1137	HMCINNIS	order acknowledged
6	10/17/21 2302	GSHOK003	Signed by SHOKAR MD,GAVIN
7	01/19/22 1027	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RAD	ABDT	20211013-0067	10/13/21		R		VO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
TRANSPORTATION? P (PORTABLE)
CLINICAL HISTORY? COVID
CAMPUS? ST. ELIZABETH HOSPITAL
REASON FOR EXAM? FEEDING TUBE PLACEMENT
COMMENTS: WILL CALL WHEN PLACED--HOLLEE 831-8661
Does the patient have an Insulin or other med infusion Pump?
N
Insulin/med infusion pump must be disconnected prior to exam

Order's Audit Trail of Events

1	10/13/21 1111	HMCINNIS	Order ENTER in OM
2	10/13/21 1111	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1111	HMCINNIS	Order Source: Verbal Ord/Read Back
4	10/13/21 1111	interface	order's status changed from TRANS to LOGGED by RAD
5	10/13/21 1137	HMCINNIS	order acknowledged
6	10/13/21 1157	interface	order's status changed from LOGGED to IN PRO by RAD
7	10/13/21 1209	interface	order's status changed from IN PRO to COMP by RAD
8	10/17/21 2302	GSHOK003	Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NS	DI	20211013-0008	10/13/21		R		VO	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
INSTRUCT ON WHAT DIET? START TUBE FEEDING TODAY

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Comment:

Order's Audit Trail of Events

1	10/13/21 1111	HMCINNIS	Order ENTER in OM
2	10/13/21 1111	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1111	HMCINNIS	Order Source: Verbal Ord/Read Back
4	10/13/21 1136	LREYN026	order viewed
5	10/13/21 1137	HMCINNIS	order acknowledged
6	10/17/21 2302	GSHOK003	Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211013-1267	10/13/21	1123	R	1		CMP	LEODA

Other Provider : **Sig Lvl Provider :**

RX: E10030394 **Start:** 10/13/21 1123 PRN CMP
Stop:

Key For Med Lock Boxes (*Key Lorazepam)
Dose: 0 EACH
Route: FS **Direction:** .DISP

Order's Audit Trail of Events

1	10/13/21 1123	HMCINNIS	Order ENTER in PHA
2	10/13/21 1123	HMCINNIS	Ordering Doctor: LEONARD DO,DANIEL P
3	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211013-1268	10/13/21	1123	R	1		CMP	LEODA

Other Provider : **Sig Lvl Provider :**

RX: E10030396 **Start:** 10/13/21 1123 PRN CMP
Stop:

LORazepam (Ativan Equiv)
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1	10/13/21 1123	HMCINNIS	Order ENTER in PHA
2	10/13/21 1123	HMCINNIS	Ordering Doctor: LEONARD DO,DANIEL P
3	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DIET	NPO	20211013-0076	10/13/21	L			VO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**

CAMPUS? ST. ELIZABETH HOSPITAL
After midnight:
With Meds: N
(Y = NPO but able to take Meds with sips of water)

Ice Chips: N
(Y = NPO but able to have Ice Chips)

Order's Audit Trail of Events

1	10/13/21 1213	HMCINNIS	Order ENTER in OM
2	10/13/21 1213	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1213	HMCINNIS	Order Source: Verbal Ord/Read Back
4	10/13/21 1214	HMCINNIS	order acknowledged
5	10/13/21 1303	0	order cancelled: OVERWRITTEN BY NEW DIET ORDER

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

6 10/13/21 1303 0 order cancelled - signature requirement removed for SHOGA

Cancel comment: OVERWRITTEN BY NEW DIET ORDER

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	TUBEEXIST	20211013-0538	10/13/21	1303			WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**
Tube Type: Nasogastric FT
F9 To View Options

Order's Audit Trail of Events

1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 interface order's status changed from TRANS to ACTIVE by NUR
6 10/13/21 1347 HMCINNIS order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
DIET	TF	20211013-0084	10/13/21	L			WO	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
To remain NPO Y
May have tray: N
Specify diet:
Caffeine:
Diabetic:
Insulin Dependent?
Fluid restriction:
Dysphagia level:
Low Phosphorous:
Thickened liquids:
Low Potassium:
RD to recommend formula & administration rate to LIP

Standard Formula: Y
Type: Standard TF w/Fiber
Specialized Formula:
Type:
Administration Schedule: PO
Standard: Begin full strength at 25 ml/hr x 8 hrs, then

Increase 25 ml/hr every 8 hours to goal of

ml/hr if tolerated
Postop/Questionable GI Tolerance/Concentrated Formula:

Begin full strength at 10 ml/hr x 8 hrs, then

Increase 10 ml/hr every 8 hours to goal of
65
ml/hr if tolerated
Intermittent feeding
Nocturnal feeding
**Please print and complete paper TF protocol (PSO: TFACUTE

or PSO: TFCHRONIC) or
enter order set to ensure that all orders are processed**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1346	HMCINNIS	order acknowledged
6	10/13/21 1414	LREYN026	order viewed
7	10/13/21 1428	LREYN026	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NS	CA	20211013-0011	10/13/21		R		WO	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
Reason for Referral: Nutrition Assessment and Monitoring (Tube Feeding Patient)
Comment:
Comment:

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
PHA	CONS	20211013-0021	10/13/21		R		WO	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
Reason for Consult: Drug-Nutrient Interactions and availability of liquid
Comment: medications

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	GM	20211013-0539	10/13/21	1303			WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: SLIDING SCALE: See MAR
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1234	Q6H	EVERY 6 HOURS (04,10,16,22)

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1344	interface	order's status changed from COMP to COMP by NUR
7	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

NUR TF 20211013-0540 10/13/21 1303 WO IPR SHOGA
Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Product:JEVITY 1.2
Ordered goal rate:65

FLUSHES: Flush feeding tube with 30-60 ml warm tap water
CONTINUOUS: Q4H
INTERMITTENT: before & after feedings
MEDS: Pre/post with 30cc water
Between with 10cc water

OPEN SYSTEM:
-Fill bags with 8 hour volume of product for continuous feeding
-Empty each bag - DO NOT add new TF to hanging TF
-Rinse feeding bag with warm water every 8 hours before adding new TF formula to bag
-Change bag every 24 hours
-Open system daily bag change due at:

CLOSED SYSTEM:
-Label container & spike set with patient's name and date/time hung
-Leave spike set intact for same duration as container for up to 48 hours per spiking
-Use a new spike set with each new bag

GRV CHECKS FOR NASOGASTRIC AND GASTROSTOMY TUBES (NO residual checks for jejunostomy tubes)
- A GRV should be checked if there are symptoms of tube feeding intolerance (nausea, abdominal pain, distension, firmness, etc).
- Do not perform routine GRVs for patients who are awake and alert and able to communicate, or who do not meet the follwing criteria: nausea, regurgitation, vomiting, or abdominal bloating, distension or pain.

RESIDUAL CHECKS:
- If the GRV is 500 mL or less and the patient is tolerating tube feeding, continue feeding at prescribed rate.
- If the GRV if 500 mL or less and the patient has intolerance:
a-Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&O s.
b-Reduce the tube feeding to half of the prior rate (but no less than 10 mL/hr).
c-Recheck a GRV in 4 hours. If the

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

second GRV is greater than 500 mL, ask
attending provider about prokinetics and
advancing the tube to the Jejunum.
d-When symptoms resolve, advance tube
feeding back to goal rate per original
order.
e-If the patient develops symptoms of
intolerance again,
i. Consult RD for further
recommendations.
ii. Notify attending provider
iii. Follow the protocol under B above
until new recommendations/orders
are available
-If the GRV is greater than 500 mL:
a-Refeed up to 250 m: of residuals.
Discard remaining residuals and document
in I&O's.
b-Hold the tube feeding for 4 hours then
recheck another GRV
c-If the second GRV is less than 500 mL,
resume TF at half of the prior rate (but
no less than 10 ml/hr) and advance to
goal rate as originally ordered. Do not
check routine GRVs unless the patient
shows signs of intolerance.
d-If the second GRV is greater than 500
mL:
i.Refeed up to 250 mL of residuals.
Discard remaining residuals and
document in I&O s.
ii.Continue to hold TF and await further
recommendations.
A.Ask about starting a prokinetic agent.
B.Ask about placing a Jejunal tube.

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1600	Q4H*	Q 4 HRS - 00-04-08-12-16-20

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1344	HMCINNIS	Supplemental Text edited:
7	10/13/21 1344	HMCINNIS	From:
8	10/13/21 1344	HMCINNIS	Product:
9	10/13/21 1344	HMCINNIS	Ordered goal rate:
10	10/13/21 1344	HMCINNIS	
11	10/13/21 1344	HMCINNIS	FLUSHES: Flush feeding tube with 30-60
12	10/13/21 1344	HMCINNIS	ml warm tap water
13	10/13/21 1344	HMCINNIS	CONTINUOUS: Q4H
14	10/13/21 1344	HMCINNIS	INTERMITTENT: before & after feedings
15	10/13/21 1344	HMCINNIS	MEDS: Pre/post with 30cc water
16	10/13/21 1344	HMCINNIS	Between with 10cc water
17	10/13/21 1344	HMCINNIS	
18	10/13/21 1344	HMCINNIS	OPEN SYSTEM:
19	10/13/21 1344	HMCINNIS	-Fill bags with 8 hour volume of product

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
20   10/13/21 1344 HMCINNIS       for continuous feeding
21   10/13/21 1344 HMCINNIS      -Empty each bag - DO NOT add new TF to
22   10/13/21 1344 HMCINNIS       hanging TF
23   10/13/21 1344 HMCINNIS      -Rinse feeding bag with warm water every
24   10/13/21 1344 HMCINNIS       8 hours before adding new TF formula to
25   10/13/21 1344 HMCINNIS       bag
26   10/13/21 1344 HMCINNIS      -Change bag every 24 hours
27   10/13/21 1344 HMCINNIS      -Open system daily bag change due at:
28   10/13/21 1344 HMCINNIS
29   10/13/21 1344 HMCINNIS      CLOSED SYSTEM:
30   10/13/21 1344 HMCINNIS      -Label container & spike set with
31   10/13/21 1344 HMCINNIS       patient's name and date/time hung
32   10/13/21 1344 HMCINNIS      -Leave spike set intact for same
33   10/13/21 1344 HMCINNIS       duration as container for up to 48
34   10/13/21 1344 HMCINNIS       hours per spiking
35   10/13/21 1344 HMCINNIS      -Use a new spike set with each new bag
36   10/13/21 1344 HMCINNIS
37   10/13/21 1344 HMCINNIS      GRV CHECKS FOR NASOGASTRIC AND
38   10/13/21 1344 HMCINNIS      GASTROSTOMY TUBES (NO residual checks
39   10/13/21 1344 HMCINNIS      for jejunostomy tubes)
40   10/13/21 1344 HMCINNIS         - A GRV should be checked if there
41   10/13/21 1344 HMCINNIS          are symptoms of tube feeding
42   10/13/21 1344 HMCINNIS          intolerance (nausea, abdominal pain,
43   10/13/21 1344 HMCINNIS          distension, firmness, etc).
44   10/13/21 1344 HMCINNIS         - Do not perform routine GRVs for
45   10/13/21 1344 HMCINNIS          patients who are awake and
46   10/13/21 1344 HMCINNIS         alert and able to communicate, or who
47   10/13/21 1344 HMCINNIS         do not meet the follwing criteria:
48   10/13/21 1344 HMCINNIS         nausea, regurgitation, vomiting,
49   10/13/21 1344 HMCINNIS         or abdominal bloating, distension or
50   10/13/21 1344 HMCINNIS         pain.
51   10/13/21 1344 HMCINNIS
52   10/13/21 1344 HMCINNIS      RESIDUAL CHECKS:
53   10/13/21 1344 HMCINNIS      - If the GRV is 500 mL or less and the
54   10/13/21 1344 HMCINNIS      patient is tolerating tube feeding,
55   10/13/21 1344 HMCINNIS      continue feeding at prescribed rate.
56   10/13/21 1344 HMCINNIS      - If the GRV if 500 mL or less and the
57   10/13/21 1344 HMCINNIS      patient has intolerance:
58   10/13/21 1344 HMCINNIS      a-Refeed up to 250 mL of residuals.
59   10/13/21 1344 HMCINNIS      Discard remaining residuals and document
60   10/13/21 1344 HMCINNIS      in I&O s.
61   10/13/21 1344 HMCINNIS      b-Reduce the tube feeding to half of the
62   10/13/21 1344 HMCINNIS      prior rate (but no less than 10 mL/hr).
63   10/13/21 1344 HMCINNIS      c-Recheck a GRV in 4 hours. If the
64   10/13/21 1344 HMCINNIS      second GRV is greater than 500 mL, ask
65   10/13/21 1344 HMCINNIS      attending provider about prokinetics and
66   10/13/21 1344 HMCINNIS      advancing the tube to the Jejunum.
67   10/13/21 1344 HMCINNIS      d-When symptoms resolve, advance tube
68   10/13/21 1344 HMCINNIS      feeding back to goal rate per original
69   10/13/21 1344 HMCINNIS      order.
70   10/13/21 1344 HMCINNIS      e-If the patient develops symptoms of
71   10/13/21 1344 HMCINNIS      intolerance again,
72   10/13/21 1344 HMCINNIS      i. Consult RD for further
73   10/13/21 1344 HMCINNIS      recommendations.
74   10/13/21 1344 HMCINNIS      ii. Notify attending provider
75   10/13/21 1344 HMCINNIS      iii. Follow the protocol under B above
76   10/13/21 1344 HMCINNIS      until new recommendations/orders
77   10/13/21 1344 HMCINNIS      are available
78   10/13/21 1344 HMCINNIS      -If the GRV is greater than 500 mL:
```

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
79   10/13/21 1344 HMCINNIS      a-Refeed up to 250 m: of residuals.
80   10/13/21 1344 HMCINNIS      Discard remaining residuals and document
81   10/13/21 1344 HMCINNIS      in I&O's.
82   10/13/21 1344 HMCINNIS      b-Hold the tube feeding for 4 hours then
83   10/13/21 1344 HMCINNIS      recheck another GRV
84   10/13/21 1344 HMCINNIS      c-If the second GRV is less than 500 mL,
85   10/13/21 1344 HMCINNIS      resume TF at half of the prior rate (but
86   10/13/21 1344 HMCINNIS      no less than 10 ml/hr) and advance to
87   10/13/21 1344 HMCINNIS      goal rate as originally ordered. Do not
88   10/13/21 1344 HMCINNIS      check routine GRVs unless the patient
89   10/13/21 1344 HMCINNIS      shows signs of intolerance.
90   10/13/21 1344 HMCINNIS      d-If the second GRV is greater than 500
91   10/13/21 1344 HMCINNIS      mL:
92   10/13/21 1344 HMCINNIS      i.Refeed up to 250 mL of residuals.
93   10/13/21 1344 HMCINNIS      Discard remaining residuals and
94   10/13/21 1344 HMCINNIS      document in I&O s.
95   10/13/21 1344 HMCINNIS      ii.Continue to hold TF and await further
96   10/13/21 1344 HMCINNIS      recommendations.
97   10/13/21 1344 HMCINNIS      A.Ask about starting a prokinetic agent.
98   10/13/21 1344 HMCINNIS      B.Ask about placing a Jejunal tube.
99   10/13/21 1344 HMCINNIS   To:
100  10/13/21 1344 HMCINNIS      Product:JEVITY 1.2
101  10/13/21 1344 HMCINNIS      Ordered goal rate:65
102  10/13/21 1344 HMCINNIS
103  10/13/21 1344 HMCINNIS      FLUSHES: Flush feeding tube with 30-60
104  10/13/21 1344 HMCINNIS       ml warm tap water
105  10/13/21 1344 HMCINNIS      CONTINUOUS: Q4H
106  10/13/21 1344 HMCINNIS      INTERMITTENT: before & after feedings
107  10/13/21 1344 HMCINNIS      MEDS: Pre/post with 30cc water
108  10/13/21 1344 HMCINNIS            Between with 10cc water
109  10/13/21 1344 HMCINNIS
110  10/13/21 1344 HMCINNIS      OPEN SYSTEM:
111  10/13/21 1344 HMCINNIS      -Fill bags with 8 hour volume of product
112  10/13/21 1344 HMCINNIS       for continuous feeding
113  10/13/21 1344 HMCINNIS      -Empty each bag - DO NOT add new TF to
114  10/13/21 1344 HMCINNIS       hanging TF
115  10/13/21 1344 HMCINNIS      -Rinse feeding bag with warm water every
116  10/13/21 1344 HMCINNIS       8 hours before adding new TF formula to
117  10/13/21 1344 HMCINNIS       bag
118  10/13/21 1344 HMCINNIS      -Change bag every 24 hours
119  10/13/21 1344 HMCINNIS      -Open system daily bag change due at:
120  10/13/21 1344 HMCINNIS
121  10/13/21 1344 HMCINNIS      CLOSED SYSTEM:
122  10/13/21 1344 HMCINNIS      -Label container & spike set with
123  10/13/21 1344 HMCINNIS       patient's name and date/time hung
124  10/13/21 1344 HMCINNIS      -Leave spike set intact for same
125  10/13/21 1344 HMCINNIS       duration as container for up to 48
126  10/13/21 1344 HMCINNIS       hours per spiking
127  10/13/21 1344 HMCINNIS      -Use a new spike set with each new bag
128  10/13/21 1344 HMCINNIS
129  10/13/21 1344 HMCINNIS      GRV CHECKS FOR NASOGASTRIC AND
130  10/13/21 1344 HMCINNIS      GASTROSTOMY TUBES (NO residual checks
131  10/13/21 1344 HMCINNIS      for jejunostomy tubes)
132  10/13/21 1344 HMCINNIS         - A GRV should be checked if there
133  10/13/21 1344 HMCINNIS          are symptoms of tube feeding
134  10/13/21 1344 HMCINNIS          intolerance (nausea, abdominal pain,
135  10/13/21 1344 HMCINNIS          distension, firmness, etc).
136  10/13/21 1344 HMCINNIS         - Do not perform routine GRVs for
137  10/13/21 1344 HMCINNIS          patients who are awake and
```

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

138	10/13/21 1344	HMCINNIS	alert and able to communicate, or who
139	10/13/21 1344	HMCINNIS	do not meet the follwing criteria:
140	10/13/21 1344	HMCINNIS	nausea, regurgitation, vomiting,
141	10/13/21 1344	HMCINNIS	or abdominal bloating, distension or
142	10/13/21 1344	HMCINNIS	pain.
143	10/13/21 1344	HMCINNIS	
144	10/13/21 1344	HMCINNIS	RESIDUAL CHECKS:
145	10/13/21 1344	HMCINNIS	- If the GRV is 500 mL or less and the
146	10/13/21 1344	HMCINNIS	patient is tolerating tube feeding,
147	10/13/21 1344	HMCINNIS	continue feeding at prescribed rate.
148	10/13/21 1344	HMCINNIS	- If the GRV if 500 mL or less and the
149	10/13/21 1344	HMCINNIS	patient has intolerance:
150	10/13/21 1344	HMCINNIS	a-Refeed up to 250 mL of residuals.
151	10/13/21 1344	HMCINNIS	Discard remaining residuals and document
152	10/13/21 1344	HMCINNIS	in I&O s.
153	10/13/21 1344	HMCINNIS	b-Reduce the tube feeding to half of the
154	10/13/21 1344	HMCINNIS	prior rate (but no less than 10 mL/hr).
155	10/13/21 1344	HMCINNIS	c-Recheck a GRV in 4 hours. If the
156	10/13/21 1344	HMCINNIS	second GRV is greater than 500 mL, ask
157	10/13/21 1344	HMCINNIS	attending provider about prokinetics and
158	10/13/21 1344	HMCINNIS	advancing the tube to the Jejunum.
159	10/13/21 1344	HMCINNIS	d-When symptoms resolve, advance tube
160	10/13/21 1344	HMCINNIS	feeding back to goal rate per original
161	10/13/21 1344	HMCINNIS	order.
162	10/13/21 1344	HMCINNIS	e-If the patient develops symptoms of
163	10/13/21 1344	HMCINNIS	intolerance again,
164	10/13/21 1344	HMCINNIS	i. Consult RD for further
165	10/13/21 1344	HMCINNIS	recommendations.
166	10/13/21 1344	HMCINNIS	ii. Notify attending provider
167	10/13/21 1344	HMCINNIS	iii. Follow the protocol under B above
168	10/13/21 1344	HMCINNIS	until new recommendations/orders
169	10/13/21 1344	HMCINNIS	are available
170	10/13/21 1344	HMCINNIS	-If the GRV is greater than 500 mL:
171	10/13/21 1344	HMCINNIS	a-Refeed up to 250 m: of residuals.
172	10/13/21 1344	HMCINNIS	Discard remaining residuals and document
173	10/13/21 1344	HMCINNIS	in I&O's.
174	10/13/21 1344	HMCINNIS	b-Hold the tube feeding for 4 hours then
175	10/13/21 1344	HMCINNIS	recheck another GRV
176	10/13/21 1344	HMCINNIS	c-If the second GRV is less than 500 mL,
177	10/13/21 1344	HMCINNIS	resume TF at half of the prior rate (but
178	10/13/21 1344	HMCINNIS	no less than 10 ml/hr) and advance to
179	10/13/21 1344	HMCINNIS	goal rate as originally ordered. Do not
180	10/13/21 1344	HMCINNIS	check routine GRVs unless the patient
181	10/13/21 1344	HMCINNIS	shows signs of intolerance.
182	10/13/21 1344	HMCINNIS	d-If the second GRV is greater than 500
183	10/13/21 1344	HMCINNIS	mL:
184	10/13/21 1344	HMCINNIS	i.Refeed up to 250 mL of residuals.
185	10/13/21 1344	HMCINNIS	Discard remaining residuals and
186	10/13/21 1344	HMCINNIS	document in I&O s.
187	10/13/21 1344	HMCINNIS	ii.Continue to hold TF and await further
188	10/13/21 1344	HMCINNIS	recommendations.
189	10/13/21 1344	HMCINNIS	A.Ask about starting a prokinetic agent.
190	10/13/21 1344	HMCINNIS	B.Ask about placing a Jejunal tube.
191	10/13/21 1347	HMCINNIS	order acknowledged
192	01/19/22 1027	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	HOB	20211013-0541	10/13/21	1303			WO	IPR	SHOGA

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Specify:
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1234	PER ORDERS	PER ORDERS

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	HEIGHT	20211013-0542	10/13/21	1303			WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Day TF started
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1234	PER ORDERS	PER ORDERS

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	WEIGHT	20211013-0543	10/13/21	1303			WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Day TF started & every other day
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1234	Q2D	EVERY OTHER DAY AT 0900

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1345	interface	order's status changed from COMP to COMP by NUR
7	10/13/21 1347	HMCINNIS	order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	I&O	20211013-0544	10/13/21	1303			WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
NURSING TEXT: Strict I&O
NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	1234	SHIFT END	END OF EVERY SHIFT: 06,14,22

Order's Audit Trail of Events

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
1    10/13/21 1303 TCARLSON   Order ENTER in OM
2    10/13/21 1303 TCARLSON   Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3    10/13/21 1303 TCARLSON   Ordering Doctor: SHOKAR MD,GAVIN
4    10/13/21 1303 TCARLSON   Order Source: Written/Fax/Electron
5    10/13/21 1303 interface  order's status changed from TRANS to ACTIVE by NUR
6    10/13/21 1345 interface  order's status changed from COMP to COMP by NUR
7    10/13/21 1347 HMCINNIS   order acknowledged

  Duplicate reason: MD ORDER
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	BOWPROG	20211013-0545	10/13/21	1303			WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**

```
NURSING TEXT:  Contact LIP for Bowel Program if no BM x
               3 days.
NUR DIRECTIONS:  ----START----
                   DATE     TIME DIRECTIONS
               1  10/13/21 1234 PRN                PRN
```

Order's Audit Trail of Events

```
1    10/13/21 1303 TCARLSON   Order ENTER in OM
2    10/13/21 1303 TCARLSON   Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3    10/13/21 1303 TCARLSON   Ordering Doctor: SHOKAR MD,GAVIN
4    10/13/21 1303 TCARLSON   Order Source: Written/Fax/Electron
5    10/13/21 1303 interface  order's status changed from TRANS to ACTIVE by NUR
6    10/13/21 1347 HMCINNIS   order acknowledged
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	NMD	20211013-0546	10/13/21	1303			WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**

```
NURSING TEXT:  -Contact LIP for Bowel Program if no BM
                in 3 days.
               -If feeding tube displacement is
                suspected or has occured, stop the
                feeding and notify LIP
               -Notify MD for signs/symptoms of tube
                feeding intolerance and for residual
                checks per feeding tube management
                orders.
NUR DIRECTIONS:  ----START----
                   DATE     TIME DIRECTIONS
               1  10/13/21 1234 PRN                PRN
```

Order's Audit Trail of Events

```
1    10/13/21 1303 TCARLSON   Order ENTER in OM
2    10/13/21 1303 TCARLSON   Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3    10/13/21 1303 TCARLSON   Ordering Doctor: SHOKAR MD,GAVIN
4    10/13/21 1303 TCARLSON   Order Source: Written/Fax/Electron
5    10/13/21 1303 interface  order's status changed from TRANS to ACTIVE by NUR
6    10/13/21 1347 HMCINNIS   order acknowledged
7    01/19/22 1028 ABUSHMAN   order viewed
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	NURORDER	20211013-0547	10/13/21	1303			WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**

```
NURSING TEXT:  If patients vomits, alert LIP:
```

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

a - Stop the tube feeding
b - Verify proper tube placement
c - Hold the tube feeding for 6 hours
d - Restart tube feedings at half the prior rate (but no less than 10 mL/hr) if the patient is not displaying signs of intolerance (nausea, abdominal pain, distension, firmness, etc).
e - Check a gastric residual volume (GRV) in 4 hours after restarting the tube feeding.
i. If the GRV is less than 500 mL advance the tube feeding back to goal rate per original order.
ii. If the GRV is greater than 500 mL, follow the steps in section C under GRV

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS	
1	10/13/21	0806	PER ORDERS	PER ORDERS

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	interface	order's status changed from TRANS to ACTIVE by NUR
6	10/13/21 1347	HMCINNIS	order acknowledged
7	10/13/21 1407	LREYN026	order viewed
8	01/19/22 1028	ABUSHMAN	order viewed

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PO4	20211013-0963	10/13/21	1303	R		WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS? On day TF initiated
COMMENTS:

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1304	interface	cc'd doctors edited in LAB
6	10/13/21 1304	interface	order's status changed from TRANS to LOGGED by LAB
7	10/13/21 1322	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/13/21 1347	HMCINNIS	order acknowledged
9	10/13/21 1422	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211013-0964	10/13/21	1303	R		WO	CMP	SHOGA

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS? On day TF initiated
COMMENTS:

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1304	interface	cc'd doctors edited in LAB
6	10/13/21 1304	interface	order's status changed from TRANS to LOGGED by LAB
7	10/13/21 1322	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/13/21 1347	HMCINNIS	order acknowledged
9	10/13/21 1422	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211013-0965	10/13/21	1303	R		WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* * * * CONTAINS NA,K,CL,CO2,GLU,BUN,CREAT,CALCIUM * * * *

COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 3 days, start on day TF initiated

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1304	interface	cc'd doctors edited in LAB
6	10/13/21 1304	interface	order's status changed from TRANS to LOGGED by LAB
7	10/13/21 1322	interface	order's status changed from LOGGED to IN PRO by LAB
8	10/13/21 1347	HMCINNIS	order acknowledged
9	10/13/21 1422	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PO4	20211014-0139	10/14/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	TCARLSON	Order created as part of series
6	10/13/21 1303	TCARLSON	AM was entered as Service Time
7	10/13/21 1347	HMCINNIS	order acknowledged

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

8 10/14/21 0001 interface cc'd doctors edited in LAB
9 10/14/21 0001 interface order's status changed from TRANS to LOGGED by LAB
10 10/14/21 0011 interface order's status changed from LOGGED to IN PRO by LAB
11 10/14/21 0151 interface order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: OE Requested Cancellation of this order (101

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PO4	20211015	10/15/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PO4	20211016	10/16/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211014-0140	10/14/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1303 TCARLSON AM was entered as Service Time
7 10/13/21 1347 HMCINNIS order acknowledged
8 10/14/21 0001 interface cc'd doctors edited in LAB
9 10/14/21 0001 interface order's status changed from TRANS to LOGGED by LAB
10 10/14/21 0011 interface order's status changed from LOGGED to IN PRO by LAB
11 10/14/21 0151 interface order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: OE Requested Cancellation of this order (101

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211015	10/15/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	MG	20211016	10/16/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 4 days, start on day TF initiated

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211014-0141	10/14/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* * * * CONTAINS NA,K,CL,CO2,GLU,BUN,CREAT,CALCIUM * * * *

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 3 days, start on day TF initiated

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	TCARLSON	Order created as part of series
6	10/13/21 1303	TCARLSON	AM was entered as Service Time
7	10/13/21 1347	HMCINNIS	order acknowledged
8	10/14/21 0001	interface	cc'd doctors edited in LAB
9	10/14/21 0001	interface	order's status changed from TRANS to LOGGED by LAB
10	10/14/21 0011	interface	order's status changed from LOGGED to IN PRO by LAB
11	10/14/21 0151	interface	order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: OE Requested Cancellation of this order (101

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	BMP	20211015	10/15/21	0559	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* * * * CONTAINS NA,K,CL,CO2,GLU,BUN,CREAT,CALCIUM * * * *

COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS: x 3 days, start on day TF initiated

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron
5	10/13/21 1303	TCARLSON	Order created as part of series
6	10/13/21 1347	HMCINNIS	order acknowledged
7	10/14/21 0129	BKG	order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211018	10/18/21	0500	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* CONTAINS ALL BMP TESTS + PROTEIN,ALB,ALT,AST,ALKP,T.BIL *

COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1	10/13/21 1303	TCARLSON	Order ENTER in OM
2	10/13/21 1303	TCARLSON	Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3	10/13/21 1303	TCARLSON	Ordering Doctor: SHOKAR MD,GAVIN
4	10/13/21 1303	TCARLSON	Order Source: Written/Fax/Electron

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CMP	20211025	10/25/21	0500	R		WO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* CONTAINS ALL BMP TESTS + PROTEIN,ALB,ALT,AST,ALKP,T.BIL *

COLL BY NURSE? N
LINE DRAW?
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events
1 10/13/21 1303 TCARLSON Order ENTER in OM
2 10/13/21 1303 TCARLSON Order from set: HS TUBE FEEDING ACUTE(INITIAL)
3 10/13/21 1303 TCARLSON Ordering Doctor: SHOKAR MD,GAVIN
4 10/13/21 1303 TCARLSON Order Source: Written/Fax/Electron
5 10/13/21 1303 TCARLSON Order created as part of series
6 10/13/21 1347 HMCINNIS order acknowledged
7 10/14/21 0129 BKG order cancelled by discharge

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-1566	10/13/21	2100	R	1	POM	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**
RX: E10030617 **Start:** 10/13/21 2100 SCH CMP
Stop:
Enoxaparin (Lovenox equiv)
Dose: 80 MG **Ordered:** 1 MG/KG
Route: SUBCUT **Direction:** BID

Order's Audit Trail of Events
1 10/08/21 1838 RMARADA Order ENTER in POM
2 10/08/21 1838 RMARADA Ordering Doctor: MARADA MD,RAMANA R
3 10/08/21 1838 RMARADA Order Source: POM
4 10/08/21 1838 RMARADA Signed by MARADA MD,RAMANA R
5 10/08/21 1838 RMARADA VIEWED LAB TEST RESULTS
6 10/08/21 1838 RMARADA Test Group CR/INR/PLT
7 10/08/21 1838 RMARADA LABORATORY
8 10/08/21 1838 RMARADA Date Time Test Result Flag Normal Range
9 10/08/21 1838 RMARADA 10/08/21 1229 PLT 181 160-475 x1000
10 10/08/21 1838 RMARADA 10/08/21 1229 CREATININE 0.95 0.57-1.11 mg/d
11 10/08/21 1838 RMARADA 10/08/21 1229 GFR CALCULATED > 60 >60 mL/min
12 10/08/21 1838 RMARADA Units: mL/min/1.73 sq.m
13 10/08/21 1838 RMARADA Assume Caucasian. For Af Amer, multiply GFRe by 1.21
14 10/08/21 1838 interface Order copied from: 1008-2222
15 10/08/21 1838 AGLOD001 Order EDIT in PHA
16 10/08/21 1838 AGLOD001 Ordering Doctor: MARADA MD,RAMANA R
17 10/08/21 1838 AGLOD001 Order Source: Pharmacy change only
18 10/08/21 1838 AGLOD001 EDIT in PHA
19 10/08/21 1838 AGLOD001 EDIT
20 10/08/21 1838 AGLOD001 Edit Dr: MARADA MD,RAMANA R Edit Source: Pharmacy change only
21 10/08/21 1838 AGLOD001 FROM:

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
10/08/21 1838 AGLOD001    ORDER TYPE: D - UD CART FILL DRUG
10/08/21 1838 AGLOD001  TO:
10/08/21 1838 AGLOD001    ORDER TYPE: F - FLOOR STOCK MED
10/08/21 1838 AGLOD001  RULES AT EDIT in PHA
10/08/21 1838 AGLOD001  RULES AT EDIT
10/08/21 1838 AGLOD001  ENOX40INJ:  Ensure baseline Hgb, Hct, & Plt have been checked in the past 3
10/08/21 1838 AGLOD001              days.
10/08/21 1838 AGLOD001  ENOX40INJ:  BMI=  39.7
10/08/21 1838 AGLOD001  ENOX40INJ:  Renal dosing required for this drug.
10/08/21 1838 AGLOD001  ENOX40INJ:  IBW =  36.7  ABW = 80.24 (218.6 %)  SCR = 0.95
10/08/21 1838 AGLOD001  ENOX40INJ:  CRCL = 54.4 (IBW), 119.9 (ABW), 81.3 (BWadj40)
10/08/21 1838 AGLOD001  VERIFIED in PHA
10/08/21 1838 AGLOD001  VERIFIED
10/08/21 1838 AGLOD001  Edit Dr: MARADA MD,RAMANA R              Edit Source: Pharmacy change only
10/08/21 1838 AGLOD001  VIEWED LAB TEST RESULTS in PHA
10/08/21 1838 AGLOD001  VIEWED LAB TEST RESULTS
10/08/21 1838 AGLOD001  Test Group CR/INR/PLT
10/08/21 1838 AGLOD001                                    LABORATORY
10/08/21 1838 AGLOD001  Date     Time Test            Result   Flag                  Normal Range
10/08/21 1838 AGLOD001  10/08/21 1229 PLT             181                            160-475 x1000
10/08/21 1838 AGLOD001  10/08/21 1229 CREATININE      0.95                           0.57-1.11 mg/dl
10/08/21 1838 AGLOD001  10/08/21 1229 GFR CALCULATED  > 60                          >60 mL/min
10/08/21 1838 AGLOD001               Units: mL/min/1.73 sq.m
10/08/21 1838 AGLOD001               Assume Caucasian.  For Af Amer, multiply GFRe by 1.21
10/08/21 1838 AMIDD011  order acknowledged
10/13/21 1303 GSHOK003  Order's Rx has been edited.
10/13/21 1303 GSHOK003  Signed by SHOKAR MD,GAVIN
10/13/21 1303 GSHOK003  order doctor edited: old value - MARRA
10/13/21 1303 GSHOK003                       new value - SHOGA
10/13/21 1303 GSHOK003  COPY AND EDIT
10/13/21 1303 GSHOK003  FROM: Rx #E10024932
10/13/21 1303 GSHOK003  WEIGHT BASED DOSING
10/13/21 1303 GSHOK003  Based on an ordered dose of 1 MG/KG and a patient weight of 80.558 KG,
10/13/21 1303 GSHOK003  a final dose of 80.558 MG was filed for the order.
10/13/21 1310 KRRAU     EDIT in PHA
10/13/21 1310 KRRAU     EDIT
10/13/21 1310 KRRAU     Edit Dr: SHOKAR MD,GAVIN                 Edit Source: Pharmacy change only
10/13/21 1310 KRRAU     FROM:
10/13/21 1310 KRRAU       SIG: Q12H
10/13/21 1310 KRRAU       DOSE: 80.558 MG (0.8056 ML PER DOSE)
10/13/21 1310 KRRAU       CHARGE: $56.40
10/13/21 1310 KRRAU       MED: ENOX100INJ - Lovenox Equivalent
10/13/21 1310 KRRAU     TO:
10/13/21 1310 KRRAU       SIG: BID
10/13/21 1310 KRRAU       DOSE: 80 MG (0.8 ML PER DOSE)
10/13/21 1310 KRRAU       CHARGE: $51.49
10/13/21 1310 KRRAU       MED: ENOX80INJ - Lovenox Equivalent
10/13/21 1310 KRRAU     RULES AT EDIT in PHA
10/13/21 1310 KRRAU     RULES AT EDIT
10/13/21 1310 KRRAU     ENOX80INJ:  Ensure baseline Hgb, Hct, & Plt have been checked in the past 3
10/13/21 1310 KRRAU                 days.
10/13/21 1310 KRRAU     ENOX80INJ:  Renal dosing required for this drug.
10/13/21 1310 KRRAU     ENOX80INJ:  IBW =  36.7  ABW = 80.558 (219.5 %)  SCR = 0.67
10/13/21 1310 KRRAU     ENOX80INJ:  CRCL = 78.2 (IBW), 171.7 (ABW), 115.6 (BWadj40)
10/13/21 1310 KRRAU     WEIGHT BASED DOSING in PHA
10/13/21 1310 KRRAU     WEIGHT BASED DOSING
10/13/21 1310 KRRAU     Based on an ordered dose of 1 MG/KG and a patient weight of 80.558 KG,
10/13/21 1310 KRRAU     a final dose of 80 MG was filed for the order.
10/13/21 1310 KRRAU     VERIFIED in PHA
```

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

```
81   10/13/21 1310 KRRAU      VERIFIED
82   10/13/21 1310 KRRAU      Edit Dr: SHOKAR MD,GAVIN                Edit Source: Pharmacy change only
83   10/13/21 1310 KRRAU      VIEWED LAB TEST RESULTS in PHA
84   10/13/21 1310 KRRAU      VIEWED LAB TEST RESULTS
85   10/13/21 1310 KRRAU      Test Group CR/INR/PLT
86   10/13/21 1310 KRRAU                                        LABORATORY
87   10/13/21 1310 KRRAU      Date     Time Test            Result   Flag                  Normal Range
88   10/13/21 1310 KRRAU      10/13/21 0357 PLT             257                            160-475 x1000
89   10/13/21 1310 KRRAU      10/13/21 1303 CREATININE      PENDING RECEIPT                0.44-1.00 mg/dL
90   10/13/21 1310 KRRAU      10/13/21 0357 CREATININE      0.67                           0.57-1.11 mg/dl
91   10/13/21 1310 KRRAU      10/13/21 1303 GFR CALCULATED  PENDING RECEIPT                >60 mL/min
92   10/13/21 1310 KRRAU      10/13/21 0357 GFR CALCULATED  > 60                          >60 mL/min
93   10/13/21 1310 KRRAU                    Units: mL/min/1.73 sq.m
94   10/13/21 1310 KRRAU                    Assume Caucasian.  For Af Amer, multiply GFRe by 1.21
95   10/13/21 1346 HMCINNIS   order acknowledged
96   10/14/21 0128 DISCHARGE  DISCONTINUE in PHA
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	GM	20211013-0549	10/13/21				WO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**

NURSING TEXT: Sliding Scale:

NUR DIRECTIONS: ----START----

	DATE	TIME	DIRECTIONS
1	10/13/21	1600	Q6H EVERY 6 HOURS (04,10,16,22)

Order's Audit Trail of Events

```
1    10/13/21 1310 TCARLSON   Order ENTER in OM
2    10/13/21 1310 TCARLSON   Order from set: HS INSULIN SLIDING SCALE
3    10/13/21 1310 TCARLSON   Ordering Doctor: SHOKAR MD,GAVIN
4    10/13/21 1310 TCARLSON   Order Source: Written/Fax/Electron
5    10/13/21 1311 interface  order's status changed from TRANS to ACTIVE by NUR
6    10/13/21 1347 HMCINNIS   order acknowledged
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-1600	10/13/21	1315	R	1	WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10030624 **Start:** 10/13/21 1315 SCH CMP
Stop:

Standard Tf W/Fiber
Dose: 0 ML
Route: TF **Direction:** AS DIRECTED
Special Instructions: BEGIN FULL STRENGTH AT 10 ML/HR X 8 HOURS
THEN INCREASE 10 ML/HR EVERY 8 HOURS TO
GOAL OF 65 ML/HR IF TOLERATED

Order's Audit Trail of Events

```
1    10/13/21 1313 KRRAU      Order ENTER in PHA
2    10/13/21 1313 KRRAU      Ordering Doctor: SHOKAR MD,GAVIN
3    10/13/21 1313 KRRAU      Order Source: Written/Fax/Electron
4    10/13/21 1338 HMCINNIS   order acknowledged
5    10/14/21 0128 DISCHARGE  DISCONTINUE in PHA
```

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-1601	10/13/21	1315	R	1	WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

RX: E10030625 **Start:** 10/13/21 1315 PRN CMP
Stop:

Pancrelipase (Creon 12)
Dose: 1 CAP
Route: TF **Direction:** PRN
PRN Reason: UNCLOG TUBE

Order's Audit Trail of Events

1	10/13/21 1313	KRRAU	Order ENTER in PHA
2	10/13/21 1313	KRRAU	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1313	KRRAU	Order Source: Written/Fax/Electron
4	10/13/21 1346	HMCINNIS	order acknowledged
5	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-1602	10/13/21	1315	R	1	WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10030626 **Start:** 10/13/21 1315 PRN CMP
Stop:

Sodium Bicarbonate Tablet
Dose: 325 MG
Route: TF **Direction:** PRN
PRN Reason: UNCLOG TUBE

Order's Audit Trail of Events

1	10/13/21 1313	KRRAU	Order ENTER in PHA
2	10/13/21 1313	KRRAU	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1313	KRRAU	Order Source: Written/Fax/Electron
4	10/13/21 1346	HMCINNIS	order acknowledged
5	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-1604	10/13/21	1700	R	1	WO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10030628 **Start:** 10/13/21 1700 SCH CMP
Stop:

Insulin Aspart (NovoLOG) (Novolog Insulin (Novo Nordisk))
Dose: 0 UNIT
Route: SUBCUT **Direction:** CCBEDTIME
Dose Instructions: SS
Special Instructions: 150-199 = 3 UNITS, 200-249 = 5 UNITS,
250-299 = 7 UNITS, 300-349 = 9 UNITS
>349 = 11 UNITS

Order's Audit Trail of Events

1	10/13/21 1314	KRRAU	Order ENTER in PHA
2	10/13/21 1314	KRRAU	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21 1314	KRRAU	Order Source: Written/Fax/Electron
4	10/13/21 1346	HMCINNIS	order acknowledged
5	10/14/21 0128	DISCHARGE	DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MIC	BC	20211013-0020	10/13/21	1407	S	2	POM	CMP	ZEIA

Other Provider : **Sig Lvl Provider :**
SOURCE? BLP (BLOOD, PERIPHERAL)
F9 To View Options

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

SOURCE 2? BLC (BLOOD, CATHETER)
F9 To View Options
Add'l Blood Culture (Source) Information:

Order's Audit Trail of Events

1	10/13/21 1407	AZEIMET	Order ENTER in POM
2	10/13/21 1407	AZEIMET	Ordering Doctor: ZEIMET DO,ANTHONY P
3	10/13/21 1407	AZEIMET	Order Source: POM
4	10/13/21 1407	AZEIMET	Signed by ZEIMET DO,ANTHONY P
5	10/13/21 1407	interface	cc'd doctors edited in LAB
6	10/13/21 1407	interface	cc'd doctors edited in LAB
7	10/13/21 1407	interface	order's status changed from TRANS to LOGGED by LAB
8	10/13/21 1407	interface	order's status changed from LOGGED to IN PRO by LAB
9	10/13/21 1410	HMCINNIS	order acknowledged
10	10/19/21 0823	interface	order's status changed from IN PRO to COMP by LAB

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	CBCDIFF	20211014-0145	10/14/21	0559	R		POM	CNC	ZEIA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/13/21 1408	AZEIMET	Order ENTER in POM
2	10/13/21 1408	AZEIMET	Ordering Doctor: ZEIMET DO,ANTHONY P
3	10/13/21 1408	AZEIMET	Order Source: POM
4	10/13/21 1408	AZEIMET	AM was entered as Service Time
5	10/13/21 1408	AZEIMET	Signed by ZEIMET DO,ANTHONY P
6	10/13/21 1410	HMCINNIS	order acknowledged
7	10/14/21 0001	interface	cc'd doctors edited in LAB
8	10/14/21 0001	interface	order's status changed from TRANS to LOGGED by LAB
9	10/14/21 0011	interface	order's status changed from LOGGED to IN PRO by LAB
10	10/14/21 0151	interface	order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: OE Requested Cancellation of this order (101

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	PROCAL	20211014-0146	10/14/21	0559	R		POM	CNC	ZEIA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1	10/13/21 1408	AZEIMET	Order ENTER in POM
2	10/13/21 1408	AZEIMET	Ordering Doctor: ZEIMET DO,ANTHONY P
3	10/13/21 1408	AZEIMET	Order Source: POM
4	10/13/21 1408	AZEIMET	AM was entered as Service Time
5	10/13/21 1408	AZEIMET	Signed by ZEIMET DO,ANTHONY P
6	10/13/21 1410	HMCINNIS	order acknowledged
7	10/14/21 0001	interface	cc'd doctors edited in LAB
8	10/14/21 0001	interface	order's status changed from TRANS to LOGGED by LAB
9	10/14/21 0011	interface	order's status changed from LOGGED to IN PRO by LAB
10	10/14/21 0151	interface	order's status changed from IN PRO to CANCEL by LAB

Cancel request comment: PATIENT DISCHARGED
Cancel comment: OE Requested Cancellation of this order (101

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
PHA	DN	20211013-0032	10/13/21		R		VO	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
DRUG NEEDED? PLEASE CHANGE SS INSULIN TIMES TO Q6H 10-16-22-04

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

REASON?
DRUG NEEDED?
REASON?
Comment:

Order's Audit Trail of Events

1 10/13/21 1636 HMCINNIS Order ENTER in OM
2 10/13/21 1636 HMCINNIS Ordering Doctor: SHOKAR MD,GAVIN
3 10/13/21 1636 HMCINNIS Order Source: Verbal Ord/Read Back
4 10/13/21 1637 HMCINNIS order acknowledged
5 10/17/21 2302 GSHOK003 Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
PHA	DN	20211013-0033	10/13/21		R		NUR	TRN	SHOGA

Other Provider : **Sig Lvl Provider :**
DRUG NEEDED? NEXT PRECIDEX GTT NEEDED 6:30PM
REASON?
DRUG NEEDED?
REASON?
Comment:

Order's Audit Trail of Events

1 10/13/21 1657 HMCINNIS Order ENTER in OM
2 10/13/21 1657 HMCINNIS Ordering Doctor: SHOKAR MD,GAVIN
3 10/13/21 1657 HMCINNIS Order Source: Nursing Routine Ord
4 10/13/21 1707 HMCINNIS order acknowledged

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
LAB	ABG	20211013-1326	10/13/21	1755	S		TO	CNC	SHOGA

Other Provider : **Sig Lvl Provider :**
CAMPUS? ST. ELIZABETH HOSPITAL
* * LEAVE PHLEBOTOMY COMMENTS BLANK - ENTER O2 INFO BELOW !!

* IF ALSO NEED Na, K, Cl, THEN ORDER `ABGS' INSTEAD *

OXYGEN STATUS(Rm.Air, L/Min, or %)?
100
DOES PT HAVE AN ART LINE? N
ARE OTHER LAB TESTS ORDERED WITH ABG(s)?
N
* * * * * PAGE RT IF NEEDED STAT OR WITHIN THE HOUR* * * * *

COLL BY NURSE? N
LINE DRAW? N
PHLEB CMNTS?
COMMENTS:

Order's Audit Trail of Events

1 10/13/21 1756 PSCHO001 Order ENTER in OM
2 10/13/21 1756 PSCHO001 Ordering Doctor: SHOKAR MD,GAVIN
3 10/13/21 1756 PSCHO001 Order Source: Telephone/Read Back
4 10/13/21 1756 interface cc'd doctors edited in LAB
5 10/13/21 1756 interface order's status changed from TRANS to LOGGED by LAB
6 10/13/21 1756 interface order's status changed from LOGGED to IN PRO by LAB
7 10/13/21 1756 PSCHO001 order acknowledged
8 10/13/21 2313 interface order cancelled - signature requirement removed for SHOGA
9 10/13/21 2313 interface order's status changed from IN PRO to CANCEL by LAB

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

Cancel comment: PATIENT DISCHARGED

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-2252	10/13/21	1830	R		VO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10031073 **Start:** 10/13/21 1830 ONE CMP
Stop: 10/13/21 1831

Morphine Inj
Dose: 0 EACH
Route: IV **Direction:** NOW
Dose Instructions: 2 MG

Order's Audit Trail of Events

1 10/13/21 1819 HMCINNIS Order ENTER in OM
2 10/13/21 1819 HMCINNIS Ordering Doctor: SHOKAR MD,GAVIN
3 10/13/21 1819 HMCINNIS Order Source: Verbal Ord/Read Back
4 10/13/21 1819 AGLOD001 VERIFIED in PHA
5 10/13/21 1831 SCHEDULER DISCONTINUE in PHA
6 10/13/21 1836 HMCINNIS order acknowledged
7 10/17/21 2302 GSHOK003 Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	ZZF	20211013-2253	10/13/21	1820	R	1		CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10031074 **Start:** 10/13/21 1820 PRN CMP
Stop:

Morphine Inj
Dose: 0 MG
Route: .ROUTE **Direction:** .DISP

Order's Audit Trail of Events

1 10/13/21 1820 PSCHO001 Order ENTER in PHA
2 10/13/21 1820 PSCHO001 Ordering Doctor: SHOKAR MD,GAVIN
3 10/14/21 0128 DISCHARGE DISCONTINUE in PHA

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MEDS	F	20211013-2290	10/13/21	1845	R		VO	CMP	SHOGA

Other Provider : **Sig Lvl Provider :**

RX: E10031106 **Start:** 10/13/21 1845 PRN CMP
Stop:

Morphine Inj
Dose: 0 EACH
Route: IV **Direction:** PRNQ4H
PRN Reason: PAIN
Dose Instructions: 2 MG

Order's Audit Trail of Events

1 10/13/21 1839 HMCINNIS Order ENTER in OM
2 10/13/21 1839 HMCINNIS Ordering Doctor: SHOKAR MD,GAVIN
3 10/13/21 1839 HMCINNIS Order Source: Verbal Ord/Read Back
4 10/13/21 1842 HRIHA EDIT in PHA
5 10/13/21 1842 HRIHA EDIT
6 10/13/21 1842 HRIHA Edit Dr: SHOKAR MD,GAVIN Edit Source: Pharmacy change only
7 10/13/21 1842 HRIHA FROM:
8 10/13/21 1842 HRIHA TO:
9 10/13/21 1842 HRIHA BULK: N

PATIENT: SCHARA,GRACE N **A/S:** 19 F **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 **LOC:** E.2-C **DISCH/DEP:** 10/13/21
RM: E.2029 **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID **BD:** 1 **UNIT NO:** E000365038

10 10/13/21 1842 HRIHA VERIFIED in PHA
11 10/13/21 1842 HRIHA VERIFIED
12 10/13/21 1842 HRIHA Edit Dr: SHOKAR MD,GAVIN Edit Source: Pharmacy change only
13 10/13/21 1850 HMCINNIS order acknowledged
14 10/14/21 0128 DISCHARGE DISCONTINUE in PHA
15 10/17/21 2302 GSHOK003 Signed by SHOKAR MD,GAVIN

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5100	20211013-0229	10/13/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/13/21 2324 ANWIED order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	9070	20211013-0230	10/13/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/13/21 2324 ANWIED order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5016	20211013-0231	10/13/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/13/21 2324 ANWIED order entered

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
RESP	5044	20211013-0232	10/13/21		R	1		CMP	BECD

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/13/21 2324 ANWIED order entered

Order Date: 10/15/21 **Service**

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CSI	0003051	20211012-0311	10/12/21		R	2		CMP	U

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events
1 10/15/21 1235 KAMEYER order entered

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

HEIGHT: 4 **ft** 8 **in** 142.24 **cm** **BODY SURFACE AREA:** 1.83 **m2**
WEIGHT: 177 **lb** 9.6 **oz** 80.558 **kg**

DRUG ALLERGIES: Sulfa (Sulfonamide Antibiotics)

ADRS:

Medication Reconciliation complete: Y Inpatient medications ordered: Y
Diagnosis 1?
Allergies: NKDA

Other Pharmacy Allergies #1?
Other Pharmacy Allergies #2?
Pharmacy Comment#1:
PREC #1: Is pt pregnant? NO Lactating:

APAP325UD - ACETAMINOPHEN 325 MG TAB

DOSE: 650 MG (2 TABLETS PER DOSE)
ROUTE: PO
SIG: PRNQ6H (PRN) PAR= **PRN Reason:** TEMP >= 38.3 C (101 F)
START: 10/07/21-0100 **STOP:** None **DC:** 10/08/21-0104
ORD DR: BECK MD,DAVID
TOT DISP: 1
Rx #: E10021946

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

DEX10INJ - dexAMETHasone INJ 10 MG/ML VIAL

DOSE: 6 MG (0.6 ML PER DOSE)
ROUTE: IV
SIG: DAILY (SCH)
START: 10/07/21-0900 **STOP:** 10/16/21-0901 **DC:** 10/13/21-1927
TOTAL DOSES: 10 (7 of 10 Given)
ORD DR: BECK MD,DAVID
TOT DISP: 7
Rx #: E10021948

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21 (10/07/21)	1016 (0900)	BBURGHAR	Y		DEV/WIRELESS	6 MG	
		scanner not scanning					
10/08/21 (10/08/21)	0806 (0900)	AMIDD011	Y			6 MG	
10/09/21 (10/09/21)	0827 (0900)	VWILLS	Y			6 MG	
10/10/21 (10/10/21)	0901 (0900)	KHALE	Y			6 MG	
10/11/21 (10/11/21)	0811 (0900)	ESTAR006	Y			6 MG	
10/12/21 (10/12/21)	0835 (0900)	HMCINNIS	Y			6 MG	
10/13/21 (10/13/21)	1014 (0900)	HMCINNIS	Y			6 MG	
ADMIN TOTALS:							298.27

NOTECOVID - PHARMACY TO RN COMMUNICATION 1 EACH EACH

DOSE: 1 EACH (1 EACH PER DOSE)
ROUTE: PO
SIG: AD (SCH)
START: 10/07/21-0115 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10021949

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

GUAIF10L - GuaiFENesin ORAL LIQ 10 ML UND

DOSE: 5 ML (0.5 UNIT DOSE CUPS PER DOSE)
ROUTE: PO
SIG: PRNQ4H (PRN) PAR= **PRN Reason:** COUGH
START: 10/07/21-0100 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 3
Rx #: E10021950

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21	1017	BBURGHAR	Y			5 ML	
10/07/21	1521	BBURGHAR	Y		DEV/WIRELESS	5 ML	
10/07/21	2357	LKEMP025	Y		BARCODE	5 ML	
		SCANNER IS NOT READING IN ROOM					
ADMIN TOTALS:							11.58

ONDAN2ML - ONDANSETRON INJ 4 MG/2 ML VIAL
(4 MG/DOSE)

DOSE: 4 MG (2 ML PER DOSE)
ROUTE: IV
SIG: PRNQ6H (PRN) PAR= **PRN Reason:** NAUSEA/VOMITING
START: 10/07/21-0100 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10021951

ENOX40INJ - ENOXAPARIN INJ 40 MG/0.4 ML SYR

***** CANCELLED ***:** 10/07/21-0302 DBECK034
DOSE: 40 MG (0.4 ML PER DOSE)
ROUTE: SUBCUT
SIG: 1600 (SCH)
START: 10/07/21-1600 **STOP:** None **DC:**
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10021968

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

HEP5000SDV - HEPARIN 5,000 UNITS/ML SDV 5,000 UNITS/ML VIAL

DOSE: 5,000 UNITS (1 ML PER DOSE)
ROUTE: SUBCUT
SIG: Q12H (SCH)
START: 10/07/21-0900 **STOP:** None **DC:** 10/08/21-1837
ORD DR: BECK MD,DAVID
TOT DISP: 3
Rx #: E10021988

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21	1017	BBURGHAR	Y			5,000 UNITS	
(10/07/21)	(0900)	**SITE:** ABDLOWL					
10/07/21	2115	MMACHURI	Y			5,000 UNITS	
(10/07/21)	(2100)	**SITE:** ABDLOWR					
10/08/21	0806	AMIDD011	Y			5,000 UNITS	
(10/08/21)	(0900)	**SITE:** ABDLOWL					

ADMIN TOTALS: 114.99

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

LORAZ2I - LORazepam 2 MG/ML VIAL

DOSE: 0.5 MG (0.25 ML PER DOSE)
ROUTE: IV
SIG: PRNQ6H (PRN) PAR= **PRN Reason:** ANXIETY/AGITATION
START: 10/07/21-1930 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 2
Rx #: E10023368

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21	1954	BBURGHAR	Y		DEV/WIRELESS	0.5 MG	
10/08/21	2338	MPAFF001	Y			0.5 MG	
10/13/21	1125	HMCINNIS	Y			0.5 MG	
10/13/21	1746	HMCINNIS	Y			0.5 MG	
10/13/21	1749	HMCINNIS	Y			0.5 MG	
		RR 55, GIVEN FOR WORK OF BREATHING					
		RULE: PRNQ6HRULE					

ADMIN TOTALS: 186.25

LORAZ2I - LORazepam 2 MG/ML VIAL

DOSE: 0.5 MG (0.25 ML PER DOSE)
ROUTE: IV
SIG: ONCE (ONE)
START: 10/07/21-2100 **STOP:** 10/07/21-2101 **DC:** 10/07/21-2101
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10023474

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21	2113	MMACHURI	Y			0.5 MG	
(10/07/21)	(2100)						

ADMIN TOTALS: 37.25

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

METOPROL5A - METOPROLOL TARTRATE INJ 5 MG/5 ML VIAL

DOSE: 2.5 MG (2.5 ML PER DOSE)
ROUTE: IV
SIG: ONCE (ONE)
START: 10/07/21-2100 **STOP:** 10/07/21-2101 **DC:** 10/07/21-2101
ORD DR: BECK MD,DAVID
TOT DISP: 1
Rx #: E10023475

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/07/21 (10/07/21)	2113 (2100)	MMACHURI	Y			2.5 MG	
		BP 131/60					
		Apical Pulse: 141					
ADMIN TOTALS:							37.09

APAPS650 - ACETAMINOPHEN 650 MG SUPP

DOSE: 650 MG (1 SUPPOSITORY PER DOSE)
ROUTE: PR
SIG: PRNQ6H (PRN) PAR= **PRN Reason:** TEMP >= 38.3 C (101 F)
START: 10/08/21-0115 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 6
Rx #: E10023614

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/08/21	0150	LKEMP025	Y		BARCODE	650 MG	
		ROOM SCANNER NOT WORKING					
10/08/21	0845	AMIDD011	Y			650 MG	
		RULE: ACETAMINOPHEN LIMIT FLAG					
10/09/21	1247	VWILLS	Y			650 MG	
10/13/21	1448	HMCINNIS	Y			650 MG	
ADMIN TOTALS:							14.88

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

ATROP1INJ - ATROPINE SULFATE 1 MG/10 ML SYR

DOSE: 0.5 MG (5 ML PER DOSE)
ROUTE: IV
SIG: ONCE (ONE)
START: 10/08/21-1600 **STOP:** 10/08/21-1601 **DC:** 10/08/21-1601
ORD DR: MARADA MD,RAMANA R
TOT DISP: 0
Rx #: E10024751

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/08/21 (10/08/21)	1610 (1600)	AMIDD011	Y			0.5 MG	

ADMIN TOTALS: 49.41

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

ENOX40INJ - ENOXAPARIN INJ 40 MG/0.4 ML SYR

DOSE: 40 MG (0.4 ML PER DOSE)
ROUTE: SUBCUT
SIG: Q12H (SCH)
START: 10/08/21-2100 **STOP:** None **DC:** 10/13/21-1303
ORD DR: MARADA MD,RAMANA R
TOT DISP: 10
Rx #: E10024932

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/08/21	2218	EMFISHER1	Y			40 MG	
(10/08/21)	(2100)	**SITE:** ABDLOWL					
10/09/21	0827	VWILLS	Y			40 MG	
(10/09/21)	(0900)	**SITE:** ABDLOWR					
10/09/21	2054	MPAFF001	Y			40 MG	
(10/09/21)	(2100)	**SITE:** ABDLOWR					
10/10/21	0901	KHALE	Y			40 MG	
(10/10/21)	(0900)	**SITE:** ABDUPL					
10/10/21	2001	MPAFF001	Y			40 MG	
(10/10/21)	(2100)	**SITE:** ABDLOWR					
10/11/21	0811	ESTAR006	Y			40 MG	
(10/11/21)	(0900)	**SITE:** ABDLOWL					
10/11/21	2032	CORISKA	Y			40 MG	
(10/11/21)	(2100)	**SITE:** ABDLOWR					
10/12/21	0835	HMCINNIS	Y			40 MG	
(10/12/21)	(0900)	**SITE:** ABDLOWL					
10/12/21	2150	SHAIN002	Y			40 MG	
(10/12/21)	(2100)	**SITE:** ABDLOWL					
10/13/21	1014	HMCINNIS	Y			40 MG	
(10/13/21)	(0900)	**SITE:** ABDLOWL					

ADMIN TOTALS: 436.00

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

FAMOT2V - FAMOTIDINE INJ 20 MG/2 ML VIAL

DOSE: 20 MG (2 ML PER DOSE)
ROUTE: IV
SIG: BID (SCH)
START: 10/09/21-0900 **STOP:** None **DC:** 10/13/21-1927
ORD DR: LEONARD DO,DANIEL P
TOT DISP: 9
Rx #: E10025396

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/09/21 (10/09/21)	1033 (0900)	VWILLS	Y			20 MG	
10/09/21 (10/09/21)	2054 (2100)	MPAFF001	Y			20 MG	
10/10/21 (10/10/21)	0901 (0900)	KHALE	Y			20 MG	
10/10/21 (10/10/21)	2001 (2100)	MPAFF001	Y			20 MG	
10/11/21 (10/11/21)	0811 (0900)	ESTAR006	Y			20 MG	
10/11/21 (10/11/21)	2032 (2100)	CORISKA	Y			20 MG	
10/12/21 (10/12/21)	0835 (0900)	HMCINNIS	Y			20 MG	
10/12/21 (10/12/21)	2150 (2100)	SHAIN002	Y			20 MG	
10/13/21 (10/13/21)	1014 (0900)	HMCINNIS	Y			20 MG	
ADMIN TOTALS:							332.15

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

FURO40INJ - FUROSEMIDE INJ 40 MG/4 ML VIAL

DOSE: 40 MG (4 ML PER DOSE)
ROUTE: IV
SIG: ONCE (ONE)
START: 10/10/21-1030 **STOP:** 10/10/21-1031 **DC:** 10/10/21-1031
ORD DR: LEONARD DO,DANIEL P
TOT DISP: 1
Rx #: E10026175

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/10/21 (10/10/21)	1122 (1030)	KHALE	Y			40 MG	

ADMIN TOTALS: 39.52

ENOX80INJ - ENOXAPARIN INJ 80 MG/0.8 ML SYR

DOSE: 80 MG (0.8 ML PER DOSE)
ROUTE: SUBCUT
SIG: BID (SCH)
START: 10/13/21-2100 **STOP:** None **DC:** 10/13/21-2100
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10030617

FIBHN1.5L - STANDARD TF W/FIBER 1,500 ML BOT

ROUTE: TF
SIG: AS DIRECTED (SCH)
START: 10/13/21-1315 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10030624

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/13/21	1338	HMCINNIS	Y			1,500 ML	
		Rate: 10					

ADMIN TOTALS: 12.00

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

CREON12C - CREON 12 (PANCRELIPASE) 1 CAP CAP

DOSE: 1 CAP (1 CAPSULE PER DOSE)
ROUTE: TF
SIG: PRN (PRN) PAR= **PRN Reason:** UNCLOG TUBE
START: 10/13/21-1315 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10030625

SODBI325T - SODIUM BICARBONATE 325 MG TAB

DOSE: 325 MG (1 TABLET PER DOSE)
ROUTE: TF
SIG: PRN (PRN) PAR= **PRN Reason:** UNCLOG TUBE
START: 10/13/21-1315 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10030626

NOVOLOG - INSULIN ASPART (NovoLOG) 1 UNIT UNIT

INSTR: SS
ROUTE: SUBCUT
SIG: CCBEDTIME (SCH)
START: 10/13/21-1700 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10030628

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/13/21 (10/13/21)	1657 (1700)	HMCINNIS	N		PARAMETERS		

Glucose: 151 Date: 10/13/21 Time: 1656

ADMIN TOTALS:

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

MS1-10 - MORPHINE SULFATE 1 EACH SYR

INSTR: 2 MG
ROUTE: IV
SIG: NOW (ONE)
START: 10/13/21-1830 **STOP:** 10/13/21-1831 **DC:** 10/13/21-1831
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10031073

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/13/21 (10/13/21)	1815 (1830)	HMCINNIS	Y			2 EACH	

ADMIN TOTALS: 0

MS1-10 - MORPHINE SULFATE 1 EACH SYR

INSTR: 2 MG
ROUTE: IV
SIG: PRNQ4H (PRN) PAR= **PRN Reason:** PAIN
START: 10/13/21-1845 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 0
Rx #: E10031106

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

DEXMED2ML - dexmedeTOMIDine INJ 100 MCG/ML VIAL - 400 MCG (4 ML)
in NS100 - 0.9% SODIUM CHLORIDE 100 ML BAG - 100 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 104 MLS **RATE:** TITRATE **DURATION:** TITRATE
SIG: TITRATE (SCH)
START: 10/07/21-2145 **STOP:** None **DC:** 10/13/21-0813
ORD DR: MARADA MD,RAMANA R
LAST BAG: 11
TOT DISP: 11
Rx #: E10023498

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN
10/07/21	2200	SHAIN002	Y			104 MLS
		Current Rate: 0				
		Rate Changed to: 1				
		MAP: If applicable				
		RASS: 3 If applicable				
10/07/21	2220	SHAIN002	N		DOSE/RATE CH	
		Current Rate: 1				
		Rate Changed to: .7				
		MAP: If applicable				
		RASS: -3 If applicable				
		NEEDED TO QUICKLY REDUCE DOSE R/T OVERSEDATION. PATIENT'S BP				
		DROPPED TO A MAP <65 AND O2 SATURATION WAS DECREAING				
10/08/21	0400	LKEMP025	Y			104 MLS
		Current Rate: 0.7				
		Rate Changed to: 0.8				
		MAP: If applicable				
		RASS: If applicable				
10/08/21	1008	AMIDD011	Y			104 MLS
		Current Rate: .8				
		Rate Changed to: .9				
		MAP: 64 If applicable				
		RASS: If applicable				
10/08/21	1320	AMIDD011	N		DOSE/RATE CH	
		Current Rate: .6				
		Rate Changed to: .5				
		MAP: 67 If applicable				

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

RASS: If applicable

10/08/21 1611 AMIDD011 N DOSE/RATE CH

Current Rate: .3
Rate Changed to: OFF
MAP: If applicable
RASS: If applicable

10/09/21 0208 EMFISHER1 N DOSE/RATE CH

Current Rate: 0
Rate Changed to: .1
MAP: If applicable
RASS: If applicable

10/10/21 0005 MPAFF001 Y 104 MLS

Current Rate: .2
Rate Changed to: .1
MAP: If applicable
RASS: If applicable

10/10/21 2000 MPAFF001 N DOSE/RATE CH

Current Rate: 0
Rate Changed to: .2
MAP: If applicable
RASS: If applicable

10/10/21 2341 MPAFF001 Y 104 MLS

Current Rate: .2
Rate Changed to:
MAP: If applicable
RASS: If applicable

10/11/21 1932 CORISKA Y 104 MLS

Current Rate: .2
Rate Changed to: .3
MAP: If applicable
RASS: +1 If applicable
freq coughing, increased RR, increased anxiety/fidgeting.

10/11/21 2042 CORISKA N DOSE/RATE CH

Current Rate: .3
Rate Changed to: .4
MAP: If applicable

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

RASS: +1 If applicable
attempting to take mask off, talk, rr increasing

10/11/21 2131 CORISKA N DOSE/RATE CH

Current Rate: .4
Rate Changed to: .5
MAP: If applicable
RASS: +1 If applicable
RESTLESS, DESAT

10/11/21 2203 CORISKA N DOSE/RATE CH

Current Rate: .5
Rate Changed to: .6
MAP: If applicable
RASS: +1 If applicable
assisting with tolerating prone position.

10/12/21 0440 CORISKA N DOSE/RATE CH

Current Rate: .6
Rate Changed to: .5
MAP: If applicable
RASS: If applicable

10/12/21 0620 CORISKA Y 104 MLS

Current Rate: .5
Rate Changed to:
MAP: If applicable
RASS: -1 If applicable

10/12/21 0830 HMCINNIS N DOSE/RATE CH

Current Rate: 0.5
Rate Changed to: 0.6
MAP: If applicable
RASS: If applicable
RR 40'S, GTT INCREASED FOR COMFORT IN BREATHING

10/12/21 1501 HMCINNIS Y 104 MLS

Current Rate: 0.7
Rate Changed to:
MAP: If applicable
RASS: If applicable

10/13/21 0000 SHAIN002 Y 104 MLS

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

Current Rate: .7
Rate Changed to: .8
MAP: If applicable
RASS: If applicable

10/13/21 0602 SHAIN002 Y 104 MLS

Current Rate: .8
Rate Changed to: .9
MAP: If applicable
RASS: If applicable

10/13/21 0700 HMCINNIS N DOSE/RATE CH

Current Rate: 0.9
Rate Changed to: 1.0
MAP: If applicable
RASS: If applicable
pt not tolerating prone position

10/13/21 0730 HMCINNIS N DOSE/RATE CH

Current Rate: 1.0
Rate Changed to: 1.1
MAP: If applicable
RASS: +1 If applicable
Pt rolling on side, increase to help tolerate prone position

10/13/21 0754 HMCINNIS N DOSE/RATE CH

Current Rate: 1.1
Rate Changed to: 1.2
MAP: If applicable
RASS: +1 If applicable
increased to help pt prone, rolling onto back and desats

ADMIN TOTALS: 1529.65

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

DEXMED2ML - dexmedeTOMIDine INJ 100 MCG/ML VIAL - 1,000 MCG (10 ML)
in NS250 - 0.9 % SODIUM CHLORIDE 250 ML BAG - 250 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 260 MLS **RATE:** TITRATE **DURATION:** TITRATE
SIG: CONT (SCH)
START: 10/13/21-0815 **STOP:** None **DC:** 10/13/21-1927
ORD DR: LEONARD DO,DANIEL P
LAST BAG: 3
TOT DISP: 3
Rx #: E10030001

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN	
10/13/21	1048	HMCINNIS	Y			260 MLS	
		Current Rate: 1.4					
		Rate Changed to:					
		MAP: If applicable					
		RASS: If applicable					
10/13/21	1837	HMCINNIS	N		DOSE/RATE CH		
		Current Rate: 1.4					
		Rate Changed to: OFF					
		MAP: If applicable					
		RASS: If applicable					
		STOP GTT FOR NOW PER DR SHOKAR, RESTART AS NEEDED					

ADMIN TOTALS: 288.82

FAMO20IVPB - FAMOTIDINE 20MG/50ML PREMIX IV 20 MG/50 ML IVPBP - 50 ML

***** CANCELLED ***:** 10/09/21-1013 AGLOD001
ROUTE: IV
SITE:
TOTAL VOLUME: 50 MLS **RATE:** 150 MLS/HR **DURATION:** 20 MIN
SIG: Q12H (SCH)
START: 10/09/21-1009 **STOP:** None **DC:**
ORD DR: LEONARD DO,DANIEL P
LAST BAG: 1
TOT DISP:
Rx #: U02554379

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

NS1000 - 0.9% SODIUM CHLORIDE 1,000 ML LVP - 1,000 ML

ROUTE: IV
SITE: IV
TOTAL VOLUME: 1,000 MLS **RATE:** 30 MLS/HR **DURATION:** 33 HR 20 MIN
SIG: CONT (SCH)
START: 10/07/21-0100 **STOP:** None **DC:** 10/07/21-0808
ORD DR: BECK MD,DAVID
LAST BAG: 0
TOT DISP: 0
Rx #: E10021952

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN	
10/07/21	0218	BCHRI039	Y			1,000 MLS	
10/07/21	0900	BBURGHAR	N		IV STOP TIME		

ADMIN TOTALS: 0

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

NS1000 - 0.9% SODIUM CHLORIDE 1,000 ML LVP - 1,000 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 1,000 MLS **RATE:** 100 MLS/HR **DURATION:** 10 HR
SIG: CONT (SCH)
START: 10/07/21-2115 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
LAST BAG: 0
TOT DISP: 0
Rx #: E10023479

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN	
10/08/21	0846	AMIDD011	Y			1,000 MLS	
10/09/21	2226	EMFISHER1	Y			1,000 MLS	
10/10/21	0845	KHALE	Y			1,000 MLS	
10/12/21	0046	CORISKA	Y			1,000 MLS	
10/13/21	1656	HMCINNIS	Y			1,000 MLS	

ADMIN TOTALS: 0

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

NOREPI4AMP - NOREPINEPHRINE INJ 4 MG/4 ML AMP - 4 MG (4 ML)
in NS250 - 0.9 % SODIUM CHLORIDE 250 ML BAG - 250 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 254 MLS **RATE:** TITRATE **DURATION:** TITRATE
SIG: CONT (SCH)
START: 10/08/21-1015 **STOP:** None **DC:** 10/13/21-1927
ORD DR: MARADA MD,RAMANA R
LAST BAG: 5
TOT DISP: 5
Rx #: E10024085

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN	
10/08/21	1549	AMIDD011	Y			254 MLS	
		Specify Site Infusing: Central Line					
		Current Rate: .01					
		Rate Changed to: start					
		MAP: 50 If applicable					
		RASS: If applicable					
10/08/21	1718	AMIDD011	N		DOSE/RATE CH		
		Specify Site Infusing: Central Line					
		Current Rate: .05					
		Rate Changed to: .02					
		MAP: If applicable					
		RASS: If applicable					
10/09/21	2226	EMFISHER1	N		DOSE/RATE CH		
		Specify Site Infusing: Central Line					
		Current Rate: .02					
		Rate Changed to: 0					
		MAP: If applicable					
		RASS: If applicable					

ADMIN TOTALS: 160.41

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

NS1000 - 0.9% SODIUM CHLORIDE 1,000 ML LVP - 500 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 500 MLS **RATE:** 500 ML/HR **DURATION:** 1 HR
SIG: ONCE (ONE)
START: 10/08/21-1200 **STOP:** 10/08/21-1259 **DC:** 10/08/21-1259
ORD DR: MARADA MD,RAMANA R
LAST BAG: 0
TOT DISP: 0
Rx #: E10024359

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN	
10/08/21 (10/08/21)	1210 (1200)	AMIDD011	Y			500 MLS	

ADMIN TOTALS: 0

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

DOP400BAG - DOPamine 400mg/250 D5W 400 MG/250 ML BAG - 250 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 250 MLS **RATE:** TITRATE **DURATION:** TITRATE
SIG: CONT (SCH)
START: 10/08/21-1700 **STOP:** None **DC:** 10/13/21-1927
ORD DR: MARADA MD,RAMANA R
LAST BAG: 0
TOT DISP: 1
Rx #: E10024814

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	VOLUME GIVEN
10/08/21	1708	AMIDD011	Y			250 MLS

Specify Site Infusing: Central Line
Current Rate: 2
Rate Changed to: START
MAP: If applicable
RASS: If applicable

10/08/21	1820	AMIDD011	N		DOSE/RATE CH	

Specify Site Infusing: Central Line
Current Rate: 2
Rate Changed to: 4
MAP: If applicable
RASS: If applicable

10/08/21	1834	AMIDD011	N		DOSE/RATE CH	

Specify Site Infusing: Central Line
Current Rate: 4
Rate Changed to: 6
MAP: If applicable
RASS: If applicable

10/08/21	2000	EMFISHER1	N		DOSE/RATE CH	

Specify Site Infusing: Central Line
Current Rate: 6
Rate Changed to: 5
MAP: If applicable
RASS: If applicable

10/08/21	2226	EMFISHER1	N		DOSE/RATE CH	

Specify Site Infusing: Central Line
Current Rate: 5

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

Rate Changed to: 4
MAP: If applicable
RASS: If applicable

10/09/21 0100 EMFISHER1 N DOSE/RATE CH

Specify Site Infusing: Central Line
Current Rate: 4
Rate Changed to: 0
MAP: If applicable
RASS: If applicable

ADMIN TOTALS: 48.99

FENT15003 - FENTANYL CITRATE/PF 1,500 MCG/30 ML SYR - 30 ML

***** CANCELLED ***:** 10/08/21-1145 SANACKER
***** INCOMPLETE *****
ROUTE: IV
SITE:
TOTAL VOLUME: 30 MLS **RATE:** **DURATION:**
SIG: CONT (SCH)
START: 10/08/21-1145 **STOP:** None **DC:**
ORD DR: MARADA MD,RAMANA R
LAST BAG: 0
TOT DISP:
Rx #: U02553433

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

ALBUTINH - ALBUTEROL HFA INHALER 8 GM INH

INSTR: 2 PUFFS
ROUTE: INH
SIG: PRNQ4H (PRN) PAR= **PRN Reason:** SHORTNESS OF BREATH
START: 10/07/21-0100 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10021953

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN	
10/09/21	1958	EMFISHER1	Y			2 PUFFS	
10/11/21	0030	MPAFF001	N		REFUSED		

ATTEMPTED TO GIVE PT DOSE OF ALBUTEROL WITH SPACER. PT REFUSED TO PARTICIPATE.

ADMIN TOTALS: 0

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

CLINDSOL - CLINDAMYCIN 1% TOP SOLN 60 ML BOT

INSTR: 1 application
ROUTE: TOP
SIG: BID (SCH)
START: 10/07/21-0900 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10022981

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN
10/07/21 (10/07/21)	1521 (0900)	BBURGHAR	Y			1 APPLICATIO
10/07/21 (10/07/21)	2113 (2100)	MMACHURI	Y			1 APPLICATIO
10/08/21 (10/08/21)	1008 (0900)	AMIDD011	Y			1 APPLICATIO
10/08/21 (10/08/21)	2215 (2100)	EMFISHER1	Y			1 APPLICATIO
10/09/21 (10/09/21)	0827 (0900)	VWILLS	Y			1 APPLICATIO
10/09/21 (10/09/21)	2055 (2100)	MPAFF001	Y			1 APPLICATIO
10/10/21 (10/10/21)	0900 (0900)	KHALE	N		DOSE MISSIN	
10/10/21	1125	KHALE	Y			1 APPLICATIO
10/10/21 (10/10/21)	2001 (2100)	MPAFF001	Y			1 APPLICATIO
10/11/21 (10/11/21)	0811 (0900)	ESTAR006	Y			1 APPLICATIO
10/11/21 (10/11/21)	2031 (2100)	CORISKA	Y		OWN MED USED	1 APPLICATIO
10/12/21 (10/12/21)	0834 (0900)	HMCINNIS	Y		BARCODE	1 APPLICATIO
10/12/21 (10/12/21)	2150 (2100)	SHAIN002	Y			1 APPLICATIO

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

10/13/21 1019 HMCINNIS Y BARCODE 1 APPLICATIO
(10/13/21) (0900)

ADMIN TOTALS: 0

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

CLOTRI30CR - CLOTRIMAZOLE 1% CREAM 30 GM TUBE

INSTR: 1 application
ROUTE: TOP
SIG: TID (SCH)
START: 10/07/21-1400 **STOP:** None **DC:** 10/13/21-1927
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10022982

ADMIN DATE	TIME	USER	GVN	BAG	REASON CODE	DOSE GIVEN
10/07/21 (10/07/21)	1520 (1400)	BBURGHAR	Y			1 APPLICATIO
10/07/21 (10/07/21)	2113 (2100)	MMACHURI	Y			1 APPLICATIO
10/08/21 (10/08/21)	1008 (0900)	AMIDD011	Y			1 APPLICATIO
10/08/21 (10/08/21)	1426 (1400)	AMIDD011	Y			1 APPLICATIO
10/08/21 (10/08/21)	2215 (2100)	EMFISHER1	Y			1 APPLICATIO
10/09/21 (10/09/21)	0827 (0900)	VWILLS	Y			1 APPLICATIO
10/09/21 (10/09/21)	1315 (1400)	VWILLS	Y			1 APPLICATIO
10/09/21 (10/09/21)	2055 (2100)	MPAFF001	Y			1 APPLICATIO
10/10/21 (10/10/21)	0901 (0900)	KHALE	N		DOSE MISSIN	
10/10/21	1125	KHALE	Y			1 APPLICATIO
10/10/21 (10/10/21)	1514 (1400)	KHALE	N		INTERRUPTION	
		CURRENTLY PRONED - WILL ADMINISTER LATER				
10/10/21	1618	KHALE	Y			1 APPLICATIO
10/10/21	2001	MPAFF001	Y			1 APPLICATIO

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

(10/10/21) (2100)

10/11/21	0811	ESTAR006	Y		1	APPLICATIO
(10/11/21)	(0900)					
10/11/21	1304	ESTAR006	Y		1	APPLICATIO
(10/11/21)	(1400)					
10/11/21	2032	CORISKA	Y	OWN MED USED	1	APPLICATIO
(10/11/21)	(2100)					
10/12/21	0834	HMCINNIS	Y	BARCODE	1	APPLICATIO
(10/12/21)	(0900)					
10/12/21	1413	HMCINNIS	Y		1	APPLICATIO
(10/12/21)	(1400)					
10/12/21	2150	SHAIN002	Y		1	APPLICATIO
(10/12/21)	(2100)					
10/13/21	1019	HMCINNIS	Y	BARCODE	1	APPLICATIO
(10/13/21)	(0900)					
10/13/21	1342	HMCINNIS	Y	BARCODE	1	APPLICATIO
(10/13/21)	(1400)					

ADMIN TOTALS: 0

IBU200T - IBUPROFEN 200 MG TAB

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/06/21-1458 **STOP:** None **DC:** 10/07/21-1508
ORD DR: ESCH DO,ALLY E
TOT DISP: 3
Rx #: E10021477

ALBUTINH - ALBUTEROL HFA INHALER 8 GM INH

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/06/21-1500 **STOP:** None **DC:** 10/07/21-1508
ORD DR: ESCH DO,ALLY E
TOT DISP: 1
Rx #: E10021478

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

DEX10INJ - dexAMETHasone INJ 10 MG/ML VIAL

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/06/21-1701 **STOP:** None **DC:** 10/07/21-1709
ORD DR: ESCH DO,ALLY E
TOT DISP: 1
Rx #: E10021681

LORAZKEY - KEY FOR MED LOCK BOXES 1 EACH EACH

ROUTE: FS
SIG: .DISP (PRN) PAR=
START: 10/07/21-1937 **STOP:** None **DC:** 10/08/21-2025
ORD DR: BECK MD,DAVID
TOT DISP: 0
Rx #: E10023372

LORAZ2I - LORazepam 2 MG/ML VIAL

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/07/21-2100 **STOP:** None **DC:** 10/08/21-2126
ORD DR: BECK MD,DAVID
TOT DISP: 1
Rx #: E10023476

LIDO1V20 - LIDOCAINE 1% INJ 20 ML VIAL

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/08/21-1238 **STOP:** None **DC:** 10/09/21-1337
ORD DR: MARADA MD,RAMANA R
TOT DISP: 1
Rx #: E10024434

ATROP1INJ - ATROPINE SULFATE 1 MG/10 ML SYR

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/08/21-1601 **STOP:** None **DC:** 10/09/21-1639
ORD DR: MARADA MD,RAMANA R
TOT DISP: 1
Rx #: E10024752

PATIENT: SCHARA,GRACE N **ACCT #:** E39547554 **LOC:** E.2-C **U #:** E000365038
AGE/SX: 19/F **ROOM:** E.2029 **REG:** 10/07/21
REG DR: BECK MD,DAVID **STATUS:** DIS INx **BED:** 1 **DIS:** 10/13/21

SCHARA,GRACE N E39547554 **(Continued)**

LORAZKEY - KEY FOR MED LOCK BOXES 1 EACH EACH

ROUTE: FS
SIG: .DISP (PRN) PAR=
START: 10/08/21-2335 **STOP:** None **DC:** 10/09/21-2342
ORD DR: MARADA MD,RAMANA R
TOT DISP: 0
Rx #: E10025123

LORAZKEY - KEY FOR MED LOCK BOXES 1 EACH EACH

ROUTE: FS
SIG: .DISP (PRN) PAR=
START: 10/13/21-1123 **STOP:** None **DC:** 10/13/21-1927
ORD DR: LEONARD DO,DANIEL P
TOT DISP: 0
Rx #: E10030394

LORAZ2I - LORazepam 2 MG/ML VIAL

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/13/21-1123 **STOP:** None **DC:** 10/13/21-1927
ORD DR: LEONARD DO,DANIEL P
TOT DISP: 2
Rx #: E10030396

MORP4VIA2 - MORPHINE SULFATE 4 MG/ML VIAL

ROUTE: .ROUTE
SIG: .DISP (PRN) PAR=
START: 10/13/21-1820 **STOP:** None **DC:** 10/13/21-1927
ORD DR: SHOKAR MD,GAVIN
TOT DISP: 1
Rx #: E10031074

NS10PF - 0.9% SODIUM CHLORIDE 10 ML VIAL - 10 ML

ROUTE: IV
SITE:
TOTAL VOLUME: 10 MLS **RATE:** ASDIRECTED **DURATION:** ASDIRECTED
SIG: .DISP (PRN) PAR=
START: 10/10/21-0824 **STOP:** None **DC:** 10/11/21-0855
ORD DR: LEONARD DO,DANIEL P
LAST BAG: 1
TOT DISP: 2
Rx #: E10026077

This is the end of the MAR Summary for patient E39547554 - SCHARA,GRACE N.

PATIENT:	SCHARA,GRACE N	**ACCT #:**	E39547554	**LOC:**	E.2-C	**U #:**	E000365038
		AGE/SX:	19/F	**ROOM:**	E.2029	**REG:**	10/07/21
REG DR:	BECK MD,DAVID	**STATUS:**	DIS INx	**BED:**	1	**DIS:**	10/13/21

Ascension Wisconsin* Consent for Treatment and Financial Agreement

PRIVACY NOTICE AND PATIENT RIGHTS

- I confirm that I received or was offered and declined a copy of the Notice of Privacy Practices. I know I can get more information about the uses of my medical record from that notice.
- I confirm that I received or was offered and declined a summary of the organization's financial assistance program.
- I confirm that I received or was offered and declined a copy of the Patient Rights and Responsibilities.
- I agree to let the facility or provider release information to other healthcare providers and school health offices through the Immunization Registry in the State of the Facility or provider.

ETHICAL & RELIGIOUS DIRECTIVES

I acknowledge that Ascension Wisconsin is a Catholic organization and provides all care in compliance with the Ethical and Religious Directives for Catholic Healthcare and that some services may not be provided at Ascension Wisconsin facilities.

TELEPHONE CONSUMER PROTECTION ACT

I authorize Hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me at any number I am providing or have previously provided orally or in writing, including my cell phone which could result in text/data charges to me and/or home phone or vOIP (voice over internet provider) using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication for any follow up purposes and to discuss any past, future or current services, including billing and collection of any past due amounts.

DOCUMENT CHANGES

I know that if I refuse to sign this form or make any changes to this form prior to non-emergent services performed it may keep me from getting the care and services.

DOCUMENT ACKNOWLEDGEMENT AND DURATION

- My signature indicates that I have read and understand the Consent to Treatment and Financial Agreement form.
- I understand that this agreement applies to all Ascension Wisconsin facilities and is valid for one year for treatment at the doctor's office (s) and for outpatient hospital services including radiology, laboratory, nutrition, cardiac diagnostic, respiratory, pulmonary, outpatient behavioral health, rehabilitation and oncology and with each episode of care for all other services including emergency room, inpatient, observation and surgical services including GI services.

Verbal consent per Grace due to COVID-19 — Patient/Legal guardian signature

10/6/21 — Date

14:27 — Time

Person signing on patient/s behalf/relationship

Date

Time

Relationship to patient

Signature of Face to Face Interpreter – **OR**
Signature of Designated Interpreter (per Waiver) – **OR**
Phone or Video Interpreter ID#

Printed Name/Affiliation

Date/Time

Patient unable or unwilling to sign form. Document reason: _____

*Ascension Wisconsin refers to all healthcare organizations wholly owned, controlled and/or managed indirectly or directly by Columbia St. Mary's, Inc., Ministry Health Care, Inc. or Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. or their successor organization.

Ascension Wisconsin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-462-4973.
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-462-4973.

Patient Identification Label

E39547554 19 F E000365030
SCHARA, GRACE N
10/06/21
920-788-0829
09/22/02

Ascension Wisconsin* Consent for Treatment and Financial Agreement

ASSIGNMENT & FINANCIAL AGREEMENT

- I assign to the facility or healthcare provider any payment for such services otherwise payable to me under a benefit plan through Medicare, Medicaid, an insurance carrier(s), an employer health plan(s) or any other third party payer(s) (each referred to as a "Plan").
- I allow my Plan (s) to send all payment directly to the billing facility or healthcare provider.
- Ascension Wisconsin will try to verify my Plan(s) coverage for services and obtain any approvals and authorization required by my Plan and shall notify me of any services it knows are not covered by the Plan.
- I understand that should my Plan deny payment for the services provided to me, I am ultimately responsible for paying the charges billed for the services, including co-pays, co-insurance, and deductibles charges consistent with any applicable, written contractual agreements between Ascension Wisconsin and my Plan and Ascension Wisconsin's patient financial assistance policies. I agree to cooperate with Ascension Wisconsin on any appeals of my payer's denials and authorize Ascension Wisconsin to be my representative on these appeals.
- I agree not to revoke this assignment and authorization without the facility's or healthcare provider's consent. If I receive payment directly from my Plan, it is my responsibility to forward it to Ascension Wisconsin within 30 days of receipt.
- I know that I am responsible for knowing the limitations of my Plan's benefit coverage. If my Plan determines that a service is not a covered benefit under the Plan or is experimental or investigational, I will be responsible for paying the charges billed by the facility or healthcare provider for the service. Ascension Wisconsin reserves the right to balance the bill for any services in which a payment is made by a Non-Network plan (i.e., there is no written contract between Ascension and patient's employer). I further acknowledge that, should the amount covered by my Plan(s) benefits be insufficient to cover the charges for the services rendered to me, I will be responsible for the payment of the difference.
- I agree that credit balances resulting from payments made by the patient or other sources may be applied to any account owed to the facility or healthcare provider by the same guarantor (me or my family).
- I understand that I may request an estimate of certain treatment costs prior to receipt of treatment by following directions posted online at the Ascension website https://healthcare.ascension.org.
- I understand Ascension offers a financial assistance program for patients who may not be able to pay for all of their medical expenses or need additional time to pay. If you would like more information, you are encouraged to contact the facility business office or on-line at https://healthcare.ascension.org.
- I understand that I should also expect to receive invoices from other healthcare providers who provided care to me, such as anesthesia, pathology and radiology which are billed separately from the facility.

COLLECTION & ASSIGNMENT

Should my account or any unpaid portion thereof be referred to an attorney for collection, I agree that I shall also be responsible for all reasonable attorney fees, including Ascension Wisconsin's attorney fees and personal attorney fees, and any other costs, fees or expenses incurred as a result of the collection process as allowed by Wisconsin law.

PATIENT'S CERTIFICATION/PAYMENT REQUEST

Patient's Certification/Payment Request under Title XVIII and Title XIX or the Social Security Act (Medicare/Medicaid):
I certify that the information given by me in applying for payment under the Title XVIII and Title XIX of the Social Security Act and Wisconsin's Medicaid Assistance law is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. As a Medicare inpatient, I acknowledge that I have received a copy of the "Important Message from Medicare/TRICARE." This authorization extends to the time when this or a related claim is paid or is finally denied.
I request that payment of authorized benefits be made on my behalf.

Patient Identification Label

2SEH0899

Ascension Wisconsin* Consent for Treatment and Financial Agreement

GENERAL CONSENT TO CARE

- I am coming for care and treatment. I agree to services including examinations, procedures, x-ray and lab services, tests and treatments, medication, monitoring, nursing care, counseling and education.
- I understand that some of the doctors and staff caring for me are not employed by the organization and the organization is not liable for any act or omission of such providers.
- I understand that for inpatient/observation services my primary care provider will be notified of the admission.
- I understand that if tissue or body parts are removed when I am in the hospital, the hospital or pathologists may use or dispose of the tissue or body parts at their discretion unless I disagree.
- I understand that electronic communication such as telemedicine may be used to help healthcare providers at different locations to participate in my care.
- I understand that some facilities participate in education and training programs and that I may receive healthcare services performed or observed by students/ trainees.
- I understand that the provision of healthcare is not an exact science and I acknowledge that no guarantees have been made to me as a result of examinations or treatments provided to me.

HOME HEALTH, MEDICAL EQUIPMENT

- In order to facilitate informed decisions about services available upon my discharge, I agree to have post-discharge care providers, including but not limited to home health agencies, involved in my discharge planning process.
- I understand my health information may be shared with post-discharge care providers to create a discharge plan for me. I understand that I am not obligated to select these providers or the services they offer.
- I understand that information about post-discharge care provider options will be provided to me should the need arise and it is my choice as to which provider I might use.

IMPORTANT INFORMATION:

- I know that I need to follow up with recommended care after I am discharged.
- I agree to notify the hospital or my doctor within 24 – 48 hours if I am canceling or rescheduling an appointment.
- I know that the facility may take pictures or video of me for my care and safety.
- If I have a baby, I agree for my baby to have pictures taken for security reasons.

ACCESS TO HEALTHCARE RECORDS

- I know that I may review my medical record during normal business hours upon reasonable notice.
- I know that I may get a copy of my medical record and I may be asked to pay for the copies.

VALUABLES (Hospitals only)

- I know I should not keep valuables such as money, jewelry, important papers, or dentures with me.
- I know that the facility has a safe place where valuables may be stored.
- I know that I keep my items at my own risk. I agree that the facility may not be liable for any loss or damage to valuables that I keep with me.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I agree that the facility and all healthcare providers participating in my treatment may release my health information to my insurers and other payers or other persons as necessary for billing, collection or payment of claims for services provided.

Patient Identification Label

Healthcare Power of Attorney
of
Grace N. Schara

E 39547554

I, Grace N. Schara, of Seymour, Outagamie County, Wisconsin, being of sound mind, intend by this document to create a Power of Attorney for Health Care, and hereby revoke all prior powers of attorney for health care. The person authorized to act on my behalf under this Power of Attorney for Health Care shall be referred to as my "Healthcare Agent" or simply as "Agent."

MY AGENT'S AUTHORITY IS EFFECTIVE IMMEDIATELY UPON MY SIGNING THIS DOCUMENT, AS PERMITTED IN WISCONSIN STATUTES SECTION 155.05(2). NO DETERMINATION OF INCAPACITY IS REQUIRED.

I want to leave my family, friends and those who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connections with decisions about my medical care, to promote family harmony and to clarify instructions to my health care providers. I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

Article One
Creation of Healthcare Power of Attorney

Section 1.01 Healthcare Power of Attorney

This document does not require activation. It is effective immediately upon signing by me. This Healthcare Power of Attorney shall remain in full force and effect until revoked in writing. Amendments shall be in writing by me personally (and not by my Agent) and shall be attached to the original of this document. This is a durable power, and my subsequent physical or mental disability, incapacity or incompetency shall not affect this power of attorney.

My Agent shall carry out my wishes despite any contrary feeling or opinions of my family, friends, conservator, trustee, or guardian. This document is made with knowledge that I can rely on the love and affection of my family and friends and with thankfulness that they will understand my reasons.

I reserve the right to remove my Agent's authority in writing.

2SEH0901

Section 1.02 Determination of Legal Capacity

A DETERMINATION OF MY INCAPACITY IS NOT REQUIRED FOR MY AGENT TO EXERCISE THE AUTHORITY GRANTED BY ME UNDER THIS HEALTHCARE POWER OF ATTORNEY. NO ACTIVATION IS REQUIRED.

Section 1.03 Designation of Healthcare Agent

I designate Cindy L. Schara to serve as my Healthcare Agent giving to my Healthcare Agent the power to make decisions with regard to my health care.

If my Agent is unwilling or unable to serve, is removed by me or is not available as determined by my health care provider, I designate the following as alternate Healthcare Agents to serve in the order in which their names appear to exercise the authority set forth in this Healthcare Power of Attorney.

Scott F. Schara

Jessica R. Vander Heiden

Levi Rocke

Section 1.04 My Agents are My HIPAA Personal Representatives

I appoint my Healthcare Agent and Successor Healthcare Agents to serve concurrently as my Personal Representatives pursuant to the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), and its regulations, 45 C.F.R. Sections 160 through 164 ("Health Insurance Portability and Accountability Act" or "HIPAA").

My Agents shall have the status, power, authority and rights to act immediately as my Personal Representative for all purposes provided in the Health Insurance Portability and Accountability Act. Therefore, I authorize any health care provider or entity covered by the Health Insurance Portability and Accountability Act, (including any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse) to give, disclose and release to my Agents, without restriction, any and all of my health information and medical records regarding any past, present, or future medical or mental health condition.

I intend that the authority given to my Agents pursuant to this Healthcare Power of Attorney shall supersede any prior agreement that I may have made with any health care provider to restrict access to or disclosure of my patient records and other protected health information that may be subject to and protected under the Health Insurance Portability and Accountability Act, and I hereby authorize my Agents to execute any and all authorizations, releases or other documents necessary to obtain disclosure.

The authority given to my Agents pursuant to this Healthcare Power of Attorney has no expiration date and shall not expire until revoked in writing in either a written document

signed by me, or a written document signed by my Agent, delivered to such individual or organization covered by the Health Insurance Portability and Accountability Act.

I authorize my Agent to appoint a Patient Advocate for me, who may be any person so designated by my Agent. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical conditions, treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

I have separately signed, on the same date as this Healthcare Power of Attorney, an Authorization for the release of my health care information under the provisions of the Health Insurance Portability and Accountability Act of 1996 authorizing the immediate release of my health care information to my Agent, even if the Agent is not yet acting as an Agent, so my health care decisions may be made by my Agent expeditiously and without the need to first prove my incapacity.

In the event my Authorization cannot be located, is by its own terms no longer in force or is otherwise deemed invalid or is not accepted, I hereby grant to my Agent the power and authority as my legal representative to sign a new Authorization naming my Agent and Successor Agents, even if not acting, as my Personal Representative, under HIPAA.

UNLESS I EXPRESSLY INSTRUCT OTHERWISE, MY PATIENT ADVOCATE, CAREGIVERS, CARE FACILITIES AND RESIDENCE FACILITIES SHALL GIVE INFORMATION ABOUT MY CONDITION AND WHEREABOUTS TO ONLY THOSE SPECIFICALLY IDENTIFIED ON MY AUTHORIZATION FOR RELEASE OF MY PROTECTED HEALTH INFORMATION. I OR MY AGENT WILL PROVIDE THIS DOCUMENT TO THE HEALTH CARE PROVIDER. MY AGENT AND PERSONAL REPRESENTATIVE MAY, AT THEIR DISCRETION, GIVE INFORMATION ABOUT MY CONDITION AND WHEREABOUTS TO ALL WHO INQUIRE.

I authorize my Agents and Personal Representatives to take any and all legal steps necessary to ensure compliance with my instructions to provide access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney fees against anyone who does not comply with this Healthcare Power of Attorney.

Article Two
My Healthcare Agent's Powers Regarding My Health Care

Section 2.01 Authority of My Healthcare Agent

My Agent is authorized to make all health care decisions for me, subject to my wishes and the limitations (if any) stated in this Healthcare Power of Attorney. My Agent has the authority to request and evaluate information concerning my medical diagnosis, prognosis, benefits or risks of the proposed health care, and alternatives to the proposed health care. My Agent shall consider the decision that I would have made if I had the ability to do so. If my Agent does not know my wishes regarding a specific health care decision, my Agent shall make a decision for me in accordance with what my Agent believes I would want under the circumstances. In determining what I would want done, my Agent shall consider my personal beliefs and basic values.

If I am unable to make health care decisions, my Agent should try to discuss with me any specific proposed health care. If I am unable to communicate in any manner, my Agent shall base his or her decisions on any health care choices previously expressed by me.

I request, but do not require, my Agent consult with my family if it is reasonably possible to do so before making a health care decision authorized under this agreement.

I authorize all health care facilities and health care providers who have treated, or may treat me, to release all records that my Agent may request. I waive all privileges that may be applicable to such records and to any communication pertaining to me made in the course of any confidential relationship recognized by law. My Agent may disclose my information as my Agent deems appropriate.

In order to carry out the directives of this document I authorize my Agent to:

act on my behalf concerning my medical care including, decisions concerning artificial life support, medical treatment, surgery and other medical procedures, artificial nutrition and hydration, resuscitation decisions (including directing or consenting to Do Not Resuscitate [DNR] orders and CPR directives), amputation of my limbs, blood transfusions, experimental drugs and medical procedures, the administration of pharmaceutical agents, and arrangements for my long-term care;

arrange for health care services, including the authority to select, employ, and discharge health care providers for my physical, mental and emotional well-being and to bind me to pay for such services and facilities;

arrange for home health care or make arrangements for me at any Health Care Facility and assure my needs are met;

revoke, withdraw, or modify consent to procedures, tests, and treatments, as well as home care or care in a Health Care Facility;

determine when medical procedures are no longer of benefit to me or that the benefits are outweighed by the burdens imposed;

give or withhold consent for any health care or medical treatment as long as health care for my comfort, dignity, and pain relief is provided;

call paramedics or other emergency medical personnel, or choose not to do so, as my Agent deems appropriate given my wishes and my medical status at the time;

make decisions regarding admission to or discharge from any Health Care Facility or service even against medical advice;

exercise my rights regarding health care or medical treatment even though the decision may be against conventional medical advice or hasten my death;

limit or restrict visits, although I desire that anyone who wants to visit me be allowed to do so, and

authorize or refuse an autopsy and direct the disposition of my remains.

Section 2.02 Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Agent, my Agent is instructed to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner, however rudimentary, even by blinking my eyes. My Agent is further instructed that if I am unable to give an informed consent to medical treatment, my Agent shall exercise judgment and be guided by the following:

the provisions of this Healthcare Power of Attorney;

any preferences that I may previously have expressed on the subject;

what my Agent believes I would want done in the circumstances if I were able to express myself; and

any information given to my Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

2SEH0905

Section 2.03 Keep Me Comfortable and Free of Pain

I authorize my Agent to order whatever is appropriate to keep me as comfortable and free of physical pain and mental anguish as is reasonably possible including, the administration of pain-relieving drugs, unconventional pain-relief therapies, and drugs and procedures that may not have been approved by the Food and Drug Administration. I realize such drugs or procedures may have adverse side effects including addiction, lower blood pressure, lower levels of breathing, and hastening the moment of (but not intentionally causing) my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

Section 2.04 Artificial Nutrition/Hydration

I authorize my Agent to determine whether artificial nutrition or hydration should be withheld or withdrawn. I request nutrition and hydration be provided in the amount and kind determined by my physician to be appropriate to prevent dehydration.

Section 2.05 Consent by Electronic Communications and Telecommunications

All health care providers are authorized to rely upon consent given by my Agent using electronic communications, telephonic communications (including telephone, emails, texts, facsimiles or any other form of communication). These instructions shall be documented in my medical records and, if requested, my Agent shall furnish written confirmation as soon as practical.

Section 2.06 Mental Health Treatment

I authorize my Agent to admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility, and a public or private treatment facility.

My Agent may consent to experimental mental health research, psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures.

Section 2.07 Admission to Care Facilities

I wish to avoid the inconvenience and expense of formal guardianship proceedings. To accomplish this purpose, my Agent is authorized to:

arrange for admission and establish my residency in a secure unit at a Care Facility within or beyond the State of Wisconsin; and

admit me for both short-term and for long term care including "protective placement."; and

facilitate my transportation to a Care Facility.

Section 2.08 Intent to Return Home

I intend to return home if I am ever in a Care Facility. I empower my Agent to convey that intention.

Article Three
My Agent's Power to Refuse Medical Treatment

Section 3.01 Terminal Condition, Permanent Coma or Severe Dementia

I wish to live and enjoy life as long as possible, but I also recognize that in some circumstances, medical treatment is futile. I direct that Feeding Tubes and Life-sustaining Procedures not be used to extend my life and that such procedures be withheld or withdrawn in the following circumstances:

if I have a Terminal Condition where Feeding Tubes and Life-sustaining Procedures only serve to postpone the moment of my death; or

if I suffer from Severe Dementia, Permanent Loss of Consciousness, or a condition from which I cannot be restored to a quality of life acceptable to me where Feeding Tubes and, Life-sustaining Procedures only serve to prolong my life.

In these circumstances, I also direct that unless required for my physical comfort, procedures used to provide nutrition and hydration not be instituted or be discontinued if previously instituted.

Section 3.02 This Healthcare Power of Attorney Governs When No Agent is Available

If no Agent is available to serve, I request that my desires, as stated in this Healthcare Power of Attorney, be honored.

Section 3.03 Living Will

I executed a Living Will. To the extent that any provisions of this Healthcare Power of Attorney are deemed to conflict with my Living Will, the provisions of my Healthcare Power of Attorney of Attorney shall prevail, and the decisions of my Healthcare Agent shall control.

If I become unconscious or incompetent in a state where my Living Will or this Healthcare Power of Attorney is not honored, I authorize my Healthcare Agent to transport me or

arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

Article Four
Hold Harmless and Enforcement

Section 4.01 Third Parties Held Harmless

Any person or entity attempting in good faith to carry out the provisions of this Healthcare Power of Attorney shall not be liable to me, my estate, or to my heirs for any damages or claims, and my estate shall defend and indemnify them, except for willful misconduct or gross negligence.

If this Healthcare Power of Attorney is revoked or amended, any party acting in good faith prior to receipt of written notice of termination or revocation shall be held harmless by me and my estate for any loss suffered or liability incurred.

Only my Agent can exercise these powers. Third Parties shall accept the direction of my Agent as being fully authorized by me, with the same force and effect as if I were personally present and acting on my own behalf.

No person acting in reliance upon any representation my Agent makes shall incur any liability to me or my estate for permitting him or her to exercise any such power, nor shall any person who deals with my Agent be responsible to determine or inquire into the scope of my Agent's authority.

Section 4.02 My Agent Held Harmless

My Agent and my Agent's estate are hereby released and forever discharged by me from liability and claims arising out of the acts or omissions of my Agent, except for willful misconduct or gross negligence.

Section 4.03 Enforcement

My Agent may take legal action to enforce this Healthcare Power of Attorney, and may demand damages, including punitive damages, for noncompliance.

Article Five
Miscellaneous Powers and Provisions

Section 5.01 Definitions

Artificial Nutrition or Hydration means food and fluids that are provided to me by artificial means such as a nasogastric tube or tube into the stomach, intestines or veins.

Care Facility means a Skilled Nursing Facility (SNF), Assisted Living Facility (ALF), Residential Care Apartment Complex (RCAC), Community Based Residential Care Facility (CBRF), Continuum of Care Residential Facility (CCRF), Senior Housing Unit, Memory Care Facility, Drug, Alcohol or any type of Addictive Rehabilitation Facility or similar facility.

Feeding Tubes means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

Health Care Facility means a Care Facility and a Hospital, Hospice, Medical Clinic, Doctors Office, Chiropractor, Alternative Medicine Facility, Community Based Care Facility or any Similar Facility.

Health Care means all medical treatment, the provision, withholding or withdrawal of any health care or medical procedure, or service to maintain, diagnose, treat or provide for a patient's physical or mental health or personal care, unless such authority is otherwise limited by this document.

Health Care Decision means an informed decision to accept, maintain, discontinue or refuse any care, treatment, intervention, service or procedure to maintain, diagnose or treat my physical or mental condition, subject to any statement of my desires and any limitations included in this document.

Life-sustaining Procedure means any medical procedure or intervention that, in the judgement of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient. "Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis or other similar procedures, but does not include:

the alleviation of pain by administering medication; or

by performing any medical procedure; or

the provision of nutrition or hydration.

Permanent Coma or **Permanent Loss of Consciousness** means that I am not conscious and am not aware of my environment, show no behavioral response, am not able to interact with others, and there is no reasonable expectation of recovery. Permanent Coma or

Permanent Loss of Consciousness include, but are not limited to, a persistent vegetative state.

Severe Dementia means I have been diagnosed with dementia from which I cannot be expected to improve, and my condition has progressed to the point where I am unable to recognize my loved ones, or I am delusional or unresponsive on most occasions.

Terminal Condition means an incurable condition caused by an injury or illness that reasonable medical judgement finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

Section 5.02 Photocopies

My Healthcare Agent is authorized to make photocopies and electronic and other facsimiles of this Healthcare Power of Attorney, which shall have the full force and effect of an original.

Section 5.03 Signing Documents, Waivers and Releases

My Agent is authorized to sign any necessary documents, waivers and releases.

Section 5.04 Reimbursement of Costs

My Agent shall be entitled to reimbursement for all reasonable expenses incurred while serving as my Healthcare Agent, however my Agent shall not be entitled to compensation for services.

Section 5.05 Resignation of My Agent

Any Agent may resign by written notice delivered to me or, to the trustee of my revocable living trust, or to my agent under any power of attorney.

If my spouse has been appointed my Agent and after signing this document an action is filed to dissolve our marriage, then the filing of such action shall automatically and immediately remove my spouse as my Agent.

Section 5.06 Severability

If any provision in this document is declared by a court of competent jurisdiction to be invalid for any reason, then insofar as reasonable and possible:

the remainder of the Agreement and the application of such provision to other persons or circumstances shall not be affected, but shall be considered valid, operative, and enforceable to the maximum extent possible under law; and

effect shall be given to the intent manifested by the portion held invalid or inoperative.

Section 5.07 Valid in Any Jurisdiction

This Healthcare Power of Attorney is intended to be valid in any jurisdiction in which it is presented.

Section 5.08 Effective Date

This Healthcare Power of Attorney takes effect upon signing. No certificate of incapacity is required to activate this Healthcare Power of Attorney.

Signature of Principal

I have read and understand the contents of this Healthcare Power of Attorney. I am emotionally and mentally competent to make this declaration. It is my intention that this document be honored by my family and health care providers as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from such refusal. I do not intend any direct taking of my life; but only that my dying not be unreasonably prolonged. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, rather, only to permit the natural process of dying. I have voluntarily signed this Healthcare Power of Attorney. I direct that photographic or facsimile copies of this document be made which shall have the same force and effect as the original. I authorize release of copies of this document to my health care providers.

I AM AWARE THAT BY SIGNING THIS DOCUMENT I HAVE AUTHORIZED MY AGENTS TO HAVE IMMEDIATE ACCESS TO MY HEALTH CARE INFORMATION UNLESS THIS HEALTHCARE POWER OF ATTORNEY IS REVOKED.

Dated: September 23, 2020

Grace Schara

Grace N. Schara, Principal

2SEH0911

Statement of Witnesses

I know Grace N. Schara personally and I believe her to be of sound mind and at least 18 years of age. I believe that her execution of this Healthcare Power of Attorney is voluntary. I am at least 18 years of age, and am not related to Grace N. Schara by blood, marriage or adoption and am not directly financially responsible for Grace N. Schara's health care. I am not a health care provider who is serving Grace N. Schara at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which Grace N. Schara is a patient. I am not Grace N. Schara's Healthcare Agent. To the best of my knowledge, I am not entitled to and do not have a claim on Grace N. Schara's estate.

Cindy Borowski, Witness
2 N Systems Drive
Appleton, Wisconsin 54914

Dated: September 23, 2020

Kimberly A. Eichhorn, Witness
2 N Systems Drive
Appleton, Wisconsin 54914

Dated: September 23, 2020

Certificate of Attorney at Law

I am a lawyer authorized to practice law in Wisconsin. I have advised Grace N. Schara concerning her rights in connection with this Healthcare Power of Attorney and the applicable law.

Sarah J. Kons, Attorney at Law

Authorization for Release of Grace N. Schara's Protected Health Information

(Valid Authorization Under 45 CFR Chapter 164)

Statement of Intent: It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits use, disclosure or release of my "individually identifiable health information," as HIPAA and the supporting Regulations define that phrase. I am signing this Authorization because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization to allow them to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care when I otherwise may not be able to do so without regard to whether any health care provider has certified in writing that I am incompetent for purposes of HIPAA.

1. Appointment of Authorized Recipients

I, Grace N. Schara, an individual, hereby appoint the following persons or entities, or any of them, as Authorized Recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

Scott F. Schara

Cindy L. Schara

Jessica R. Vander Heiden

Daniel N. Holbrock

P. Steven Barnett

Levi Rocke

Sarah Rocke

Bonnie Boehm

Adam Vander Heiden

the Trustee or Successor Trustee of any trust of which I am a beneficiary or a trustee, for the sole specific purpose of determining my capacity as defined in the trust agreement; and

the staff and attorneys at, Hooper Law Office, LLC, for the limited purposes of determining my capacity to make gifts, to execute estate planning documents and whether, and to what extent, a guardianship, conservatorship or other protective proceeding for me is necessary or desirable.

2. Grant of Authority

I authorize all my "covered entities" (as defined by HIPAA) to use, release and disclose my individually identifiable health information to my Authorized Recipients in accordance with and as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528, including but not limited to, medical reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care except as specifically limited as to any Authorized Recipient named in Paragraph 1 above.

This disclosure includes the ability to ask questions and discuss my individually identifiable health information with the person or entity that has possession of my individually identifiable health information even if I am fully competent to ask questions and discuss this matter at the time.

It is my intention to give a full authorization for access to, disclosure, and release of ANY individually identifiable health information by or to the persons named in this Authorization as if each person were me.

3. Covered Entities

"Covered entities" means those entities specifically defined by HIPAA or the supporting Regulations including, but not limited to, any physician, podiatrist, chiropractor, osteopathic physician, health-care professional, dentist, hospital, clinic, laboratory, pharmacy, ambulance service, assisted living facility, nursing home or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services.

4. Termination

My subsequent disability or incapacity will neither affect nor terminate this Authorization. This Authorization will terminate 6 months following my death or upon my written revocation expressly referring to this Authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. Such revocation is effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it.

5. Re-disclosure

By signing this Authorization, I acknowledge that the information used, disclosed, or released pursuant to this Authorization may be subject to re-disclosure by an Authorized Recipient and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity may require an Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

6. Instructions to the Authorized Recipient

An Authorized Recipient may bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, an Authorized Recipient is authorized to sign any documents that the Authorized Recipient deems appropriate to obtain use, disclosure, or release of my individually identifiable health information.

7. Effect of Duplicate Originals or Copies

If I have executed this Authorization in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Recipient may make photocopies (photocopies shall include: facsimiles and digital or other reproductions, hereafter referred to collectively as "photocopy") of this Authorization and each photocopy will have the same force and effect as the original.

8. My Waiver and Release

With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my individually identifiable health information in reliance upon this Authorization and for any actions taken by an Authorized Recipient.

9. Severability

I intend that this authorization conform to United States and Wisconsin law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

Dated: September 23, 2020

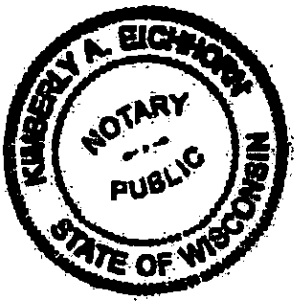
Grace Schara xoxo♡

Grace N. Schara, Principal
DOB: September 22, 2002

STATE OF WISCONSIN)
) ss.
COUNTY OUTAGAMIE)

This instrument was acknowledged before me by Grace N. Schara, as Principal on this September 23, 2020.

[Seal]



Kimberly A. Eichhorn, Notary Public
My commission expires July 4, 2021

I have personally examined Grace Schara and in my opinion, he/she is unable to receive and evaluate information effectively or to communicate decisions to such an extent that he/she lacks the capacity to manage his or her health care decisions.

Health care decisions means informed decisions in which this individual exercises his/her right to accept, maintain, discontinue and refuse care, treatment, service or procedure to maintain, diagnose or treat his/her physical or mental condition.

10/8/21 — Date of Examination
1730 — Time
KBaum — Signature of Physician
Karl Baum MD — Printed Name of Physician

10/8/21 — Date of Examination
22:15 — Time
B — Signature of Second Physician or of Psychologist
David Beck — Printed Name of Second Physician or of Psychologist

NOTE TO STAFF: The revocation section must be completed when the patient regains capacity for decision making.

REVOCATION OF CERTIFICATION OF INCAPACITY

_____, who was found to be incapacitated as above, has as of _____.
(Name of Patient) (Date)
regained his or her ability to make his or her own medical decisions and accordingly, the previous finding of incapacity as stated above is revoked.

Date — Time — Signature of Physician

Printed Name of Physician

Date — Time — Signature of Second Physician or of Psychologist

Printed Name of Second Physician or of Psychologist

Reference: Wisconsin Act 200, Chapter 155.05 (2)

Affinity HEALTH SYSTEM
- ☐ Affinity Medical Group
- ☐ Affinity Occupational Health
- ☐ Calumet Medical Center
- ☐ Mercy Medical Center
- ☐ Network Health Plan
- ☒ St. Elizabeth Hospital
- ☐ Surgery Center
- ☐ _____

STATEMENT OF INCAPACITATION

10/97

Patient Identification

E39547554 19 F
SCHARA,GRACE N

E000365038
BECK MD,DAVID
NORDSTROM MD,MARY E
ADM 10/07/21 E.2029-1
920-788-0829
DOB 09/22/02

MR

Adult ADM intake Assess 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Adult Admission Intake Assessment

Ht-Ft: 4 **In:** 8 **Cm:**
Wt-Lbs: 185 **Kg:** 84 **BMI:** .00
Patient admitted from: Emergency Department
Name of Transfer/Other Facility:
Reason for Visit: COVID
Information obtained from:
Unable to Obtain Info Due To:
Do you want family notified of your admission?
Name of person notified:
Do you want your primary care provider notified of your admission? Y
List name/method of contact: DR NORDSTROM AT ST ELIZABETHS
Primary Support Person(s): SCOTT - DAD
Patient's preferred name:
Do you think of yourself as:
Describe other sexual orientation:
What is your current gender identity?
Describe other gender identity:
Preferred communication method:
Preferred written language for discussing healthcare: English eng
Preferred verbal language for discussing healthcare: English eng
Is interpretation needed?
Interpreter Services Declined Reason:

Sensory Deficits:	Sensory Devices Needed:	Sensory Devices At Bedside:
Vision Impaired	Glasses	Glasses

Surgical and Hospitalization Hx: NO
[Pertinent &/or within the last year]
Implanted or Applied Medical Device: None
Enrolled in clinical trial: No
Type:
Other:
Enrolled in Palliative Care: N
Advance Directives: NA
Would you like additional information about AD:
Location:
Travel Associated Infectious Disease Screen:
Have you traveled recently: No
Where:
Do you have any of the following symptoms? Cough
Fatigue
Fever
Respiratory Illness
Shortness of Breath
Weakness
General Infectious Disease Screen:
Have you been exposed to someone with a suspected infectious disease within the past 3 weeks: Yes
(i.e. Tuberculosis (TB), Ebola, Influenza, Pertussis, Measles, Mumps, Chicken Pox, etc.)
If Yes, what disease have you recently been exposed to: COVID

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Communicable Disease History:
CDIFF: N
MRSA: N
MDRO (Multi-Drug Resistant Organism): N
VRE (Vancomycin-Resistant Enterococcus): N
CRE (Carbapenem-Resistant Enterobacteriaceae): N
****If BOTH active infection that cannot be contained by dressing AND if Hx of MRSA, VRE or MDRO then initiate Contact Precautions. If patient has a history of or an active infection of CRE then initiate Contact Precautions for every admission****
Influenza Vaccine Date (Mo/Yr): N
Tetanus Date:
COVID-19 Vaccine
Vaccine #1 Received: N **Date:**
Vaccine #2 Received: **Date:**
Vaccine #3 Received: **Date:**
Vaccine Booster Received: **Date:**
Vaccine Manufacturer:
Is pt pregnant? NO **Lactating:**
Malnutrition Screening Tool [MST]
Have you lost weight recently WITHOUT trying: No
Have you been eating poorly b/c of decreased appetite: No
Malnutrition Screening Tool (MST) Score: 0
Risk: Not at risk
MST of 0-1 = Not at Risk MST of 2 or more = At Risk

Tobacco Use:	**Tobacco Type:**	**Patient age 13 & older: Smoker status:**	No
Smokeless Tobacco Use:	**Smokeless Tobacco Type:**	**Smokeless Tobacco Frequency:**	No
E-Cig/Vape Use:	**E-Cig/Vape Type:**	**E-Cig/Vape Frequency:**	No
Substance Use:	**Substance Type:**	**Substance Frequency:**	No
Alcohol Use:	**Alcohol Type:**	**Alcohol Frequency:**	No

Pt feels they are/have been abused, neglected, or exploited:
**** Columbia Suicide Severity Rating Scale (C-SSRS) **** **[SHIFT F8] for reference text**
Begin questions 1-5 with: 'In the past month...' (If asking caregiver, reframe question)
******Patients 12 and up:**
1. Wish to be Dead: Have you wished you were dead or wished you could go to sleep and not wake up?
2. Suicidal Thoughts: Have you actually had any thoughts of killing yourself?
****If YES to 2, ask questions 3,4,5 and 6. If NO to 2, go directly to question 6****
3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Have you been thinking about how you might do this?
4. Suicidal Intent (without Specific Plan): Have you had some intention of acting on them?
5. Suicidal Intent with Specific Plan: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Suicidal Behavior Lifetime Question

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

a. Have you ever done anything, started to do anything or prepared to do anything to end your life?
b. If 6a = Yes, was this in the past 3 months?
C-SSRS Score : [SHIFT F8] for reference based on score
Religious preference: Religious restrictions:

Spiritual/cultural concerns or practices: Describe:
Support system in place:
Learning style preferred by patient:
Barriers to learning:
Patient's Discharge Goal:
Pt would like to speak to someone regarding concerns /services:
Community Agencies being used:
Advised to send valuables home w/family:
Intake reviewed for accuracy & completion this admission?

Occurred Date: 10/07/21 Occurred Time: 0305
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

Adult ADM intake Assess 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Adult Admission Intake Assessment

Ht-Ft: 4 **In:** 8 **Cm:**
Wt-Lbs: 185 **Kg:** 84 **BMI:**
Patient admitted from: Emergency Department
Name of Transfer/Other Facility:
Reason for Visit: COVID
Information obtained from:
Unable to Obtain Info Due To:
Do you want family notified of your admission?
Name of person notified:
Do you want your primary care provider notified of your admission? Y
List name/method of contact: DR NORDSTROM AT ST ELIZABETHS
Primary Support Person(s): SCOTT - DAD
Patient's preferred name:
Do you think of yourself as:
Describe other sexual orientation:
What is your current gender identity?
Describe other gender identity:
Preferred communication method:
Preferred written language for discussing healthcare: English eng
Preferred verbal language for discussing healthcare: English eng
Is interpretation needed?
Interpreter Services Declined Reason:

Sensory Deficits:	Sensory Devices Needed:	Sensory Devices At Bedside:
Vision Impaired	Glasses	Glasses

Surgical and Hospitalization Hx: NO
[Pertinent &/or within the last year]
Implanted or Applied Medical Device: None
Enrolled in clinical trial: No
Type:
Other:
Enrolled in Palliative Care: N
Advance Directives: NA
Would you like additional information about AD:
Location:
Travel Associated Infectious Disease Screen:
Have you traveled recently: No
Where:
Do you have any of the following symptoms? Cough
Fatigue
Fever
Respiratory Illness
Shortness of Breath
Weakness
General Infectious Disease Screen:
Have you been exposed to someone with a suspected infectious disease within the past 3 weeks: Yes
(i.e. Tuberculosis (TB), Ebola, Influenza, Pertussis, Measles, Mumps, Chicken Pox, etc.)
If Yes, what disease have you recently been exposed to: COVID

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Communicable Disease History:
CDIFF: N
MRSA: N
MDRO (Multi-Drug Resistant Organism): N
VRE (Vancomycin-Resistant Enterococcus): N
CRE (Carbapenem-Resistant Enterobacteriaceae): N
****If BOTH active infection that cannot be contained by dressing AND if Hx of MRSA, VRE or MDRO then initiate Contact Precautions. If patient has a history of or an active infection of CRE then initiate Contact Precautions for every admission****
Influenza Vaccine Date (Mo/Yr): N
Tetanus Date:
COVID-19 Vaccine
Vaccine #1 Received: N **Date:**
Vaccine #2 Received: **Date:**
Vaccine #3 Received: **Date:**
Vaccine Booster Received: **Date:**
Vaccine Manufacturer:
Is pt pregnant? NO **Lactating:**
Malnutrition Screening Tool [MST]
Have you lost weight recently WITHOUT trying: No
Have you been eating poorly b/c of decreased appetite: No
Malnutrition Screening Tool (MST) Score: 0
Risk: Not at risk
MST of 0-1 = Not at Risk MST of 2 or more = At Risk

Tobacco Use:	**Tobacco Type:**	**Patient age 13 & older: Smoker status:**	No
Smokeless Tobacco Use:	**Smokeless Tobacco Type:**	**Smokeless Tobacco Frequency:**	No
E-Cig/Vape Use:	**E-Cig/Vape Type:**	**E-Cig/Vape Frequency:**	No
Substance Use:	**Substance Type:**	**Substance Frequency:**	No
Alcohol Use:	**Alcohol Type:**	**Alcohol Frequency:**	No

Pt feels they are/have been abused, neglected, or exploited:
**** Columbia Suicide Severity Rating Scale (C-SSRS) **** **[SHIFT F8] for reference text**
Begin questions 1-5 with: 'In the past month...' (If asking caregiver, reframe question)
******Patients 12 and up:**
1. Wish to be Dead: Have you wished you were dead or wished you could go to sleep and not wake up?
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4. Suicidal Intent (without Specific Plan): Have you had some intention of acting on them?
5. Suicidal Intent with Specific Plan: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Suicidal Behavior Lifetime Question

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

a. Have you ever done anything, started to do anything or prepared to do anything to end your life?
b. If 6a = Yes, was this in the past 3 months?
C-SSRS Score : [SHIFT F8] for reference based on score
Religious preference: Religious restrictions:

Spiritual/cultural concerns or practices: Describe:
Support system in place:
Learning style preferred by patient:
Barriers to learning:
Patient's Discharge Goal:
Pt would like to speak to someone regarding concerns /services:
Community Agencies being used:
Advised to send valuables home w/family:
Intake reviewed for accuracy & completion this admission?

Occurred Date: 10/07/21 Occurred Time: 0113
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT

Check if patient has difficulty with:
Problem(s): Y **Balance/coordination:** **Walking:** **Stairs:**
Arm Function: **Leg Function:** **Strength/Endurance:** **Sensation:**
Short of breath with activity: Y
Problem(s): N **Eating:** **Swallowing:**
Dressing: **Bathing/grooming:**
Problem(s): N **Speech or communication impairment:**
Understands requests/directions: **Memory:** **Hearing:**
Comment: PT HAS DOWN SYNDROME. COGNITIVE AS 11-12 YR OLD
****Functional assessment indicators can be viewed by clicking blue ? on toolbar or pressing shift <F8>****
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE
2. Therapy Screening Request due to functional impairments identified: N
If NO & functional impairments identified, state reason:
Cardiac Rehab Referral: No Referral
Comments:

PAIN ASSESSMENT

Current pain: N **Time of onset:** **Location:**
(Acute)
Describe pain: **Pain caused by:**
Pain interferes with activities:
Chronic pain: N **Location:**
Describe pain: **Obtains relief w/:**
Short-term pain relief goal during hospitalization:
Tolerable pain level (0-10):
Comments:

SAFETY

Is patient of small size or stature and at risk for side rail entrapment: N
Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N
Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift
Does patient verbalize or exhibit intent to leave facility: N
Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)
History of wandering &/or elopement from any setting: N
Does the patient demonstrate any of the following behaviors: N
Agitation: **Verbal or physical aggressive behavior:** **Aimless wandering:** **Pacing:**
Does the patient exhibit any of the following NEW behaviors or status changes: N

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:
***Patients who are on legal hold as outlined below are automatically considered at risk for elopement:** **Court commitment** **Resident of mental health facility**
Known outstanding warrant **Federal, State or Local inmate**
Legal detention or 72 hour hold **History of elopement/wandering**
Family/responsible party voices concerns **Suicide attempt**
Initiate Elopement Risk Precautions intervention: N **(Check all that apply):**
Wander gaurd: **Bed alarm:** **Chair alarm:** **Video monitoring:**
1:1 **Pt in hospital gown:** **Frequent checks:**
If NO, state reason:
Comments:
ADMISSION PRESSURE ULCER ASSESSMENT
Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission: Y
If not assessed, document reason:
Pressure ulcers present on admission: N ***If yes, document on pressure ulcer intervention.**
4 Eye Assessment Complete? Y **Comments** RED BUMPS IN GROIN AREA
Pre-admission Treatment:
If patient is a Diabetic Initiate Hypoglycemia intervention:
Comments:
******MORSE FALL SCALE****** **[SHIFT F8] to view scoring**

History of Fall:	**Has the patient fallen recently or within the last three months?**	No-0	**Score:** 0
Secondary Diagnosis:	**Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP**	Yes-15	**Score:** 15
Use of Ambulatory Aid:	**Does the patient use any of the following to assist with ambulation?**	None, bedrest, uses W/C	**Score:** 0
IV or IV Lock:	**Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?**	Yes	**Score:** 20
Gait-Transferring:	**([SHIFT/F8] for gait definitions)**	Normal, or Immobile-0	**Score:** 0
Mental Status:	**To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'**	Forgets Limitations	**Score:** 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 **Morse Fall Risk Score:** 50

Occurred Date: 10/07/21 Occurred Time: 0306
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT
Check if patient has difficulty with:
Problem(s): Y **Balance/coordination:** **Walking:** **Stairs:**
Arm Function: **Leg Function:** **Strength/Endurance:** **Sensation:**
Short of breath with activity: Y
Problem(s): N **Eating:** **Swallowing:**
Dressing: **Bathing/grooming:**
Problem(s): N **Speech or communication impairment:**
Understands requests/directions: **Memory:** **Hearing:**
Comment:
****Functional assessment indicators can be viewed by clicking blue ? on toolbar or pressing shift <F8>****
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE
2. Therapy Screening Request due to functional impairments identified: N
If NO & functional impairments identified, state reason:
Cardiac Rehab Referral: No Referral
Comments:

PAIN ASSESSMENT
Current pain: N **Time of onset:** **Location:**
(Acute)
Describe pain: **Pain caused by:**
Pain interferes with activities:
Chronic pain: N **Location:**
Describe pain: **Obtains relief w/:**
Short-term pain relief goal during hospitalization:
Tolerable pain level (0-10):
Comments:

SAFETY
Is patient of small size or stature and at risk for side rail entrapment: N
Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N
Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift
Does patient verbalize or exhibit intent to leave facility: N
Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)
History of wandering &/or elopement from any setting: N
Does the patient demonstrate any of the following behaviors: N
Agitation: **Verbal or physical aggressive behavior:** **Aimless wandering:** **Pacing:**
Does the patient exhibit any of the following NEW behaviors or status changes: N

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:
***Patients who are on legal hold as outlined below are automatically considered at risk for elopement:** **Court commitment** **Resident of mental health facility**
Known outstanding warrant **Federal, State or Local inmate**
Legal detention or 72 hour hold **History of elopement/wandering**
Family/responsible party voices concerns **Suicide attempt**
Initiate Elopement Risk Precautions intervention: N **(Check all that apply):**
Wander gaurd: **Bed alarm:** **Chair alarm:** **Video monitoring:**
1:1 **Pt in hospital gown:** **Frequent checks:**
If NO, state reason:
Comments:
ADMISSION PRESSURE ULCER ASSESSMENT
Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission:
If not assessed, document reason:
Pressure ulcers present on admission: ***If yes, document on pressure ulcer intervention.**
4 Eye Assessment Complete? **Comments**
Pre-admission Treatment:
If patient is a Diabetic Initiate Hypoglycemia intervention:
Comments:

******MORSE FALL SCALE****** **[SHIFT F8] to view scoring**

History of Fall:	**Has the patient fallen recently or within the last three months?**	No-0	**Score:** 0
Secondary Diagnosis:	**Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP**	Yes-15	**Score:** 15
Use of Ambulatory Aid:	**Does the patient use any of the following to assist with ambulation?**	None, bedrest, uses W/C	**Score:** 0
IV or IV Lock:	**Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?**	Yes	**Score:** 20
Gait-Transferring:	**([SHIFT/F8] for gait definitions)**	Normal, or Immobile-0	**Score:** 0
Mental Status:	**To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'**	Forgets Limitations	**Score:** 15

Scoring Risk Levels [SHIFT/F8]: High Risk >44 **Morse Fall Risk Score:** 50

Occurred Date: 10/07/21 Occurred Time: 0303
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Adult Admission B Screen Assessment

FUNCTIONAL ASSESSMENT
Check if patient has difficulty with:
Problem(s): Y **Balance/coordination:** **Walking:** **Stairs:**
Arm Function: **Leg Function:** **Strength/Endurance:** **Sensation:**
Short of breath with activity: Y
Problem(s): N **Eating:** **Swallowing:**
Dressing: **Bathing/grooming:**
Problem(s): N **Speech or communication impairment:**
Understands requests/directions: **Memory:** **Hearing:**
Comment:
****Functional assessment indicators can be viewed by clicking blue ? on toolbar or pressing shift <F8>****
If impairments are identified: 1. Obtain/request Physician Order for PT eval, OT eval, Speech Pathology eval, Recreational Therapy eval,Physician Consult for Inpt Rehab Program OR IF UNSURE
2. Therapy Screening Request due to functional impairments identified: N
If NO & functional impairments identified, state reason:
Cardiac Rehab Referral: No Referral
Comments:

PAIN ASSESSMENT
Current pain: N **Time of onset:** **Location:**
(Acute)
Describe pain: **Pain caused by:**
Pain interferes with activities:
Chronic pain: N **Location:**
Describe pain: **Obtains relief w/:**
Short-term pain relief goal during hospitalization:
Tolerable pain level (0-10):
Comments:

SAFETY
Is patient of small size or stature and at risk for side rail entrapment: N
Patient moving with no rational purpose, oblivious to need for safety, or displayed a history of wandering in the last 6 months: N
Is patient mobile: Y
If patient is mobile & YES is answered to any of the following questions, initiate elopement precautions & document every shift
Does patient verbalize or exhibit intent to leave facility: N
Does patient exhibit any the following conditions: N
Confusion, dementia, &/or disorientation:
Current alcohol abuse:
Current drug abuse:
Current Psychiatric conditions:
(ie. impaired thought process R/t schizophrenia, borderline personality disorder, anxiety, or antisocial behavior)
History of wandering &/or elopement from any setting: N
Does the patient demonstrate any of the following behaviors: N
Agitation: **Verbal or physical aggressive behavior:** **Aimless wandering:** **Pacing:**
Does the patient exhibit any of the following NEW behaviors or status changes: N

Adult ADM B Assessment 7/21

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Abnormal verbalizations:
Emotional lablity:
Attention changes (hyper vigilance or hypoactive):
Changes in mentation or altered mentation:
Abnormal appearance such as inappropriate dress:
Other:
***Patients who are on legal hold as outlined below are automatically considered at risk**
for elopement: Court commitment **Resident of mental health facility**
Known outstanding warrant **Federal, State or Local inmate**
Legal detention or 72 hour hold **History of elopement/wandering**
Family/responsible party voices concerns **Suicide attempt**
Initiate Elopement Risk Precautions intervention: N **(Check all that apply):**
Wander gaurd: **Bed alarm:** **Chair alarm:** **Video monitoring:**
1:1 **Pt in hospital gown:** **Frequent checks:**
If NO, state reason:
Comments:
ADMISSION PRESSURE ULCER ASSESSMENT
Heels, hips, elbows, ischiums, sacrum, coccyx, ears, vertebral column, occiput, scapula assessed on admission:
If not assessed, document reason:
Pressure ulcers present on admission: ***If yes, document on pressure ulcer intervention.**
4 Eye Assessment Complete? **Comments**
Pre-admission Treatment:
If patient is a Diabetic Initiate Hypoglycemia intervention:
Comments:
******MORSE FALL SCALE****** **[SHIFT F8] to view scoring**
History of Fall: **Has the patient fallen recently or within the last three months?** **Score:**
Secondary Diagnosis: **Does the patient have >1 diagnosis? consider factors that may increase risk of falls ie dementia, dizziness, frequent urination, low BP** **Score:**
Use of Ambulatory Aid: **Does the patient use any of the following to assist with ambulation?** **Score:**
IV or IV Lock: **Does the patient have continuous, intermittent or heparin/saline lock present or is attached to equipment?** **Score:**
Gait-Transferring: **([SHIFT/F8] for gait definitions)** **Score:**
Mental Status: **To test mental status ask the patient 'Are you able to go to the bathroom alone or do you need assistance?'** **Score:**
Scoring Risk Levels [SHIFT/F8]: **Morse Fall Risk Score:**

Occurred Date: 10/07/21 Occurred Time: 0123
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

COVID Screening

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Is pt able to be assessed? Y
Have you recently tested positive for COVID-19? Y
If so, was the test done more than 14 days ago? N
Are you still having symptoms of COVID-19? Y
Have you had a recent known exposure to COVID-19?
(defined as un-masked close contact, less than 6 ft. for greater than 15 minutes with an individual with confirmed or suspected case of COVID-19)
Have you had a fever >99.5 (37.5 Celsius), NEW or CHANGING cough, shortness of breath, nasal drainage/congestion or sore throat?
Do you have a NEW loss of taste or smell?
Are you experiencing extreme fatigue, muscle/body aches or headache, more frequent than normal?
Have you had nausea/vomiting or diarrhea, more frequent than normal?
Is pt suspect for COVID-19? Pt is suspect for COVID19
Have you received a COVID-19 vaccination? No
Have you had a COVID-19 Vaccine in the last 7-days?
Was this COVID-19 vaccine your?

Occurred Date: 10/07/21
Occurred Time: 0127
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

SEPSIS SCREENING TOOL 6/20

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

SEPSIS SCREENING TOOL

1. Is the patient's history suggestive of an infection? Y

****To view possible options to consider, use blue ? on tool bar or shift F8**

2. SIRS - Systemic Inflammatory Response Syndrome

SIRS Criteria: Are any two of following signs & symptoms of infection both present AND NEW to the patient? N

Hyperthermia > 38 C (100.4F) or Hypothermia < 36 C (96.8F)?	N	**T:**	97.4		
Tachycardia > 90 beats per minute?	N	**P:**	59		
Tachypnea > 20 breaths per minute?	N	**R:**	18		
PaCO2 < 32mmHG?	N	**PaCO2:**		**Date:**	
WBC < 4.0 x 1000 or > 12.0 x 1000 or		**WBC:**	3.5	**Date:**	10/06/21 1212
Bands > 10%? Y		**Bands:**		**Date:**	

3. Signs of Organ Dysfunction (excluding chronic conditions)

Are ANY of the following organ dysfunction criteria present? Y

Acute respiratory failure:					
- NEW non-invasive ventilation (BiPAP)?	Y				
- invasive ventilation?	N				
Urine output < 0.5 ml/kg/hour for > 2 hours?					
Systolic BP decrease > 40 mmHg from baseline?					
Systolic BP < 90 mmHg?	N	**BP:**	99/58		
MAP < 65 mmHg?	N	**MAP:**	71		
Bilirubin > 2 mg/dL?	N	**Bilirubin:**	0.3	**Date:**	10/06/21 1658
Platelet count < 100 x 1000?	N	**Platelets:**	149	**Date:**	10/06/21 1212
Lactate > 2 mmol/L?	N	**Lactate:**		**Date:**	
Creatinine:					
- > 2.0 mg/dL?	N	**Creatinine:**	1.40	**Date:**	10/06/21 1211
- increase > 0.5 above baseline for CKD?					
Coagulopathy - for patients NOT on warfarin					
- INR > 1.5?	N	**INR:**		**Date:**	
- aPTT > 60 secs?	N	**APTT:**		**Date:**	

4. Mortality Screening: qSOFA = Quick Sepsis Organ-Related Failure Assessment

qSOFA score: How many of the following signs & symptoms are present? 1

Altered Mental Status?
Tachypnea > 22/min N
Systolic BP < 100 mmHg? Y

qSOFA >= 2 is a positive score and reflects increased mortality risk

5. Screening suggestive of:

Infection	Y	
Sepsis	N	**Infection + 2 SIRS Criteria**
Severe Sepsis	N	**Infection + 2 SIRS Criteria + 1 Organ Dysfunction Criteria**
Septic Shock	N	**Sepsis characterized by unresponsive hypotension and lactic acidosis (lactate > 2 mmol/L) requiring vasopressor therapy to maintain MAP > 65 mmHg despite adequate fluid resuscitation**
Mortality Risk	N	**qSOFA >= 2 reflects increased mortality risk**

Comments:

RN: notify provider of any positive screening results, concerns or uncertainty
Provider determines the diagnosis and subsequent orders
If provider does not respond and patient deteriorates, call a Rapid Response

SEPSIS SCREENING TOOL 6/20

Patient: SCHARA,GRACE N
Account #: E39547554
Admit Date: 10/07/21
Status: DIS INx
Attending: BECK MD,DAVID

Age/Sex: 19 F
Unit #: E000365038
Location: E.2-C
Room/Bed: E.2029-1

Occurred Date: 10/07/21 **Occurred Time: 0133**
Monogram: BC Initials: BCHRI039 Name: CHRISTENSON,BRITTANY Nurse Type: RN

NAME: SCHARA,GRACE N

UNIT # E000365038 **LAST EDIT:** 10/13/21 **SOC SEC #:** xxx-xx-5783
BIRTHDATE: 09/22/02 **MAR STATUS:** S **RACE:** W
AGE: 19 **RELIGION:** CHNP **MOTHER'S NAME:**
SEX: F **AFFILIATION:** **MAIDEN/OTHER NAMES**
EXP DATE: 10/13/21 **TYPE**
EPI # 000000000976362

FAMILY PHYSICIAN:
PRIMARY CARE PHYSICIAN: NOR NORDSTROM MD,MARY E

PATIENT'S ADDRESS
N4833 MISTY MEADOWS DR
SEYMOUR,WI 54165
(HOME) 920-788-0829
(OTHER) 920-428-0551

PATIENT'S EMPLOYER
STUDENT

(BUS) 920-428-0551
OCCUPATION: STUDENT **EMP STATUS:** ST

PERSON TO NOTIFY
SCHARA,CINDY L **REL:** M
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-788-5578 **(BUS)** 920-428-0551

NEXT OF KIN
SCHARA,SCOTT F **REL:** F
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-788-5578 **(BUS)** 920-788-0829

GUARANTOR
SCHARA,CINDY L **REL:**
N4833 MINSTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-788-0829 **SS #** xxx-xx-8112

GUARANTOR'S EMPLOYER
,
(BUS)
OCCUPATION: **EMP STATUS:**

INSURANCES

INSURANCE: UNITED HEALTHCARE/WMA
STREET: PO BOX 5280
STREET:
CITY: KINGSTON
STATE: NY
ZIP: 12402
PHONE: 800-504-9660

INS ORDER: Facility: . (1) Facility: LC (1) Facility: STE (1)
SUBSCRIBER: SCHARA,GRACE N
RELATION: P
POLICY #: 7426225372
EFFECT DATE:
EXPIRE DATE:
COVERAGE #:
PRE-ADMIT CERT REQUIRED?
WHAT IS PRE-CERT APPROVAL NUMBER?
DO FIRST & LAST NAME ON INS CARD & REGISTRATION MATCH?
ENTER NAME EXACTLY AS SHOWN ON CARD-LAST,FIRST NAME:

**********COPAY QUESTION IS FOR CLINICS ONLY**********
Did you collect a Copay? (F9 Lookup)
COMMENTS?
IS THIS A HPSA ELIGIBLE PATIENT?

BENEFIT PLAN
COMP/ORGAN: MEDICAID FOR SSI
COMP/ORG #:
EMP STATUS: S
EMP NAME: STU
EMP LOC:

FINANCIAL CLASS: WMA
SPECIAL PGM IND:

2SEH0933

NAME: SCHARA,GRACE N

ALLERGIES:

UB82 EMP INFO DATA

	-EI DATA-	-EMP STATUS-	-EMPLOYER-	-EMPLOYER LOCATION-	-EMPLOYEE ID-
1	F	FT	SCHARA & A	APPLETON	
2	M	NE	HW	-	

Customer Defined Queries - CD

ADDRESS: N4833 MISTY MEADOW RD
ADDRESS 2:
Allow Appt Rem Call? Y
DID ADOLESCENT SIGN?
ACCESS TO RECORDS:
RELEASE OF INFO:
BY: GRACE
BY: GRACE
COPAY AMT:
COPAY?
PT COUNTY: OUTAGAMIE
DATE SIGNED: 10/06/21
DATE ADOLESCENT SIGNED?
DATE: 10/06/21
Does patient have a documented disability? Y
DT INS CD COPY\VIEW: 10/07/05
EXCLUSIONS: VERBAL/COVID
ANY EXCLUSIONS? N
FINANCIAL AGREEMENT:
WHERE SIGNED? CLMAD1
IF MINOR/FATHER DOB: 04/14/63
GENERAL CONSENT:
HEALTH CARE EDUCATION:
WHY UNABLE TO SIGN?
Administrative Gender:
DATE ASSISTANT VERIFIED:
IF MINOR/MOTHER DOB: 02/06/63
SIGNED: Y
PREC #1:
PREC #2:
PREC #3:
PRE/REG DATE: 10/06/21
PERSONAL VALUABLES:
RACE 1:
RACE 2:
RELATIONSHIP: PATIENT
RELATIONSHIP: PATIENT
CONSENT SIGNED? Y
HIV TESTING:
VETERAN: NA
SP VETERAN: NA
DOES PT HAVE WKCOMP ACCT?
INJ/ACC DT:
WHERE: AMG
CITY NAME: SEYMOUR
CITY: 54165 SEYMOUR

NAME: SCHARA,GRACE N

Did you get a copy of the ins card? N
Date: 04/16/21
Language Understood: ENGLISH
Preferred verbal language for discussing healthcare: English eng
Preferred written language for discussing healthcare: English eng
Preferred Written Language: ENGLISH
Preferred Contact Method: CELL PHONE
Ethnicity: Not-Hispanic or Latino
Portal enrollment instructions given or already enrolled? Y
Race2:
Advance Directives: NA
Patient requests additional information: N
Date asked:
Location:
:
:
PHONE: 920-788-5578
INS VER: 11/21/02
SPECIAL NEEDS?
STATE: WI
RESTRICT DIR DISCLOSURE:

VIP PATIENT: N

ACCOUNT # E39547554 **NAME:** SCHARA,GRACE N

EPI # 000000000976362
UNIT # E000365038 **PAT STATUS:** DIS IN **SOC SEC #:** xxx-xx-5783
BIRTHDATE: 09/22/02 **MAR STATUS:** S **RACE:** W
AGE: 19 **RELIGION:** CHNP **MOTHER'S NAME:**
SEX: F **AFFILIATION:** **MAIDEN/OTHER NAMES**

TYPE

PATIENT'S ADDRESS
N4833 MISTY MEADOWS DR
SEYMOUR,WI 54165
(HOME) 920-788-0829
(OTHER) 920-428-0551
ALTERNATE ADDRESS N

PATIENT'S EMPLOYER
STU
(BUS)
OCCUPATION: STUDENT **EMP STATUS:** ST

PERSON TO NOTIFY
SCHARA,CINDY L **REL:** M
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-428-0551 **(BUS)** 920-428-0551

NEXT OF KIN
SCHARA,SCOTT F **REL:** F
N4833 MISTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-788-0829 **(BUS)** 920-788-0829

GUARANTOR
SCHARA,CINDY L **REL:** M
N4833 MINSTY MEADOW RD
SEYMOUR,WI 54165
(HOME) 920-788-0829 **SS #** xxx-xx-8112

GUARANTOR'S EMPLOYER
(BUS)
OCCUPATION: **EMP STATUS:**

INSURANCE #1
INSURANCE: UNITED HEALTHCARE/WMA **SUBSCRIBER:** SCHARA,GRACE N **COMP/ORGAN:** MEDICAID FOR SSI
STREET: PO BOX 5280 **RELATION:** P **COMP/ORG #**
STREET: **POLICY #** 7426225372 **EMP STATUS:** S
CITY: KINGSTON **STATUS:** **ON** **EMP NAME:** STU
STATE: NY **EFFECT DATE:** **EMP LOC:**
ZIP: 12402 **EXPIRE DATE:** **DEDUCTIBLE:**
PHONE: 800-504-9660 **COVERAGE #** **CO-PAY:**
BENEFIT PLAN

AUTHORIZATION #	EFF DATE	EXP DATE	AUTH STATUS	VERIFY STATUS/DATE	UNITS	REF TYPE	RQSTD PROV	DIAG CODE
A136561421	10/07/21	10/13/21	APPROVED	VERIFIED 10/15/21				

PRE-ADMIT CERT REQUIRED? N
WHAT IS PRE-CERT APPROVAL NUMBER?
DO FIRST & LAST NAME ON INS CARD & REGISTRATION MATCH?
ENTER NAME EXACTLY AS SHOWN ON CARD-LAST,FIRST NAME:

**********COPAY QUESTION IS FOR CLINICS ONLY**********
Did you collect a Copay? (F9 Lookup)
COMMENTS?
IS THIS A HPSA ELIGIBLE PATIENT?

CONDITIONS
 # CONDITION

ADM SOURCE: NHF **LAST HOSP:**
SPECIAL PGM: **FROM:**
THROUGH:

ACCOUNT # E39547554 **NAME:** SCHARA,GRACE N

OCCURRENCES

#	OCCURRENCE	DATE	TIME	STATE
1	OSI	10/06/21		

OCCURRENCE SPAN CODES

#	SPAN CODE	FROM DATE	THROUGH DATE

PHYSICIANS

PRI: NOR NORDSTROM MD,MARY E
ADM: BECD BECK MD,DAVID
ATT: BECD BECK MD,DAVID
ER: ESCAL ESCH DO,ALLY E
FAM:
REF: BARLA BARLOW MD,LAUREN K
OTH:

FINANCIAL CLASS: WMA
ADM/SVC/RES DATE: 10/07/21
ADM/SVC/RES TIME: 0012
ADMIT PRIORITY: ER

REASON FOR VISIT
BREATHING DIFFICULTY - COVID +

COMMENT

VISIT DIAGNOSIS:

LOCATION: E.2-C

REQUESTED ACCOM: I **ROOM:** E.2029 **DISCHARGE DATE:** 10/13/21 **TIME:** 1927
SMK/OBJ/NEITHER: O **BED:** 1 **DISCHARGE DISPO:** E
SERVICE: ICU/CCU **PHONE:** 108-5488 **DISCHARGE DIAGNOSIS:**
ROOM RATE ACCOM: I **EXP LOS:** **DISCHARGE COMMENT:**
LOA:

Preferred Pharmacy
Mnemonic
Address
City
State **Postal Code**
Phone **Fax**
24hrs **eRx** **Mail Order**

VIP PATIENT: N
CONFIDENTIAL: N
RESTRICT DIRECTORY DISCLOSURE: NONE

Is pt able to be assessed? Y
Have you recently tested positive for COVID-19? Y
If so, was the test done more than 14 days ago? N
Are you still having symptoms of COVID-19? Y
Have you had a fever AND/OR symptoms of a
respiratory illness (nasal drainage, congestion,
cough, shortness of breath), new loss of taste
or smell, diarrhea more frequent than usual,
chills, fatigue, muscle pain or body aches,
headache, sore throat, nausea or vomiting?
ADDRESS: N4833 MISTY MEADOW RD
ADDRESS 2:
CITY: 54165 SEYMOUR
CITY NAME: SEYMOUR

ACCOUNT # E39547554 **NAME:** SCHARA,GRACE N

STATE: WI
ZIP: 54165
PHONE: 920-788-5578
Is patient available to answer COVID-19 questionaire? UA
IF YES, PROCEED IMMEDIATELY TO PAPER FORM
*****CONSENT*****
DATE SIGNED: 10/06/21 BY: GRACE RELATIONSHIP: PATIENT
CONSENT SIGNED? Y EXCLUSIONS: VERBAL/COVID
ANY EXCLUSIONS? N
*****HIPAA*****
DATE: 10/06/21 BY: GRACE RELATIONSHIP: PATIENT
SIGNED: Y WHY UNABLE TO SIGN?
RESTRICT DIR DISCLOSURE: Publicity:
Important Message Inpatient Date: Re-sign:
Important Message Outpatient Date:
Advance Directives: NA Date asked:
Location:
Patient requests additional information: N
Does patient have a documented disability? Y
ADMIT LOCATION: STE ST ELIZABETHS HOSP REFER DR:
VETERAN: NA
SP VETERAN: NA
NON MD PROVIDER:
PRE-REG COMPLETED? PRE/REG DATE: 10/06/21 PT COUNTY: OUTAGAMIE
LEFT MESSAGE DATE:
INFO OBTAINED FROM: PATIENT PT GAVE INFO
Did you get a copy of the ins card? N Date: 04/16/21
PREC #1:
PREC #2: OTHER #:
PREC #3: IF MINOR/MOTHER DOB: 02/06/63
IF MINOR/FATHER DOB: 04/14/63
Allow Appt Rem Call? Y
Portal and application access information given? Y
ER Disposition: ACRR Trauma patient? N
Race2: Ethnicity: Not-Hispanic or Latino
Advance Directives: NA
Preferred Contact Method: CELL PHONE
Preferred verbal language for discussing healthcare: English eng
Preferred written language for discussing healthcare:English eng
Administrative Gender:

LAST UPDATE: 01/28/22 1527 *BAR.STE

[redacted]
DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-05043 PART 1 (Rev 01/17)

PART 1 Faxed 10/14

STATE OF WISCONSIN
Chapter 69, Wis. Stats.
Page 1 of 3

NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY

Hospital / Nursing Home / Hospice Care

Items 1-31 of Part I and all items in Part 2 to be completed by the facility or hospice administrator (or a designee).
Items 32-38 to be completed by a Wisconsin licensed funeral director, coroner/medical examiner, or family member.

TYPE OR PRINT IN PERMANENT BLACK INK ONLY

1. DECEDENT'S CURRENT LEGAL NAME- First	Middle	Last	Suffix
AKA: Grace	N	Schara	

2. SEX	3. AGE AT DEATH (include age and age unit)	4. SOCIAL SECURITY NUMBER	5. DATE PRONOUNCED DEAD	6. TIME PRONOUNCED DEAD (0000-2359)
F	☑ Years ☐ Hours ☐ Months ☐ Mins 19 ☐ Days ☐ Stillbirth	391-23-5783	10-13-2021	1927

7. DEATH PRONOUNCED BY (Only professions listed may pronounce death. Check only one.)
☑ Physician ☐ Coroner/M.E. ☐ Deputy Coroner/M.E. ☐ Hospice R.N. (ONLY if 9 is Yes)

8. PRONOUNCER'S NAME: DR. AMY WATTON, MD

9. HOSPICE RESPONSIBLE FOR CARE? ☐ Yes ☑ No

10. HOSPICE NAME:

11. HOSPITAL DEATH (includes hospice patients)
☑ Inpatient ☐ DOA from NH ☐ DOA from Other
☐ Outpatient ☐ ER from NH ☐ ER from Other

12. OTHER PLACE OF DEATH (Complete this item if the death did not occur at a hospital. Includes hospice patients)
☐ Nursing Home ☐ Decedent's Residence ☐ Hospice Facility ☐ CBRF
☐ Residence Care Apt (RCAC) ☐ Adult Family Home (AFH) ☐ Other

13. FACILITY NAME (if applicable): Ascension - St Elizabeth Campus

14. COUNTY OF DEATH: Outagamie

15. CITY, VILLAGE, OR TOWNSHIP OF DEATH: Appleton ☑ City ☐ Village ☐ Township

16. ADDRESS OF DEATH: 1506 S. Oneida St. Appleton, Wisconsin

17. ZIP CODE: 54915

18. **MEDICAL CERTIFIER INFORMATION**
☑ **PHYSICIAN LICENSE #** _____
Physician with a valid Wisconsin physician license (not 1st year resident)
Physician with a temporary Wisconsin physician license
Other licensed physician working in a Veteran's Hospital
☐ **WISCONSIN CORONER/M.E. or DEPUTY CORONER/M.E.**

19. CERTIFIER'S NAME & TITLE — death certificate to be signed by: David Beck

20. CERTIFIER'S PHONE NUMBER: 920-831-8675

21. CERTIFIER'S FAX NUMBER: 920-628-9803

22. CERTIFIER'S FACILITY NAME: Ascension NE Wisconsin, St Elizabeth

23. CERTIFIER'S MAILING ADDRESS:

24. ALTERNATE CERTIFIER'S NAME:

25. ALT. PHONE NUMBER:

26. ALT. FAX NUMBER:

COMMUNICABLE DISEASE ALERT: See PART 2 - PART 2 MUST be completed even if the decedent has none of the conditions listed
In accordance with Wis. Stat. s. 69.18(3)(g) and Administrative Rule DHS 135.04(3), the facility or hospice must complete Part 2 of this form at the time the body is removed from their facility. Part 2 of this form is to be completed and GIVEN TO THE PERSON REMOVING THE BODY AT THE TIME THE BODY IS REMOVED. Part 2 of this form is NOT to be transmitted to the local vital records office.

REPORTABLE DEATHS - (Per Wis. Stats. ss. 30.67, 69.18, 157, 346.71, 350, and 979)
Prior to removal and embalming of body, you MUST notify the coroner or medical examiner if any of the following circumstances regarding the decedent's death apply: all homicides, suicides, or poisonings, all deaths following an accident/injury (includes any type of injury that occurred at any time if the injury significantly affected the health of the decedent), all deaths following an abortion procedure, all deaths involving a motor vehicle (includes snowmobiles, ATVs, boats, etc), all deaths with no physician or spiritual healer in attendance within 30 days, all deaths of correctional inmates, when the physician refuses to sign the death certificate, all deaths in which there are unexplained, unusual, or suspicious circumstances, all sudden deaths and all deaths reportable under county policies.

27. **NOTIFICATION OF THE CORONER/MEDICAL EXAMINER REQUIRED?** ☒ No ☐ Yes
(This form does NOT constitute notification of the Coroner or Medical Examiner)

28. **STATE & COUNTY OF INCIDENT** (required if 27 is Yes)

29. NAME OF STAFF PERSON COMPLETING THIS SECTION	30. **SIGNATURE** OF PERSON COMPLETING THIS SECTION	31. PHONE NUMBER
Johnna Castro	Johnna Castro	920-738-2000

32. STATUS OF PERSON REMOVING BODY (Check one)
☒ Wisconsin Licensed Funeral Home Representative ☐ Coroner/M.E. (pursuant to a death investigation per ss. 979.01 and 979.10, Wis. Stats., for body storage or disposition)
☐ Family Disposition (Per Wisconsin Statutes section 69.18, an immediate family member removing a body must **personally** conduct the final disposition and is responsible for the preparation of the Notice of Removal and the preparation and filing of the Report for Final Disposition and Death Certificate)

33. FUNERAL DIRECTOR'S NAME & WI LICENSE NUMBER (or person acting as such)
LEE SCHUBERT #5776

34. FUNERAL HOME NAME (if applicable): Muehl Buettcher

35. MAILING ADDRESS OF FUNERAL HOME (or of person acting as such): Seymour, WI

36. **SIGNATURE** - FUNERAL DIRECTOR (or person acting as such)	37. DATE SIGNED	38. PHONE NUMBER
[signature]	10/13/2021	920-833-2328

IMPORTANT NOTES

- The facility/hospice MUST send this form to the local registrar (Register of Deeds or Milwaukee City Health Office or West Allis City Health Office) within 24 hours of death (Wis. Stat. s. 69.18). The facility/hospice should keep one copy of the form for the medical chart. The funeral director (or other person removing the body) also requires a copy. For hospice deaths, the funeral director may fax the Notice of Removal to the hospice organization for filing. See instructions on time extension.
- This form is not required for stillborns, but may be used to document release of the remains. Hospital staff and funeral directors must verify the actual legal status of the neonate (liveborn or stillborn) before removal of the body to insure legal documentation of the event.
- Hospice R.N.s may only pronounce death under conditions specified in Wis. Stat. s. 69.18(1)(cm). For anticipated deaths of enrolled hospice patients.
- Each Coroner/M.E. has county-specific written policies on reporting deaths. Reporting nonhospital/nursing home deaths (including deaths under hospice care) may still be mandatory [Wis. Stats. ss. 979.01, 979.10, and 69.18(2), and/or DHS Administrative Rule 135.08].

01-4700-4 Rev. 9/17

2SEH0939

NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY
INSTRUCTIONS FOR COMPLETING PART 1

The facility or hospice agency must send this document to the local vital records office in the first available mail delivery (or by fax if the local vital records registrar allow faxing of this document). Home hospice deaths may require additional time to convey the Notice of Removal from the funeral director to the hospice agency before filing, but should not delay the filing by more than 2 days. Failure to comply with filing requirements for this document could result in fine of not more than $1,000 or imprisonment for 90 days or both [s. 69.24 (2)(d), Wis. Stats.]

1. NAME OF DECEASED
Print the decedent's first, middle, and last name. Print the decedent's suffix, if applicable.

2. SEX
Indicate male, female or unknown to designate the decedent's sex.

3. AGE
Enter the decedent's age. If the decedent was a stillborn, check the "Stillbirth" box and complete the form for use by the hospital and the person removing the body. For a stillborn, the form should not be filed with the local registrar.

4. SOCIAL SECURITY NUMBER
Enter the decedent's social security number. This information is required to complete the death certificate.

5. DATE PRONOUNCED DEAD
Enter the date the decedent was legally pronounced dead. Use alpha characters for the month (example: May 1, 2005, NOT 5/1/2005).

6. TIME PRONOUNCED DEAD
Enter the hour and minute in military time (0000-2359) that the decedent was legally pronounced dead.

7-8. DEATH PRONOUNCED BY / PRONOUNCER'S NAME
Check the appropriate box. Only persons in the professions listed may legally pronounce death in Wisconsin [per Wis. Stat. s. 69.01(6g)]. Paramedics, E.M.T.s, L.P.N.s and physician assistants cannot pronounce death. A R.N. may only pronounce death if the R.N. is employed by a hospice agency, the decedent is enrolled in hospice, and the decedent was under the care of a physician at the time of death. Enter the first and last name of the person who pronounced death.

9-10. HOSPICE RESPONSIBLE FOR CARE?/ HOSPICE NAME
Check the appropriate box and if hospice was responsible for care, enter the name of the hospice in item 10. Services provided by a hospital, long-term care facility, outpatient surgical center or home health agency do not constitute a hospice program of care unless that entity establishes a free-standing or distinct hospice unit within the medical facility, or has a distinct hospice program including staff, facility and services certified under DHS s. 105.50 to provide hospice care. If "Hospice Responsible for Care" box is "YES", the hospice agency must file the Notice of Removal.

11. HOSPITAL DEATH
If the death occurred in a hospital (even if hospice was responsible for care or if the decedent was DOA at the hospital), check the appropriate box to designate the decedent's patient status at the time of death.

12. OTHER PLACE OF DEATH
(Note: This form is not required for deaths occurring at a private residence, a CBRF, a RCAC or an AFH unless the patient was under hospice care.)
Check the appropriate box indicating the category of place of death for the decedent. Check "Other" if the death occurred in someone's house or apartment where the decedent did NOT reside. For reporting purposes, an unlicensed assisted living center is considered a **residence**. Check "CBRF" if the patient died at a licensed community-based residential facility (a CBRF can be a licensed assisted living center or group home). Check "Hospice Facility" only when the death occurred in a stand-alone hospice facility. Check "Other" if the death occurred in some other category of place of death.

13. FACILITY NAME
If the death occurred in a hospital, nursing home or a stand-alone hospice facility, list the name of the facility in 13. If the death occurred at any other place, leave this item blank.

14-17. COUNTY OF DEATH / CITY, VILLAGE OR TOWNSHIP OF DEATH / ADDRESS WHERE DEATH OCCURRED / ZIP CODE
List the county, city, village or township, address and zip code where the decedent was pronounced dead. Do not enter the corporate address of a hospice unless the death occurred there.

18. MEDICAL CERTIFIER INFORMATION
Check the appropriate box for the type of medical certifier that is expected to sign the death certificate.

19-23. CERTIFIER'S NAME AND TITLE / CERTIFIER'S PHONE/FAX NUMBER / CERTIFIER'S FACILITY NAME/CERTIFIER'S MAILING ADDRESS
Enter the name and title of the person expected to sign the death certificate. Then enter the expected certifier's phone / fax number, the facility they are associated with (if applicable) and their mailing address. (NOTE: The provided fax number will be used to contact the physician to complete the death certificate. It is important that the fax number be accurate.)

24-26. ALTERNATE CERTIFIER'S NAME / ALT. PHONE NUMBER / ALT. FAX NUMBER
List another physician who could sign the death certificate if the attending physician cannot sign the death certificate because of absence or other reason. This physician could be a specialist treating the patient or a doctor who sees the attending physician's patients in his or her absence.

27. NOTIFICATION OF THE CORONER/MEDICAL EXAMINER REQUIRED?/ STATE & COUNTY OF INCIDENT
If the circumstances of the death require reporting of the death to a Coroner/M.E., check the "Yes" box in 27 and in 28, list the county where the incident (injury, sudden collapse, etc.) occurred.

29-31. NAME / SIGNATURE / PHONE NUMBER OF THE STAFF PERSON COMPLETING THIS SECTION
List the staff person responsible for completing this section of the form in 29. That person must sign the form in 30 and list his or her work phone number in item 31. The staff person responsible for completing this form must be someone who has access to the patient's medical file so that he or she can provide accurate data in Part 1.

32. STATUS OF PERSON REMOVING BODY
Check the appropriate box. Funeral service licensees (including apprentices) should check the first box. A Coroner/M.E. may personally remove a body for examination or designate a livery service to act on his or her behalf (that person should sign his or her name and state "for X County Coroner/M.E.). According to Wis. Stat. s. 69.18 (1), a family member is allowed to remove a body for disposition if that family member personally prepares for and conducts the decedent's final disposition. If a family member in this situation needs the other forms that must be completed, the family member may call the county Register of Deeds and/or the Coroner/M.E., for those forms.

33-35. FUNERAL DIRECTOR' NAME / WI LICENSE NUMBER / FUNERAL HOME NAME / MAILING ADDRESS OF FUNERAL HOME
The person removing the decedent's remains must enter his or her name and WI license number (if applicable) in 33. Enter the name and mailing address of the funeral home in items 34-35. If the Coroner/M.E., or family member is acting as the funeral home, they will complete all of this section with information about the Coroner/M.E., office or the family member, except the funeral director's license number and item 34. This information would be left blank.

[redacted]

Date: 10-13-2021 Time of Death: 1927 Pronounced by: David Beck

Funeral Home: Meuehl Bethke (920-833-2328)

(MH/CH Only) Time Funeral Home notified: 2146 Funeral Home spoke with family: ☐ Yes ☐ No

Attending Physician: David Beck

Legal next-of-kin: Cindy Schara

Relationship: mother Phone: 920-428-0551

Family contact person of different from above: _____

Relationship: _____ Phone: _____

YES	NO	
☑	☐	Hospital Coordinator or Unit Manager/Designee notified
☑	☐	Two RNs document death assessment (if physician not present)
☑	☐	Physician/Consulting MD notified
☑	☐	Telephone order to pronounce death is written (if physician not present)
☑	☐	Family notified
☑	☐	Spiritual Services offered Name of AHS Chaplain, if present: _____
☐	☐	ED Registration notified MMC - 31899 SEH - 82105 CMC Registration - 0
☐	☐	Nursing Home/Homecare Agency notified, if applicable
☑	☐	ID on deceased
☑	☐	Isolation (type): COVID-19 (contact/droplet/airborne)
☑	☐	Removal of Corpse form Part 1 & 2 completed
☑	☐	Disposition of possessions documented on Personal Property Checklist
☑	☐	Bereavement folder given (remove sympathy card from folder, address envelope)

YES	NO	
☐	☑	**CORONER** notified, Time: _____ Name: _____
		☐ Body released by coroner
		☐ Coroner Hold, Restrictions to Organ/Tissue Donation? _____

Winnebago County #424-0024
Outagamie County #832-5841
Calumet County #849-2335

☐	☑	**AUTOPSY** Requested by: ☐ Coroner ☐ MD ☐ Family
		(None of the below apply to Coroner cases)
		☐ Autopsy consent signed
		☐ Pathology notified
		☐ Record (disassembled) taken to pathology office

RESTRAINTS

☐	☑	Did the patient expire within 1 week of restraint/seclusion. **If Yes**, complete below.
		Patient died while in Restraint, Seclusion, or Both ☐ Yes ☐ No
		Patient died within 24 hours of removal of Restraint, Seclusion, or Both ☐ Yes ☐ No
		Patient died within 1 week of removal where Restraint, Seclusion, or Both may have caused physical harm based on review of documentation ☐ Yes ☐ No

If yes to any of the above: Complete the Restraint/Seclusion Death Report (Y DEATHRS) and fax the form to Quality/Risk Management at 920-628-8935

Sent to Quality: Date: _____ Time: _____ Initials: _____

Continue to complete back of document

Ascension

Record of death

Original copy to patient record
MMC: Provide 2 copies for ED registration
CMC: Provide 1 copy for registration

Ascension Wisconsin
ASCWI-1934 03/2020

Patient identification

2SEH0941

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
(Rev 01/17)

PART 2

STATE OF WISCONSIN
Chapter 69, Wis. Stats.

NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY

Communicable Diseases Reportable to Personnel Involved in Postmortem Activities

(Confidential Information Available Only to the Funeral Director or Person Acting as Such)

DO NOT TRANSMIT THIS PORTION OF THE NOTICE OF REMOVAL TO THE LOCAL VITAL RECORDS OFFICE.

1. DECEDENT'S CURRENT LEGAL NAME- First	Middle	Last	Suffix
Grace	N	Schara	

AKA:

2. SEX	3. AGE AT DEATH	4. DATE PRONOUNCED DEAD	5. TIME PRONOUNCED DEAD (0000-2359)
19	☑ Years ☐ Months ☐ Days ☐ Hours ☐ Minutes ☐ Stillbirth	10-13-2021	1927

6. FACILITY NAME	7. FACILITY MAILING ADDRESS
Ascension NE WI – St Elizabeth	1506 S Oneida St, Appleton, WI, 54915

Per Wisconsin Statute ss. 69. 18(3)g and 252.15 (3m)(d)7 and DHS Administrative Rule 135.04(3), a hospital, nursing home, or hospice must provide in formation concerning certain existing communicable diseases to the funeral director, the person acting as funeral director, the Coroner/M.E., or the representative of the Coroner/M.E., at the time the body is removed. See important notes below. Both 8 and 9 below must be completed.

8. To the best of my knowledge and belief, the above-named decedent's medical record documents the presence of the following communicable disease(s) suspected or confirmed for this person:

- ☐ Clostridium Difficile
- ☐ HIV (Positive Results) (Available only to funeral directors per s.252.15(5), Wis. Stats.)
- ☐ Other serious blood-borne transmittable disease (e.g., Hepatitis)
- ☐ Methicillin-Resistant Staphylococcal Aureus (MRSA)
- ☐ Plague
- ☐ Prion diseases (such as CJD)
- ☐ Rabies (human)
- ☑ SARS - COVID-19
- ☐ Smallpox and other orthopox diseases
- ☐ Staph
- ☐ Tuberculosis
- ☐ Tularemia
- ☐ Vancomycin-Resistant Staphylococcal Aureus (VRSA)
- ☐ Varicella
- ☐ Viral hemorrhagic fevers

☐ The designee completing this report examined the patient's active medical record but did not find any of the above-mentioned conditions documented in the active medical record available to him or her at the time of release of the body.

☐ The decedent died in the ER or was DOA and there was no historical medical record at the facility at the time of release of the body.

9. NAME OF STAFF PERSON COMPLETING PART 2 (must be a person who can reasonably attest to the above statements)

Jorizza Castro

10. SIGNATURE - STAFF PERSON COMPLETING PART 2	11. DATE SIGNED	12. PHONE NUMBER
Jorizza Castro	10-13-21	920-531-8661

IMPORTANT NOTES

- Per Wisconsin Statute section 69.18 (3)g, it is the legal responsibility of the health care facility or hospice agency to provide the funeral director, or person acting as such, with information about any known dangerous communicable diseases documents in the decedent's medical record.
- It is understood that, in some cases, diseases may be present but undiagnosed or the facility may not be aware of a prior diagnosis that is not documented in the medical records available to the medical facility.
- Funeral directors, or persons acting as such, and Coroners/M.E.s and their representatives must use universal precautions when handling <u>all</u> bodies to prevent the transmission of bloodborne pathogens and to be in compliance with OSHA standards.

2SEH0942

YES NO

ORGAN/TISSUE DONATION

☐ Organ Procurement Organization (OPO) notified within 1 hour of all deaths: Date: 10-13-21 Time: 2149
Initials: _____

Pre-Death donation referral (optional): Date: _____ Time: _____ Initials: _____

CMC/SEH - call 1-800-432-5405 **MMC** - CALL 1-866-894-2676 OPO Referral # 125-14150
Contact Person Tiana

Document the OPO's decision related to patient suitability for donation:
Is patient suitable for **EYE** donation? ☐ Yes ☑ No/Reason: COVID-19
Is patient suitable for **TISSUE** donation? ☐ Yes ☑ No/Reason: COVID-19
Is patient suitable for **ORGAN** donation? ☐ Yes ☑ No/Reason: COVID-19

☐ ☐ Patient's donation wishes explored
☐ Not applicable, patient is not a suitable donor

Is the patient on the Wisconsin Donor Registry? ☐ Yes ☐ No
If yes: ☐ "Record of Intent" ☐ "Record of Gift"

Does the patient have an Advance Directive for health Care? ☐ Yes ☐ No
If yes: ☐ Wishes to be a donor ☐ Does not wish to be a donor ☐ Donation wishes not noted

☐ ☐ Organ/Tissue donation options discussed with _____
(Name/Relationship of family member)
by _____
(Staff Name/Title - must be a trained designated requestor if patient is a suitable donor candidate)

☐ Family informed that no donation options are available

☐ Consent to donation: ☐ eyes ☐ tissue ☐ organs ☐ Memory Kit given to family
(Select *either* first person or family below)
☐ First person consent: ☐ Donor Registry ☐ Driver's License ☐ Advance Directive
☐ Copy of consent document placed in patient record
☐ Family Consent:
☐ Consent signed: ☐ in person ☐ via recorded phone line with recovery coordinator

☐ Donation options declined:
(Select *either* first person or family below)
☐ First person decline: ☐ Advance Directive ☐ Other: _____
☐ Family decline

Date: 10-13-21 Time: 2149 RN Signature: J. Rizzo Carbonard

Time to Morgue: 2300

Ascension Wisconsin
ASCWI-1935

Staple Bag receipts Here

	Item	Description	Direct Admit ED/SPA Admit Date/Initials	Additional items brought in Date/Initials	Transfer to Room Date/Initials	Transfer to Room Date/Initials	Transfer to Room Date/Initials	Discharge Date
	Include description of item and number of items in each column (Ex. Yellow band ring with 3 green stones)							
Assistive Devices	Glasses							
	Contacts							
	Dentures (upper, lower, partials)							
	Hearing Aids (R, L)							
	Prosthesis							
	Brace/Support							
	Wires		X					
Medical Equipment	O2							
	Wheelchair							
	Cane/Walker							
	CPAP/BiPAP							
	Bipap		X					
Money	Currency: $							
	Credit Cards							
	Wallet							
	Purse							
Jewelry	Watch							
	Rings							
	Necklace							
	Bracelet							
	Earrings							
	Body Piercing							
	MASK		X					
Electronics	Cell Phone/Charger		X					
	IPOD/MP3							
	Laptop/Tablet/E-reader							
	Electric Shaver							
	DVD/CDs							
Clothing / Other	Keys							
	Slippers							
	Shoes		X					
	Socks		X					
	Shirt		XX					
	Pants							
	Shorts							
	Robe							
	Duffel Bag							
	Suitcase							
	CPAP		X					
	PJ		X					
	Underwear		X					
Initials: Staff and Patient/Family								

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

PERSONAL PROPERTY CHECKLIST
PART C
(Page 1 of 1)

2/15

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0944

Home Medications (list number of bottles, inhalers, etc. brought in with patient upon admission.
Please note it is advisable to send home any medications not needed by patient during their hospital stay, with family member whenever possible.

bottles: _____
creams: _____
drops: _____
inhalers: _____
Other: _____
Other: _____

***Complete this note section for medication or belongings sent home with family or additional items brought into the hospital. Also note when items locked in a secure location (cashier's safe, room safe)**
NOTES: _____

Security bag receipt # _____ Signature of Staff securing bag: _____
Security bag receipt # _____ Signature of Staff securing bag: _____
Security bag receipt # _____ Signature of Staff securing bag: _____
Medication bag receipt #: _____ Signature of Staff securing bag: _____
Medication bag receipt #: _____ Signature of Staff securing bag: _____
Medication bag receipt #: _____ Signature of Staff securing bag: _____
Bag receipts to be stapled to the top left corner of page 1

Please send jewelry, credit cards, and money home with your family. A secure location for valuables is available, kept in your room.
The hospital is not responsible for the loss of any valuables.
It is the responsibility of the patient or responsible person to inform nursing of items sent home or brought in after the initial inventory is made.

Admission Patient signature: _____ Date: _____ Time: _____

By signing below, I acknowledge that I have received all of my personal belongings that I brought with me, upon discharge.

Discharge Patient signature: _____ Date: _____ Time: _____

By signing below, I acknowledge that all patient home medications and valuables have been returned to the patient or family, upon discharge.

Discharge RN signature: _____ Date: _____ Time: _____

I, _____ request and give consent to _____ to perform the
(Type or Print Patient Name) (Type or Print Doctor or Practitioner Name)
following procedure(s) Peri Phe rally inserted dental catheter.

(Please list site and side as appropriate)

The benefits, risks, complications and alternative to the above procedure(s) have been explained to me including the risks related to not receiving the proposed care, treatment, and services.

I understand that the procedure(s) will be performed under the supervision of my doctor or practitioner. My doctor or practitioner may use the services of other doctors or practitioners, or members of the resident staff as he or she deems necessary or advisable.

I authorize my doctor or practitioner and his or her associates and assistants to perform such additional procedures, which in their judgment are necessary and appropriate to carry out my diagnosis or treatment.

I authorize the hospital to retain, preserve and use for scientific, teaching or transplant purposes or to make other dispositions of, at their convenience, any specimens, tissues or parts taken from my body during the course of this operation **excluding (include arrangements)** _____

I consent to observers in the operating room in accordance with hospital policy. I consent to photography or video taping of my surgical procedure for documentation of medical care or educational purposes. If photography or video taping is used for education, my identity will remain anonymous and confidential.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me including the risks related to not receiving the proposed care, treatment and services.

If anesthesia is required, I consent to the administration of anesthesia by members of the Department of Anesthesiology. I also consent to the use of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the operation itself including, but not limited to, dental injury, hoarseness, vocal cord injury, infection, nerve injury, corneal abrasion, difficulty voiding, seizures, heart attack, stroke, lack of oxygen to the brain and even death. Regional and spinal anesthesia risks include but are not limited to localized bleeding, infection and pain as well as nerve damage, partial or failure to produce anesthesia. There is the risk of bleeding or infection in the brain or spine with spinal and epidural anesthesia.

I hereby acknowledge that an LIP (Licensed Independent Practitioner) has informed me that a blood or blood product transfusion is, or may be, medically indicated in my case.

I CERTIFY THAT I HAVE READ/HAD READ TO ME AND FULLY UNDERSTAND THE CONTENT OF THE ABOVE AUTHORIZATION AND I:

- ☐ **DO consent to a transfusion**
- ☐ **DO NOT consent to a transfusion**

I certify that I have read and understand the above consent statements. In addition, I have been offered the opportunity to ask my doctor or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s). Please review back of form prior to consent signature.

Patient/legal guardian signature	Date	Time	Witness	Date	Time
	10/8/21	2:09pm	A Mandi Nuell	10/8/21	2:10

Person signing on patient's behalf/relationship	Date	Time	Reason patient is unable to sign

Physician/Dentist/Podiatrist/Midwife	Date	Time

- ☐ **Ascension Calumet Hospital**
- ☐ **Ascension Mercy Hospital**
- ☒ **Ascension St. Elizabeth Hospital**

SURGICAL / BLOOD CONSENT FORM

7/20

Patient Identification

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0946

PRE-PRINTED ORDERS: TUBE FEEDING - ACUTE (INITIAL)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Allergies : ☐ NKDA ☐ List: _____

Directions: Orders with a check box ☐ must be checked to be instituted. Orders without a check box or with a ■ check box are to be instituted unless specifically lined through.

Administration Route:

☒ Use tube in place:
- ☐ Anderson / Salem NG ☒ NG FT ☐ ND FT ☐ NJ FT ☐ OG FT
- ☐ PEG / G-Tube ☐ PEG-J / NC J-tube / J-tube

☐ Insert Feeding Tube (FT)
- ☐ Nasogastric (NG)
- ☐ Nasoduodenal (ND) - Recommended with aspiration risk
- ☐ Nasojejunal (NJ) - Recommended with delayed gastric emptying, pancreatitis, aspiration risk
- ☐ NJ FT > 105 cm to be placed via fluoroscopy or endoscopy

☐ NG/OG to suction ☐ None ☐ Intermittent ☐ Continuous ☐ High ☐ Low ☐ Gravity ☐ Other:_____

☐ NG/OG clamp ☐ Yes ☐ No

Consults/Evaluations:

■ Nutrition Consult: Nutrition Assessment and Monitoring (Tube Feeding Patient)

■ Pharmacy Consult: Drug-Nutrient interactions and availability of liquid medications

Tube Feeding Formula & Schedule:

If left blank, RD will recommend formula and administration rate to LIP for appropriate order

☐ TF consult: RD to assess and manage appropriate formula and administration rate

☒ NPO

☐ May have tray - specify diet: _____

Standard Enteral Formulas:
- ☒ Standard TF with Fiber, 1.2 Kcal/ml (Jevity 1.2 Cal)
- ☐ Standard TF no Fiber, 1.2 Kcal/ml (Osmolite 1.2 Cal)
- ☐ Glucose Intolerance TF with Fiber, 1.2 Kcal/ml (Glucerna 1.2 Cal)
- ☐ Calorie Dense TF with Fiber, 1.5 Kcal/ml (Jevity 1.5 Cal)

Specialized Enteral Formulas: **Some may require 24-48 hours to obtain**
- ☐ Very high protein TF, 1 Kcal/ml (Vital High Protein)
- ☐ Elemental TF with NutraFlora scFOS and Fish Oil, 1.2 Kcal/ml (Vital AF 1.2 Cal)
- ☐ Renal TF, 1.8 Kcal/ml (Nepro with Carb Steady)

Administration Schedule:
- ☐ Standard:
  - a) Begin full strength at 25 ml/hour x 8 hours then
  - b) Increase 25 ml/hour every 8 hours to goal of _____ ml/hour if tolerated
- ☒ Early Post-op Feeding / Questionable GI Tolerance / Concentrated Formulas:
  - a) Begin full strength at 10 ml/hour x 8 hours then
  - b) Increase 10 ml/hour every 8 hours to goal of 105 ml/hour if tolerated

☐ Free Water Bolus: _____ ml every _____ hours

☐ Protein Modular Liquid Dose: _____ Frequency: _____

SCANNED

FAXED

Diagnostics:

X-Ray: ☐ Abdominal flat plate X-ray to verify new tube placement unless placed under fluoro/endoscopy

Labs:
- ■ CMP on day TF initiated & every Monday AM x 4
- ■ CBC on day TF initiated
- ■ Phosphorus every AM x 4 days starting on day TF initiated
- ■ Magnesium every AM x 4 days starting on day TF initiated
- ■ BMP every AM x 3 days starting on day TF initiated

10-13-21 1314 Initial Enteral

11/1/21 6pm

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Shokar | Jamie Rynearson RDN, CD

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

TUBE FEEDING - ACUTE (INITIAL)
(Page 1 of 3)

9/21 HSTFACUTE

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

TUBE FEEDING FORMULARY

TUBE FEEDING FORMULAS	OSMOLALITY	Kcal/ml	PRO g/L	PRODUCT FEATURES
Standard TF with fiber: **Jevity® 1.2 Cal** - 1500 ml, Ready-To-Hang®	450 mOsm/kg H2O	1.2	56	- Complete, Balanced Nutrition ® - High in protein - Fiber fortified, 18 g/L (Includes NutraFlora® scFOS ®)
Standard TF no fiber: **Osmolite® 1.2 Cal** - 1500 ml, Ready-To-Hang®	360 mOsm/kg H2O	1.2	56	- Complete, Balanced Nutrition® - High in protein - Fiber fortified, 18 g/L (Includes NutraFlora®scFOS®)
Glucose Intolerance TF with fiber: **Glucerna® 1.2 Cal** - 1500 ml, Ready-To-Hang®	720 mOsm/kg H2O	1.2	60	- Unique carbohydrate blend for enhanced glycemic control, also contains chromium - Low in saturated FA and rich in mono-unsaturated FA - Provides omega-3 FA from canola oil, EPA, DHA - High in protein - Fiber fortified, 17 g/L (Includes NutraFlora® scFOS®)
Very High Protein TF with EPA/DHA: **Vital® High Protein** - 1000 ml, Ready-to-Hang®	400 mOsm/kg H2O	1	87.5	- Complete, balanced nutrition for critically ill obese patients to meet 2009 Critical Care Guidelines - Very high protein - EPA + DHA - Balanced blend of MCT:LCT to promote feeding tolerance and enhance fat absorption
Elemental TF: **Vital AF® 1.2 Cal** - 1000 ml Ready-To-Hang	425 mOsm/kg H2O	1.2	75	- Complete elemental nutrition - Contains prebiotic (NutraFlora® scFOS®) to stimulate growth of beneficial bacteria in colon - Fortified with EPA and DHA to help modulate inflammation and support immune function - MCT/fish oil structured lipid - High protein - Elevated levels of antioxidant vitamin C & E
Renal TF: **Nepro® with CARBSTEADY®** - 1000 ml, Ready-To-Hang®	745 mOsm/kg H2O	1.8	81	- Contains CARBSTEADY®, a carbohydrate blend to help manage blood glucose response - Calorically dense - Excellent source of protein - Low in phosphorus, potassium and sodium - Fiber fortified-13 g/L
Calorie Dense TF with fiber: **Jevity® 1.5 Cal** - 1000 ml, Ready-To-Hang®	525 mOsm/kg H2O	1.5	63.8	- Complete balanced nutrition - Fiber-fortified, 21 g/L (includes NutraFlora® scFOS®)

Rev 9/21

PRE-PRINTED ORDERS: TUBE FEEDING - ACUTE (INITIAL)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Medications:

Pancrelipase (12/38/60) 1 capsule PO daily PRN declog feeding tube
Sodium Bicarbonate 325 mg PO daily PRN declog feeding tube
☐ Initiate Hospital Service medium-dose insulin sliding scale (HSSSIMOD)
☐ Initiate Hospital Service hypoglycemia protocol (HSHYPOGLY)

Nursing Assessments/Treatments:

Bedside Glucose monitoring every 6 hours or every _____ hours as ordered
Start tube feeding with confirmed FT placement
Elevate HOB 30 degrees during and for 1/2 hour after feeding
Height day TF started
Weight day TF started & every other day
Strict I&O end of every shift
Contact LIP for Bowel Program if no BM in 3 days
If feeding tube displacement is suspected or has occurred, stop the feeding and notify LIP
Notify LIP for signs/symptoms of tube feeding intolerance and for residual checks per feeding tube management orders
If patient vomits, alert LIP:
a) Stop the tube feeding
b) Verify proper tube placement
c) Hold the tube feeding for 6 hours
d) Restart tube feedings at half the prior rate (but no less than 10 mL/hr) if the patient is not displaying signs of intolerance (nausea, abdominal pain, distension, firmness, ect).
e) Check a gastric residual volume (GRV) in 4 hours after restarting the tube feeding
i) If the GRV is less than 500 mL advance the tube feeding back to goal rate per original order
ii) If the GRV is greater than 500 mL, follow the steps in section C under GRV Management

Tube Feeding Management:

FLUSH tube with 30-60 ml warm tap water
- CONTINUOUS feeding: every 4 hours
- INTERMITTENT feeding: before and after feedings
- MEDICATIONS: pre and post meds with 30 ml water and between meds with 10 ml water

OPEN system management:
- Fill bags with 8 hour volume of product for continuous feeding
- Empty each bag - DO NOT add new TF to hanging TF
- Rinse feeding bag with warm water every 8 hours before adding new TF formula to bag
- Change bag every 24 hours
- Open system bag change due at: _____

CLOSED system management:
- Label container and spike set with patient's name and date/time hung
- Leave spike set intact for same duration as container for up to 48 hours per spiking
- Use a new spike set with each new bag

GRV CHECKS for **Nasogastric** and **Gastrostomy tubes.** (NO residual checks for Jejunostomy tubes)
- A GRV should be checked if there are symptoms of tube feeding intolerance (nausea, abdominal pain, distension, firmness, ect.)
- Do not perform routine GRVs for patients who are awake and alert and able to communicate, or who do not meet the following criteria: nausea, regurgitation, vomiting, or abdominal bloating, distension or pain

SCANNED

FAXED

10-13-21 1314 Triage Entered

Date: 10/13/21 Time: 1215 LIP Signature: VORB: Dr. Shokar / Jaclyn Raymeker, RDN, CD

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA, GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD, DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

11/1/21 6pm

2SEH0949

PRE-PRINTED ORDERS: TUBE FEEDING - ACUTE (INITIAL)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Tube Feeding Management (cont.):

■ **GRV Management:**

- If the GRV is 500 mL or less and the patient is tolerating tube feeding, continue feeding at prescribed rate
- If the GRV is 500 mL or less **and** the patient has intolerance:
  a) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os.
  b) Reduce the tube feeding to half of the prior rate (but no less than 10 mL/hr)
  c) Recheck a GRV in 4 hours. If the second GRV is greater than 500 mL, ask attending provider about prokinetics and advancing the tube to the Jejunum
  d) When symptoms resolve, advance tube feeding back to goal rate per original order
  e) If the patient develops symptoms of intolerance again
    i) Consult RD for further recommendations
    ii) Notify attending provider
    iii) Follow the protocol under B above until new recommendations/orders are available
- If the GRV is greater than 500 mL:
  a) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os
  b) Hold the tube feeding for 4 hours then recheck another GRV
  c) If the second GRV is less than 500 mL, resume TF at half of the prior rate (but no less than 10 mL/hr) and advance to goal rate as originally ordered. Do not check routine GRVs unless the patient shows signs of intolerance
  d) If the second GRV is greater than 500 mL:
    i) Refeed up to 250 mL of residuals. Discard remaining residuals and document in I&Os
    ii) Continue to hold TF and await further recommendations
      A) Ask about starting prokinetic agent
      B) Ask about placing a Jejunal tube

■ **DECLOG:**

- Crush Pancrelipase (12/38/60) cap & Sodium Bicarbonate 325 mg tab & dissolve in 5 ml warm water
- Instill into occluded FT & wait 5 minutes, then flush with tap water

FAXED

10-13-21
1357
Trinac Entered

11/1/21 10pm

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Snokar Jana Reynebeau, RDN, CD

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

TUBE FEEDING - ACUTE (INITIAL)
(Page 3 of 3)

9/21 HSTFACUTE

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

PRE-PRINTED ORDERS: INSULIN THERAPY-SUBCUTANEOUS INJECTION

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Directions: Orders with a check box ☐ must be checked to be instituted. Orders without a check box or with a ■ check box are to be instituted unless specifically lined through.

This order set not intended to be used without an admission order set

Insulin Therapy (Subcutaneously Dosed):

☐ Blood Glucose Monitoring: Before meals and at bedtime or every 6 hours in NPO

Insulin Orders	Breakfast	Lunch	Dinner	Bedtime
☐ Pre-meal Scheduled	Give _____ Units of: ☐ Novolog ☐ _____	Give _____ Units of: ☐ Novolog ☐ _____	Give _____ Units of: ☐ Novolog ☐ _____	
☐ Scheduled	Give _____ Units of: ☐ NPH ☐ Lantus		Give _____ Units of: ☐ NPH	Give _____ Units of: ☐ NPH ☐ Lantus

-Suggested lag times for prandial insulin: Novolog 0-15 minutes before eating; Regular 30 minutes before eating

-For blood glucose < 70 mg/dL:

- If patient can eat or drink, give 4 oz fruit juice/non diet soda, 8oz nonfat milk, or 3-4 glucose tablets
- If patient cannot eat or drink, give D50W 25 mL as IV push
- Check finger capillary glucose every 15 minutes until ≥ 80 mg/dL. Repeat above if < 80 mg/dL

Sliding Scale Insulin (check one box below):

☐ Premeal "correction dose" algorithm for hyperglycemia ☐ Novolog ☐ Regular
Administer in addition to scheduled insulin dose to correct premeal hyperglycemia.
Circle desire algorithm below.

SCANNED

FAXED

- Use low-dose algorithm for patients requiring < 40 units of scheduled insulin/day
- Use medium-dose algorithm for patients requiring 40-80 units of scheduled insulin/day
- Use high-dose algorithm for patients requiring > 80 units of scheduled insulin/day

Premeal "correction dose" Insulin Dose (units)				
Algorithm	Low Dose	Medium Dose	High Dose	Individualized Dose
150-199	1	1	1	_____
200 - 249	2	3	4	_____
250 - 299	3	5	7	_____
300 - 349	4	7	10	_____
>349	5	8	12	_____

10-13-21 1317 Trinac Entered

☒ **Sliding scale insulin algorithm** ☒ **Novolog** ☐ **Regular**

Sliding Scale Insulin Dose (units)		
Algorithm	Sliding Scale Dose	Individualized Dose
150-199	3	_____
200 - 249	5	_____
250 - 299	7	_____
300 - 349	9	_____
>349	11	_____

Gaitlyn 11/1/21 60m

☐ **See Insulin Drip Protocol**

Date: 10/13/21 **Time:** 1215 **LIP Signature:** VORB: Dr. Shokar Jana Seymeaux, FPN, C

☐ **Ascension Calumet Hospital**
☐ **Ascension Mercy Hospital**
☒ **Ascension St. Elizabeth Hospital**

INSULIN THERAPY-SUBCUTANEOUS INJECTION

2/20 PSOINSSUB

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

PRE-PRINTED ORDERS: IV THERAPY PICC or MIDLINE CATHETERS (Radiology)

LICENSED INDEPENDENT PRACTITIONER (LIP) ORDER

Date: 10/8/21 In: _____ Out: _____
Allergies: _____

INSERTION REPORT	PHYSICIAN ORDER
Inserted by: Kralik, Jon MD Catheter manufacturer: _____ Lot # _____ Exp: _____ Catheter type: ☒ PICC ☐ Midline Catheter gauge: ☒ 5 FR ☐ 4 FR ☐ 3 FR Placement: ☐ Right ☒ Left Vein: ☒ Basilic ☐ Cephalic Catheter length: 40 cm External length: _____ # Attempts: 1 # Lumens: 2 Blood Return: _____ X-Ray: confirmed Tip Location: SVC Report: _____ LIP Signature: _____	1. Sterile dressing change 24 hours post-insertion, if gauze dressing present - remove gauze a. Subsequent dressing change every 7 days or PRN (loose, soiled, drainage). Dressing only/no gauze - Use "Biopatch" (light blue side up) - Cover catheter and extension set connection - Secure with Statlock or steri-strips at hub - Extension set placed during insertion remains until line pulled 2. Cap change every 7 days and PRN - Clamp all unused lumens 3. ☐ Regular PICC - Heparin flush 10 units/ml 5 ml IV every 12 hours (use only a 10 ml or larger syringe) - Flush with Sodium Chloride 0.9% 20 ml between TPN bags - Clamp line after flush is complete 4. Warm moist compress and elevation to arm from exit site to shoulder 20 minutes 4 times daily x 48 hours post-insertion 5. MAY / MAY NOT use PICC for blood sampling 6. Repeat chest x-ray every 7 days for PICC line tip location with infusions of TPN. (NOTE: Not necessary if other chest x-rays are ordered during this time - tip should be in SVC 7. LIP to write order for PICC line removal when treatment completed
☐ **Time out completed** Flushed: _____ Dressing: _____ **Complete Insertion Bundle Documentation Checklist** Date: _____ Time: _____ RN/Tech Signature: _____	Date: 10/8/21 Time: 1111 LIP Signature: _____

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

RADIOLOGY PICC or MIDLINE CATHETERS PHYSICIAN ORDERS

6/13 PSO7109A, M.IVPICRAD, H.IVPICRAD

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

DATE	TIME	PROGRESS NOTES	DATE	TIME	Licensed Independent Practitioner (LIP) ORDER
10/7/21	1400	Clindamycin 1% Topically twice a day and Clotrimazole 1% Topically TID			Verified by 2 RNs per isolation policy. X [redacted] RN X Pringle RN
		FAXED TO PHARM 10/7/21 @ 1413 BP			
10/8/21	1058	OT/PT - braden assessment referral received + chart reviewed. Pt is febrile, hypotensive, on bipap currently not appropriate for mpt needs. D/C PT + OT. Please reorder services if indicated closer to pt discharge. [redacted] PT			
10/10/21	1830				Chart reviewed - [redacted] RN

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

PROGRESS RECORD / ORDER SHEET

5/13 Form #4180

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

Non-Event Chemical Restraint Order

Part of permanent medical record

Date: 10/7/21

Restraint MD Order

NVNSD Check all that apply	Device Type: Check all that apply
☒ Agitation	☐ Geri Chair
☐ Fall Risk Potential	☐ Soft Ankle
☐ Confusion/Cognitive Impairment	☒ Soft Wrist
☒ Interference with Medical Device	☐ 4 Side Rails (unless patient/family requested)
	☐ Other _____

This Order Expires After 24 Hours

VO/TO _____ MD/ _____ RN

Time: _____ Date: 10/7

MD Signature: [signature] Date: _____

Time: _____

Ascension NE Wisconsin - St. Elizabeth Hospital Campus
A3173 12/2019

Date: 10/8

Restraint MD Order

NVNSD Check all that apply	Device Type: Check all that apply
☐ Agitation	☐ Geri Chair
☐ Fall Risk Potential	☐ Soft Ankle
☒ Confusion/Cognitive Impairment	☒ Soft Wrist
☐ Interference with Medical Device	☐ 4 Side Rails (unless patient/family requested)
	☐ Other _____

This Order Expires After 24 Hours

VO/TO _____ MD/ _____ RN

Time: _____ Date: 10/8

MD Signature: [signature] Date: _____

Time: _____

Ascension NE Wisconsin - St. Elizabeth Hospital Campus
A3173 12/2019

Date: _____

Date: _____

Date: _____

Date: _____

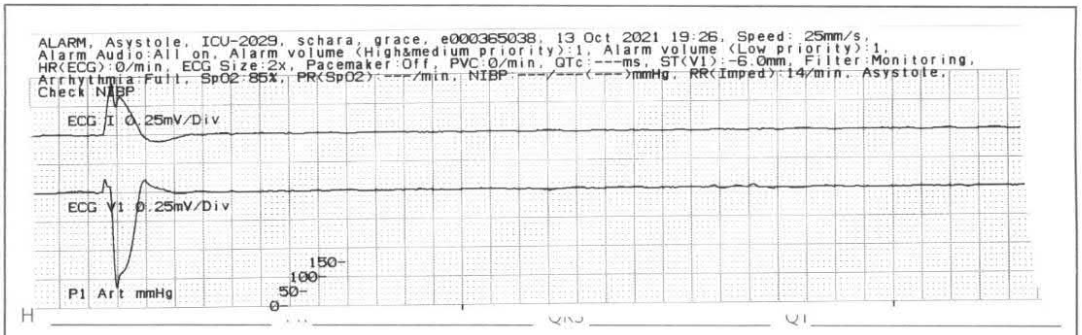
Ascension | St. Elizabeth Hospital

E39547554 19 F
SCHARA GRACE N

E0003650308
BECK MD DAVID
NORDSTROM MD MARY E
10/07/21
920-788-[illegible]329
09/22/02

2029

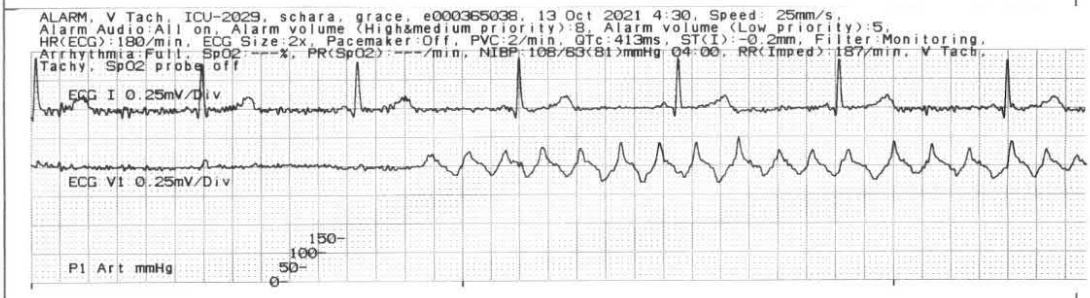
2SEH0954



H _____ PR _____ QRS _____ QT _____

Interpretation: _____

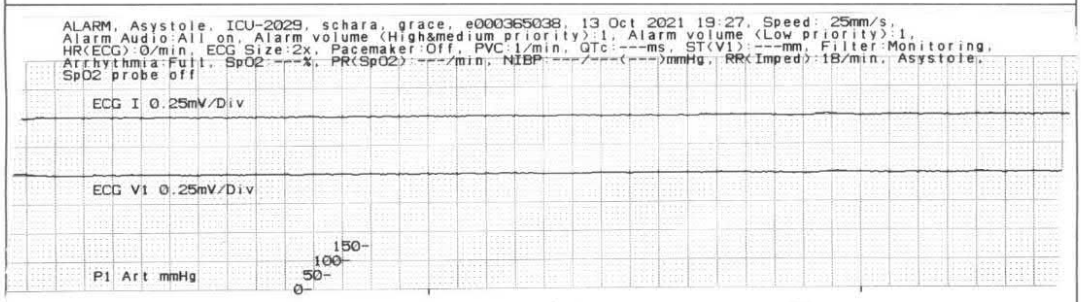
Date: Time:



HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:



HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐

Rhythm Strip Mount Sheets

Ascension Wisconsin
0007136 02/2020

E39547554 19 F
SCHARA,GRACE N

E000365038
BECK MD,DAVID
NORDSTROM MD,MARY E
ADM 10/07/21 E 2029-1
920-788-0829
DOB 09/22/02

2SEH0955

ADMIT

SCHARA,GRACE TELE:2029* PID:999999999 TTX#8654AP MANUAL 07-OCT-2021 03:29:27
@25 MM/S HR 64 PVC X ECG SIZE 2X ST I X

HR 64 PR .14 QRS .08 QT .36

Interpretation: SR

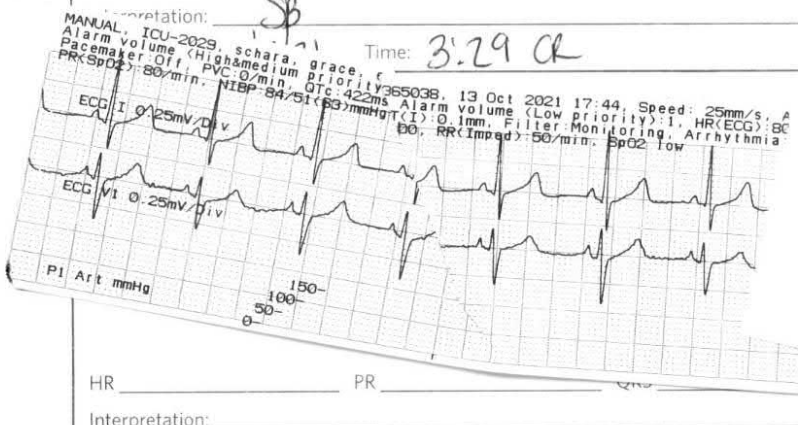
Date: 10/7/2021 Time: 3:29 C. Radtke

SCHARA,GRACE TELE:2029* PID:999999999 TTX#8654AP MANUAL 07-OCT-2021 03:29:37
@25 MM/S HR 59 PVC X ECG SIZE 2X ST I X

HR 59 PR QRS QT

Interpretation: SB

Time: 3:29 CR



HR PR

Interpretation:

Date: Time:

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐ _____

Rhythm Strip Mount Sheets

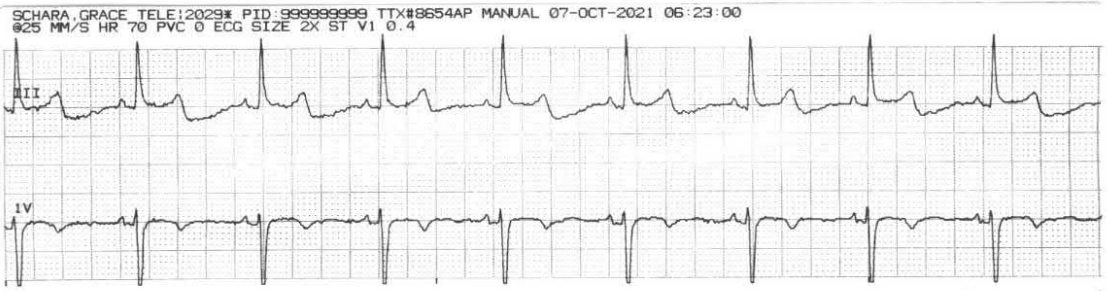
Ascension Wisconsin
0007136 02/2020

E39547554 19 F
SCHARA,GRACE N

E000365038
BECK MD,DAVID
NORDSTROM MD,MARY E
ADM 10/07/21 E 2029-1
920-788-0829
DOB 09/22/02

2SEH0956

SCHARA,GRACE TELE:2029* PID:999999999 TTX#8654AP MANUAL 07-OCT-2021 06:23:00
@25 MM/S HR 70 PVC 0 ECG SIZE 2X ST V1 0.4



HR 70 PR .16 QRS .08 QT .34

Interpretation: SR

Date: 10.7.21 Time: 0623 MT

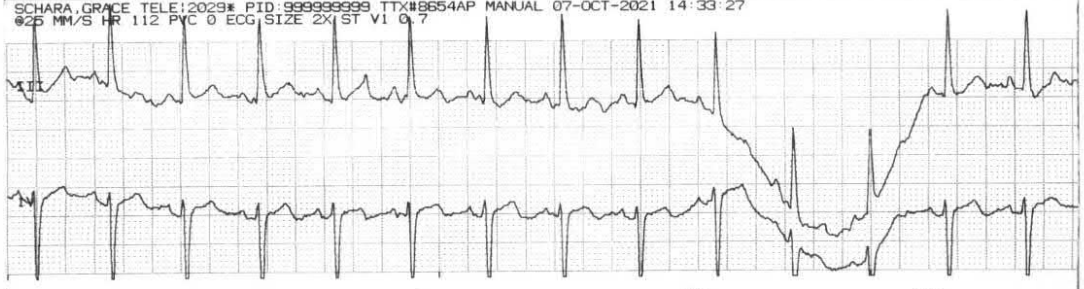
SCHARA,GRACE TELE:2029* PID:999999999 TTX#8654AP 07-OCT-2021 10:55:29
ALARM HISTORY *PVC* 07-OCT-2021 09:38:36 HR 111 @25 MM/S

HR 111 PR QRS QT

Interpretation: ST

Date: 10.7.21 Time: 0938 MT

SCHARA,GRACE TELE:2029* PID:999999999 TTX#8654AP MANUAL 07-OCT-2021 14:33:27
@25 MM/S HR 112 PVC 0 ECG SIZE 2X ST V1 0.7



HR 112 PR .16 QRS .08 QT .30

Interpretation: ST

Date: 10.7.21 Time: 1433 MT

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐ _____

Rhythm Strip Mount Sheets

Ascension Wisconsin
0007136 02/2020

E39547554 19 F
SCHARA,GRACE N

E000365038
BECK MD,DAVID
NORDSTROM MD,MARY E
ADM 10/07/21 E 2029-1
920-788-0829
DOB 09/22/02

2SEH0957

HR _____ PR _____ QRS _____ QT _____

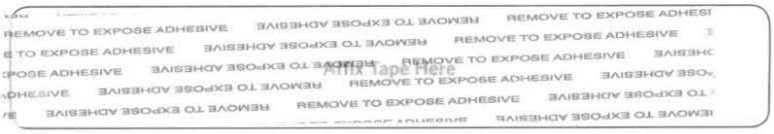
Interpretation: D/C Pt taken off tele

Date: 10/7/24 Time: 22:12 CR

HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:



HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐

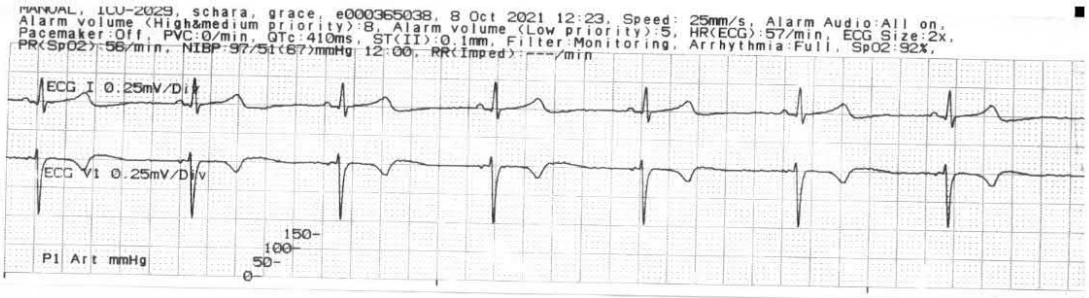
Rhythm Strip Mount Sheets

Ascension Wisconsin
0007136 02/2020

E39547554 19 F
SCHARA,GRACE N

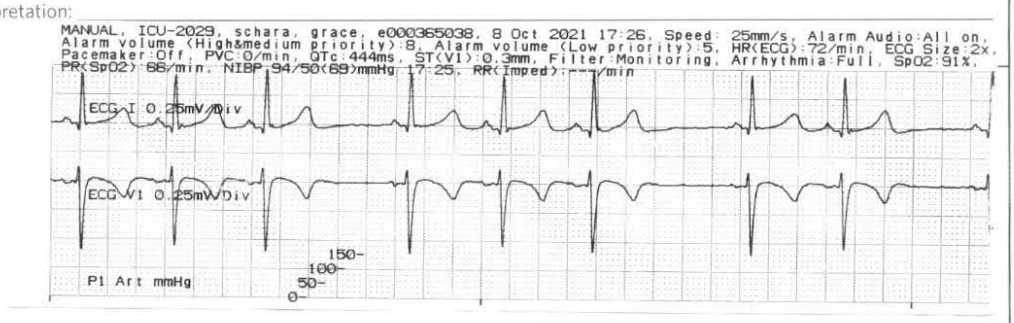
E000365038
BECK MD,DAVID
NORDSTROM MD,MARY E
ADM 10/07/21 E.2029-1
920-788-0829
DOB 09/22/02

2SEH0958



HR 100 PR _____ QRS _____ QT _____

Interpretation: _____



HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: 10/8 Time: 17:30 after Dopamine was started.

Affix Tape Here

REMOVE TO EXPOSE ADHESIVE

HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐

Rhythm Strip Mount Sheets

Ascension Wisconsin
0007136 02/2020

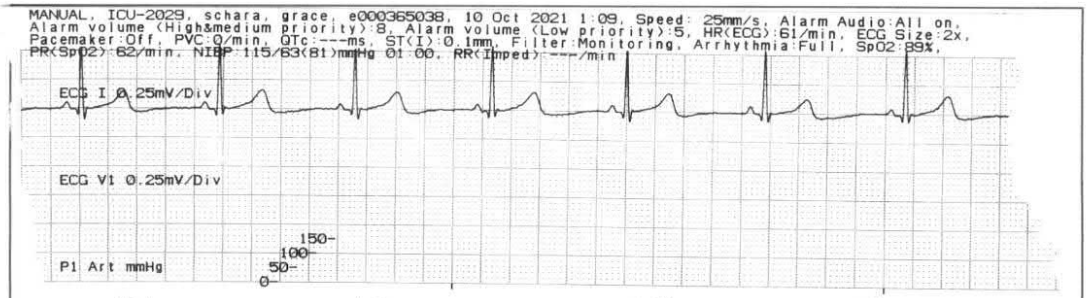
Patient Identification Label (if available)

Name: _____

Patient No: _____

DOB/Age: _____

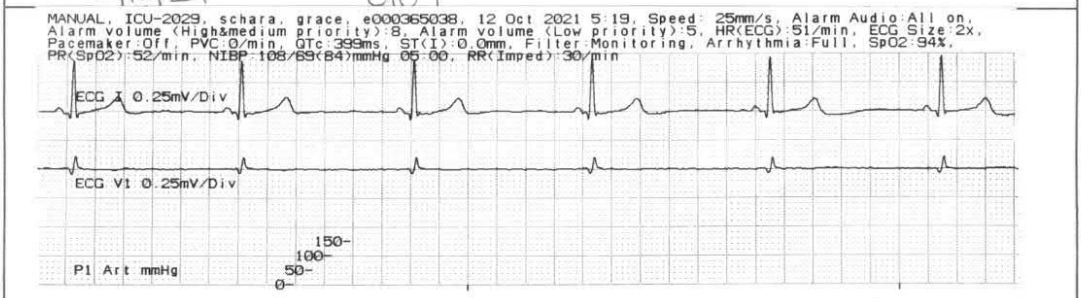
Attending Physician: _____



HR 61 PR .12 QRS .08 QT .4

Interpretation: SR

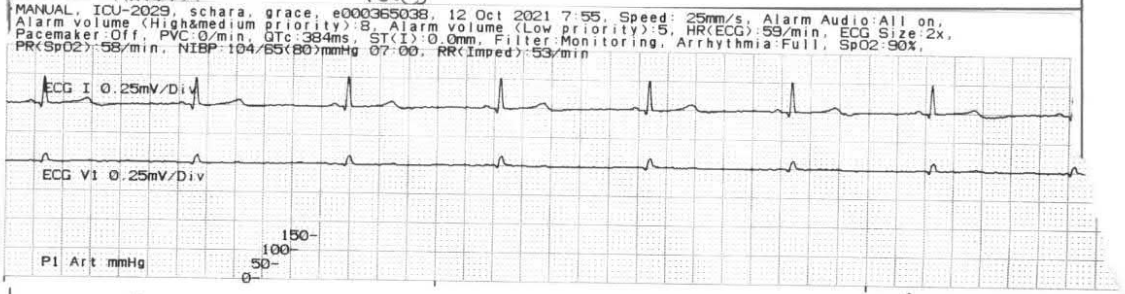
Date: 10/10/21 Time: 0109



HR ___ PR .10 QRS .04 QT .40

Interpretation: SB

Date: 10/12/21 Time: NOCs



HR 59 PR .12 QRS .04 QT .36

Interpretation: SB

Date: 10/12/21 Time: 0755

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐ _____

Rhythm Strip Mount Sheets

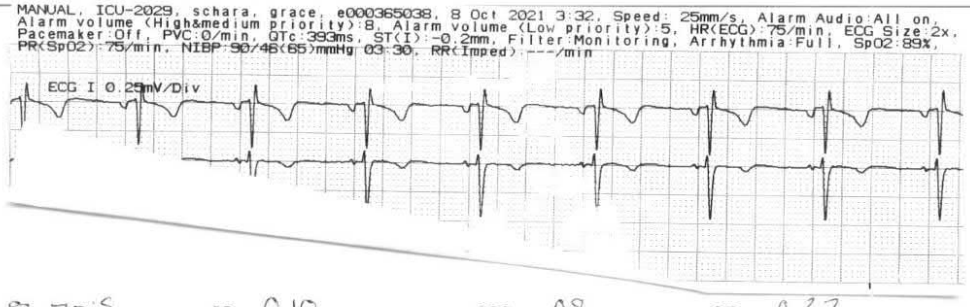
Ascension Wisconsin
0007136 02/2020

Patient Identification Label (if available)

E39547554 19 F
SCHARA GRACE N

E000365038
BECK MD, PA ID
NORDSTRO MAR
10/07/21
922-78B-
09/22/02

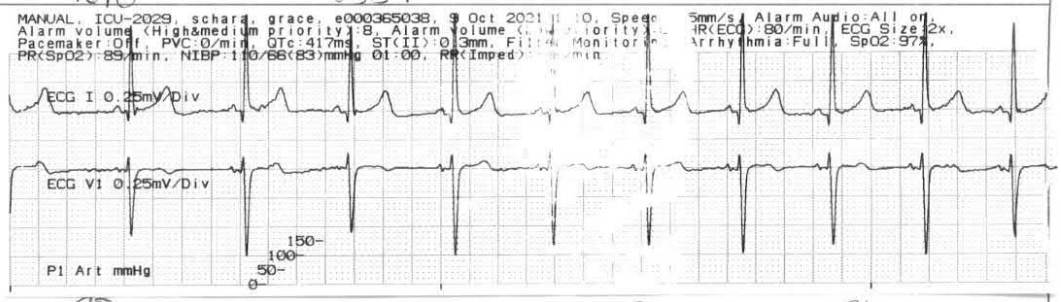
2SEH0960



HR 70's PR 0.10 QRS .08 QT 0.32

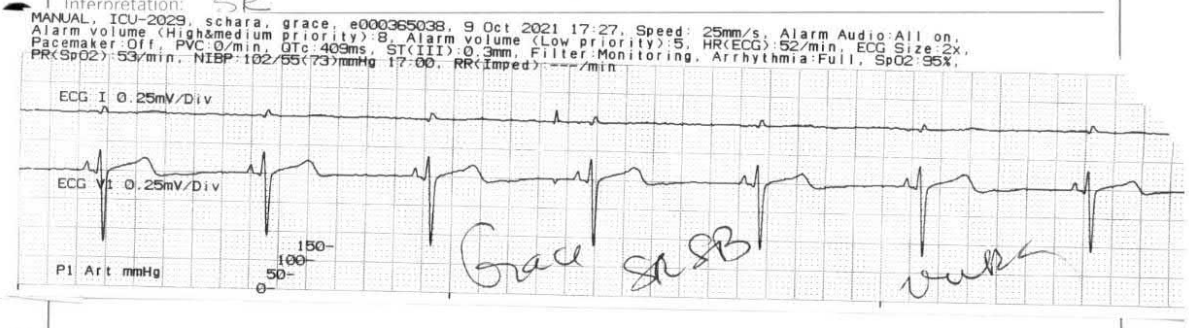
Interpretation: SR

Date: 10/8 Time: 0337



HR 80 PR .10 QRS .08 QT .36

Interpretation: SR



HR _____ PR _____ QRS _____ QT _____

Interpretation: _____

Date: Time:

☐ Ascension Medical Group ☐ Ascension Medical Group at Appleton Road
☐ Ascension Calumet Hospital, Inc. ☐ Network Health Plan
☐ Ascension NE Wisconsin - Mercy Hospital Campus ☐ Surgery Center
☐ Ascension NE Wisconsin - St. Elizabeth Hospital Campus
☐

Patient Identification Label (if available)

E3954754 1º F
SCHARA GRACE N

E000365038
BECK MD DAVID
NORDSTROM MD MARY E
10/07/21
920 788 0829
09/22/02

Rhythm Strip Mount Sheets

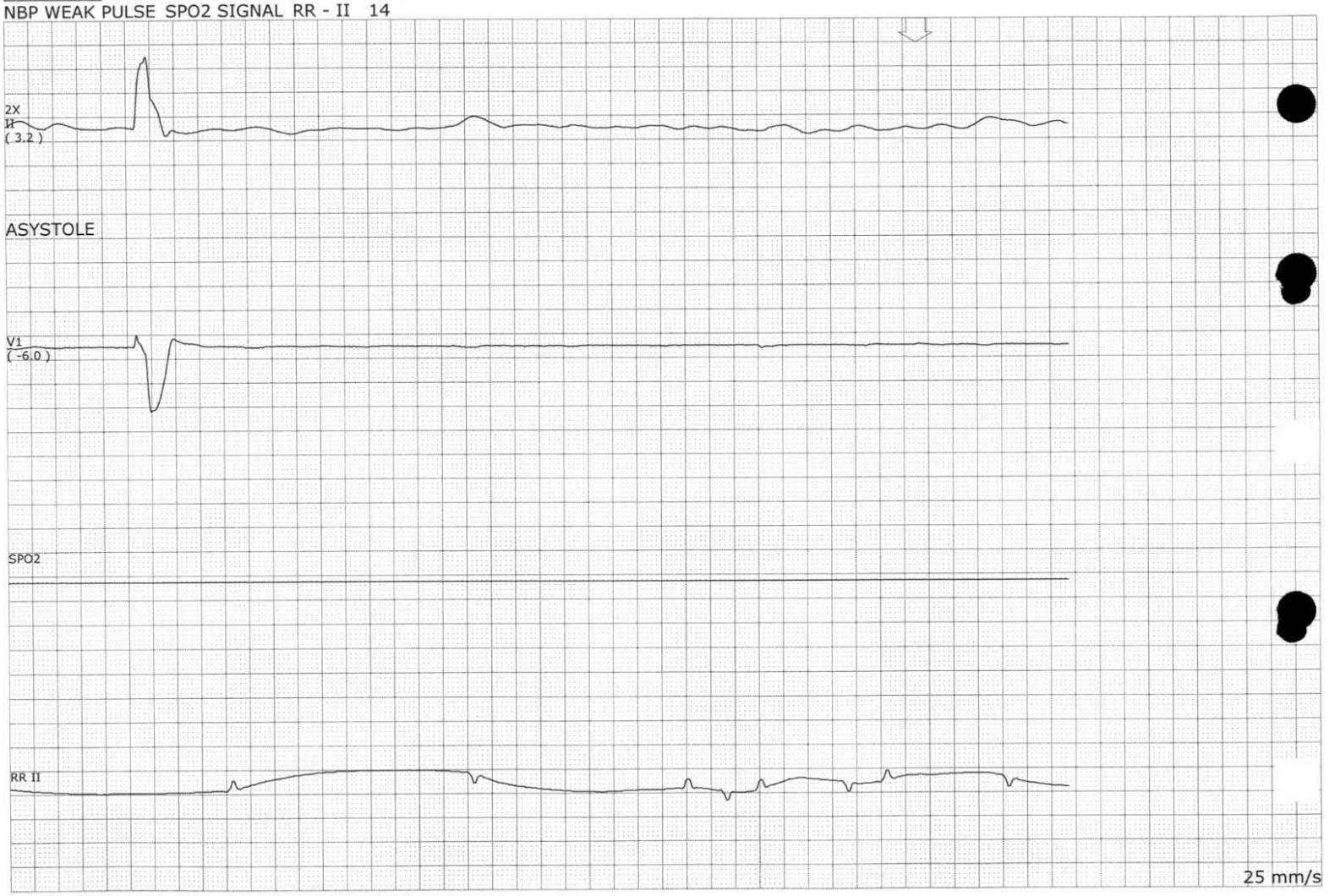
Ascension Wisconsin
0007136 02/2020

2SEH0961

schara,grace e000365038 13-Oct-2021 19:26:27

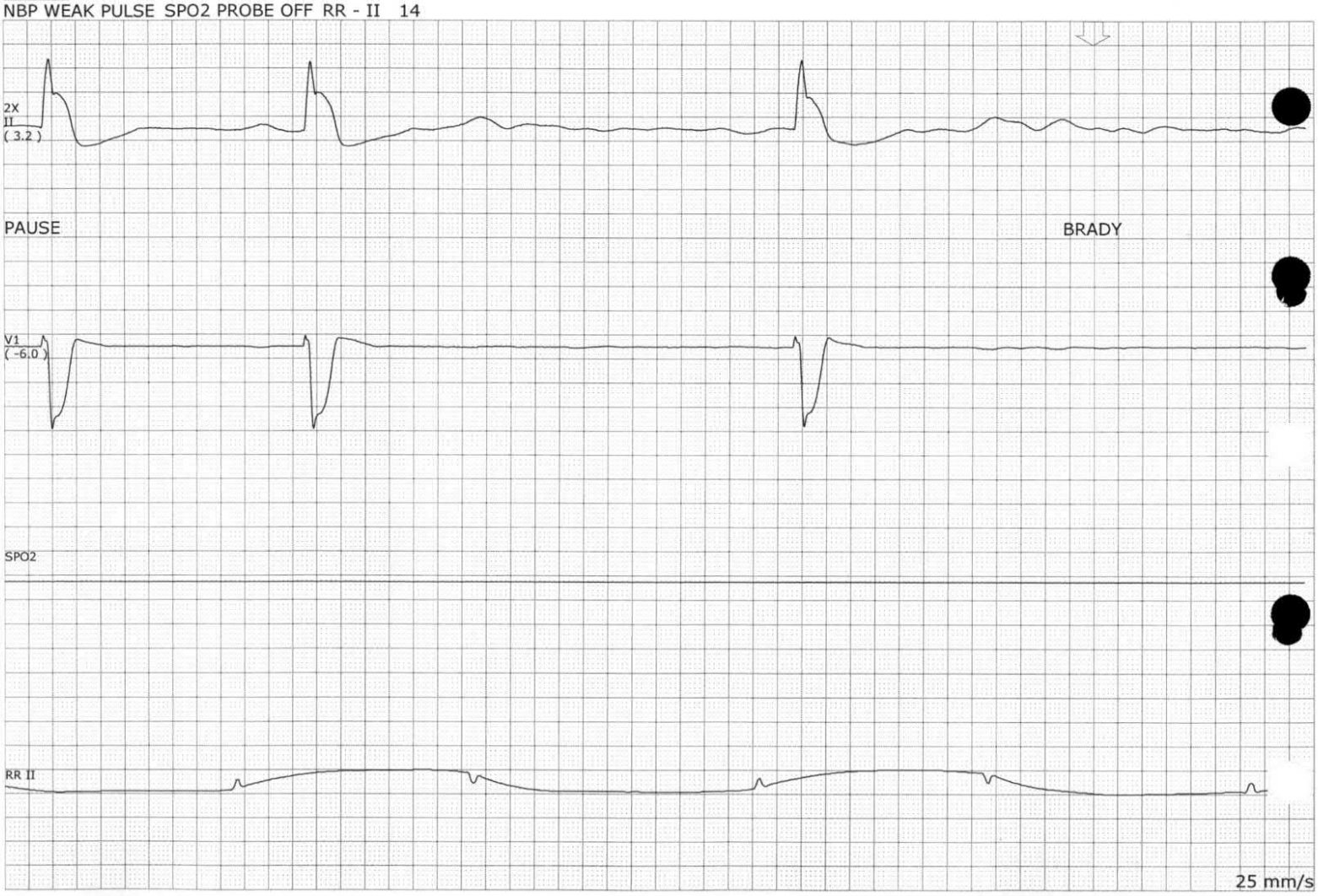
ASYSTOLE HR 0 PVC 1 ST V1 -6.0 mm Alarms Silenced ECG Size: 2X

NBP WEAK PULSE SPO2 SIGNAL RR - II 14



2SEH0962

schara,grace e000365038 13-Oct-2021 19:26:07 ICU|2029
BRADY HR 20 PVC 0 ST V1 -6.0 mm ECG Size: 2X
NBP WEAK PULSE SPO2 PROBE OFF RR - II 14



GE Medical Systems Information Technologies
CIC Version 5.1.1
Wednesday, October 13, 2021 7:42:08 PM

2SEH0963

I, _____ request and give consent to _____ to perform the
(Type or Print Patient Name) (Type or Print Doctor or Practitioner Name)
following procedure(s) Peripherally inserted central catheter.

(Please list site and side as appropriate)

The benefits, risks, complications and alternative to the above procedure(s) have been explained to me including the risks related to not receiving the proposed care, treatment, and services.

I understand that the procedure(s) will be performed under the supervision of my doctor or practitioner. My doctor or practitioner may use the services of other doctors or practitioners, or members of the resident staff as he or she deems necessary or advisable.

I authorize my doctor or practitioner and his or her associates and assistants to perform such additional procedures, which in their judgment are necessary and appropriate to carry out my diagnosis or treatment.

I authorize the hospital to retain, preserve and use for scientific, teaching or transplant purposes or to make other dispositions of, at their convenience, any specimens, tissues or parts taken from my body during the course of this operation **excluding (include arrangements)** _____

I consent to observers in the operating room in accordance with hospital policy. I consent to photography or video taping of my surgical procedure for documentation of medical care or educational purposes. If photography or video taping is used for education, my identity will remain anonymous and confidential.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me including the risks related to not receiving the proposed care, treatment and services.

If anesthesia is required, I consent to the administration of anesthesia by members of the Department of Anesthesiology. I also consent to the use of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the operation itself including, but not limited to, dental injury, hoarseness, vocal cord injury, infection, nerve injury, corneal abrasion, difficulty voiding, seizures, heart attack, stroke, lack of oxygen to the brain and even death. Regional and spinal anesthesia risks include but are not limited to localized bleeding, infection and pain as well as nerve damage, partial or failure to produce anesthesia. There is the risk of bleeding or infection in the brain or spine with spinal and epidural anesthesia.

I hereby acknowledge that an LIP (Licensed Independent Practitioner) has informed me that a blood or blood product transfusion is, or may be, medically indicated in my case.

I CERTIFY THAT I HAVE READ/HAD READ TO ME AND FULLY UNDERSTAND THE CONTENT OF THE ABOVE AUTHORIZATION AND I:

- ☐ **DO consent to a transfusion**
- ☐ **DO NOT consent to a transfusion**

I certify that I have read and understand the above consent statements. In addition, I have been offered the opportunity to ask my doctor or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s). Please review back of form prior to consent signature.

Patient/legal guardian signature	Date	Time	Witness	Date	Time
X	10/8/21	2:09pm	A Marsh RMT	10/8/21	2:10

Person signing on patient's behalf/relationship	Date	Time	Reason patient is unable to sign

Physician/Dentist/Podiatrist/Midwife	Date	Time

- ☐ **Ascension Calumet Hospital**
- ☐ **Ascension Mercy Hospital**
- ☒ **Ascension St. Elizabeth Hospital**

SURGICAL / BLOOD CONSENT FORM

7/20

Patient Identification 10/07/21

E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0964

This form provides basic information concerning transfusions and is used to AUTHORIZE or NOT AUTHORIZE the procedure by qualified medical personnel.

Benefits of Blood or Blood Products Transfusion:
Red Blood Cells improve oxygen delivery to vital organs and tissues and may be life saving. Platelets, Fresh Frozen Plasma, and Cryoprecipitate are used to replenish factors which are needing to prevent or control bleeding.

Risks of Blood or Blood Products Transfusion:
Although tested and determined safe, transfusions are associated with some risk factors which include, but are not limited to:

- Allergic reaction or fever
- Fluid overload
- Local site complications including bruising or infection
- Hemolytic and rarely fatal transfusion reaction
- Bloodborne infections, including a very small risk of viral infections, such as:
  - AIDS virus (HIV)
  - Hepatitis B
  - Hepatitis C
  - Human T-cell Leukemia Virus (HTLV1)

Potential Alternatives to a Transfusion:

- When circumstances allow, use your own blood
- Use of other medical treatments and therapies to be discussed with your physician, including modifying or postponing treatment

(This consent is valid for the current hospitalization or for one (1) year for outpatient use.)

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

Date 13-Oct-2021
Time 19:45:15
Page 1 of 2

		13-Oct 18:25	13-Oct 18:30	13-Oct 18:35	13-Oct 18:40	13-Oct 18:45	13-Oct 18:50	13-Oct 18:55
ECG-HR	beats/min	80	83	76	75	83	82	88
ECG-PVC	#/min	0	0	0	0	0	0	0
ECG-afibTrend	unitless	NO	NO	NO	NO	NO	NO	NO
NBP-Sys	mmHg			98				
NBP-Dias	mmHg			68				
NBP-Mean	mmHg			79				
SpO2	%	88	90	93	99	100	77	99
SpO2-Rate	beats/min	79	77	37	36	40	70	38
RESP-RR	breaths/min	36	39	37	36	39	36	36
ECG-ST-I	mm	0.0	0.1	0.3	0.2	0.1	0.0	0.2
ECG-ST-II	mm	-0.2	-0.3	-0.1	0.0	0.2	0.0	0.4
ECG-ST-III	mm	-0.2	-0.4	-0.5	-0.2	0.0	-0.1	0.0
ECG-ST-V	mm	0.5	0.4	0.5	0.2	0.2	0.2	0.3
ECG-ST-avR	mm	0.1	0.1	-0.1	-0.1	-0.1	0.0	-0.3
ECG-ST-avL	mm	0.1	0.2	0.4	0.2	0.1	0.0	0.1
ECG-ST-avF	mm	-0.2	-0.3	-0.3	-0.1	0.1	0.0	0.2

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

Date 13-Oct-2021
Time 19:45:15
Page 2 of 2

		13-Oct 19:00	13-Oct 19:05	13-Oct 19:10	13-Oct 19:15	13-Oct 19:20	13-Oct 19:25
ECG-HR	beats/min	101	84	61	76	64	27
ECG-PVC	#/min	0	0	0	0	0	0
ECG-afibTrend	unitless	NO	NO	NO	NO	YES	NO
NBP-Sys	mmHg				71...		
NBP-Dias	mmHg				44...		
NBP-Mean	mmHg				53...		
SpO2	%	97	82	74	85	86	
SpO2-Rate	beats/min	39	38	58	86	97	
RESP-RR	breaths/min	36	30	23	27	15	14
ECG-ST-I	mm	0.3	0.1	0.0	0.3	0.0	2.6
ECG-ST-II	mm	0.9	0.6	0.1	0.0	0.2	2.9
ECG-ST-III	mm	0.4	0.3	0.1	-0.4	0.1	-0.2
ECG-ST-V	mm	0.7	0.7	0.4	0.9	0.5	-5.1
ECG-ST-avR	mm	-0.6	-0.3	0.0	-0.1	-0.1	-2.7
ECG-ST-avL	mm	0.0	-0.1	0.0	0.3	0.0	1.4
ECG-ST-avF	mm	0.6	0.4	0.1	-0.2	0.1	1.3

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

Date 13-Oct-2021
Time 19:45:32

		13-Oct 13:30	13-Oct 14:00	13-Oct 14:30	13-Oct 15:00	13-Oct 15:30	13-Oct 16:00	13-Oct 16:30
ECG-HR	beats/min	72	87	80	81	76	78	106
ECG-PVC	#/min	0	0	0	0	0	0	0
ECG-afibTrend	unitless	NO	NO	NO	NO	NO	NO	NO
NBP-Sys	mmHg	116...	100	103		90...	85	86
NBP-Dias	mmHg	65...	52	56		55...	52	52
NBP-Mean	mmHg	82...	70	73		68...	64	64
SpO2	%	70	80	80	77	84	77	78
SpO2-Rate	beats/min	67	86	79	79	76	60	69
RESP-RR	breaths/min	41	48	52	49	0	49	47
ECG-ST-I	mm	0.3	0.2	0.2	0.2	0.1	0.2	
ECG-ST-II	mm	0.1	0.0	0.1	0.2	0.1	0.0	
ECG-ST-III	mm	-0.3	-0.2	-0.2	-0.1	0.0	-0.2	
ECG-ST-V	mm	0.1	0.2	0.1	0.0	0.0	0.0	
ECG-ST-avR	mm	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	
ECG-ST-avL	mm	0.2	0.1	0.2	0.2	0.1	0.2	
ECG-ST-avF	mm	-0.1	-0.1	0.0	0.0	0.0	-0.1	

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

Date 13-Oct-2021
Time 19:45:32
Page 2 of 2

		13-Oct 17:00	13-Oct 17:30	13-Oct 18:00	13-Oct 18:30	13-Oct 19:00	13-Oct 19:30
ECG-HR	beats/min	80	83	79	83	101	0
ECG-PVC	#/min	0	0	0	0	0	3
ECG-afibTrend	unitless	NO	NO	NO	NO	NO	NO
NBP-Sys	mmHg	84			98...	71...	
NBP-Dias	mmHg	51			68...	44...	
NBP-Mean	mmHg	63			79...	53...	
SpO2	%	80	55	45	90	97	
SpO2-Rate	beats/min	108	83	80	77	39	
RESP-RR	breaths/min	49	54	51	39	36	14
ECG-ST-I	mm	0.1	-0.1	0.1	0.1	0.3	-2.1
ECG-ST-II	mm	0.2	-0.1	0.0	-0.3	0.9	-5.1
ECG-ST-III	mm	0.0	0.0	-0.2	-0.4	0.4	-2.6
ECG-ST-V	mm	0.0	0.0	0.1	0.4	0.7	-1.7
ECG-ST-avR	mm	-0.1	0.1	0.0	0.1	-0.6	3.6
ECG-ST-avL	mm	0.0	-0.1	0.2	0.2	0.0	0.2
ECG-ST-avF	mm	0.1	0.0	-0.1	-0.3	0.6	-3.8

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

Date 13-Oct-2021
Time 19:45:35
Page 1 of 2

		13-Oct 07:00	13-Oct 08:00	13-Oct 09:00	13-Oct 10:00	13-Oct 11:00	13-Oct 12:00	13-Oct 13:00
ECG-HR	beats/min	74	90	95	73	95	73	69
ECG-PVC	#/min	0	0	0	0	0	0	1
ECG-afibTrend	unitless	NO	NO	NO	NO	NO	NO	NO
NBP-Sys	mmHg	106	107...	121	106...	88...	105...	102...
NBP-Dias	mmHg	75	58...	79	60...	53...	58...	56...
NBP-Mean	mmHg	84	76...	95	76...	66...	76...	74...
SpO2	%	95	95	92	91	88	82	85
SpO2-Rate	beats/min	74	91	93	73	94	72	72
RESP-RR	breaths/min	35	35	32	52	34	44	46
ECG-ST-I	mm	0.1	0.0	0.3	0.1	0.1	0.2	0.2
ECG-ST-II	mm	0.1	0.0	0.2	0.0	0.0	0.0	0.1
ECG-ST-III	mm	0.0	0.0	-0.2	-0.1	-0.2	-0.2	-0.2
ECG-ST-V	mm	0.0	0.0	0.4	0.3	0.5	0.1	0.0
ECG-ST-avR	mm	-0.1	0.0	-0.2	0.0	0.0	-0.1	-0.1
ECG-ST-avL	mm	0.0	0.0	0.2	0.0	0.2	0.2	0.2
ECG-ST-avF	mm	0.1	0.0	0.0	0.0	-0.1	-0.1	0.0

GE Healthcare

2SEH0970

Vital Signs

Name schara,grace
MRN e000365038
Unit ICU
Bed 2029

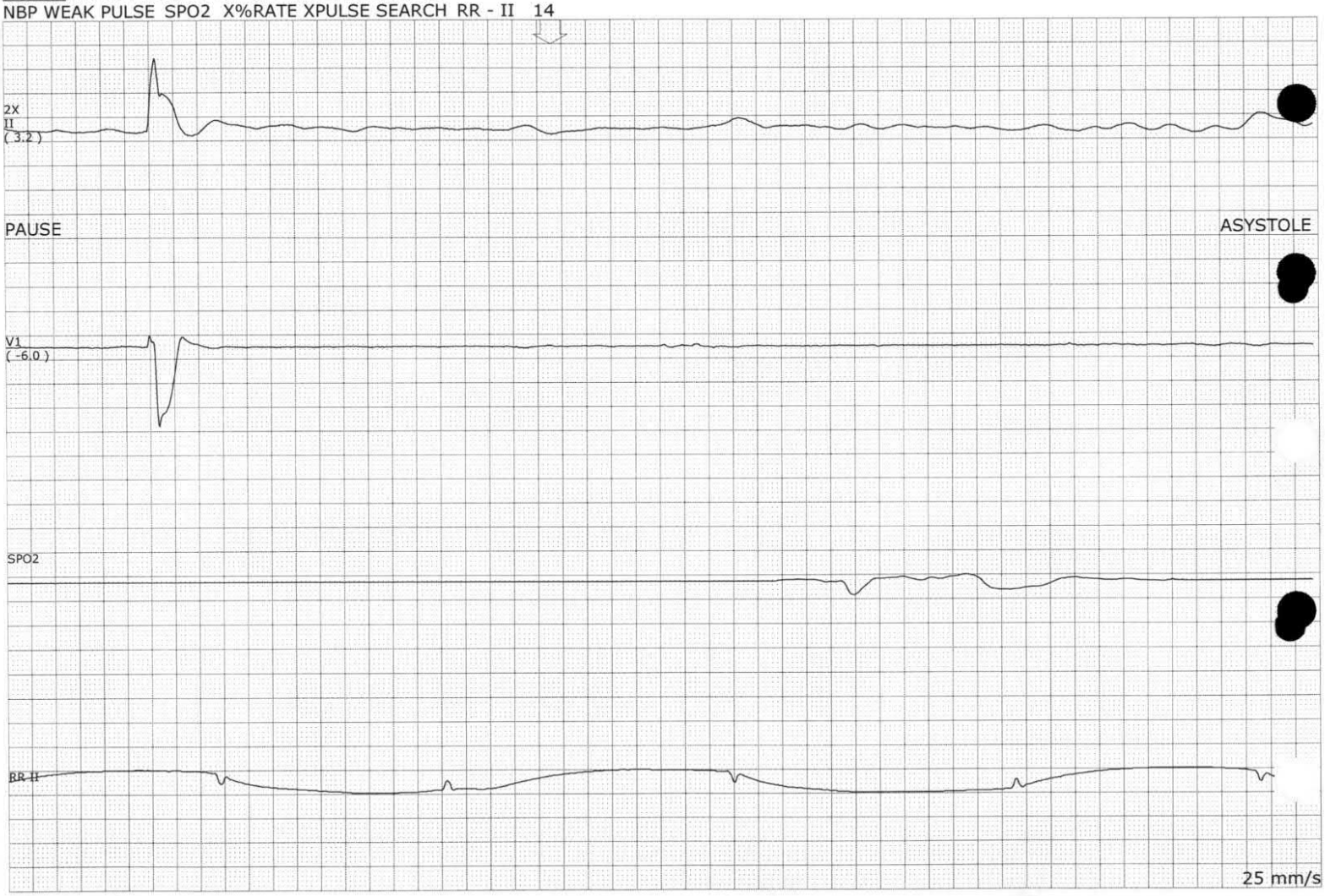
Date 13-Oct-2021
Time 19:45:35

		13-Oct 14:00	13-Oct 15:00	13-Oct 16:00	13-Oct 17:00	13-Oct 18:00	13-Oct 19:00
ECG-HR	beats/min	87	81	78	80	79	101
ECG-PVC	#/min	0	0	0	0	0	0
ECG-afibTrend	unitless	NO	NO	NO	NO	NO	NO
NBP-Sys	mmHg	100...	103...	85...	84...		71...
NBP-Dias	mmHg	52...	56...	52...	51...		44...
NBP-Mean	mmHg	70...	73...	64...	63...		53...
SpO2	%	80	77	77	80	45	97
SpO2-Rate	beats/min	86	79	60	108	80	39
RESP-RR	breaths/min	48	49	49	49	51	36
ECG-ST-I	mm	0.2	0.2	0.2	0.1	0.1	0.3
ECG-ST-II	mm	0.0	0.2	0.0	0.2	0.0	0.9
ECG-ST-III	mm	-0.2	-0.1	-0.2	0.0	-0.2	0.4
ECG-ST-V	mm	0.2	0.0	0.0	0.0	0.1	0.7
ECG-ST-avR	mm	-0.1	-0.2	-0.1	-0.1	0.0	-0.6
ECG-ST-avL	mm	0.1	0.2	0.2	0.0	0.2	0.0
ECG-ST-avF	mm	-0.1	0.0	-0.1	0.1	-0.1	0.6

schara,grace e000365038 13-Oct-2021 19:26:14 1927

PAUSE HR 14 PVC 0 ST V1 -6.0 mm ECG Size: 2X

NBP WEAK PULSE SPO2 X%RATE XPULSE SEARCH RR - II 14

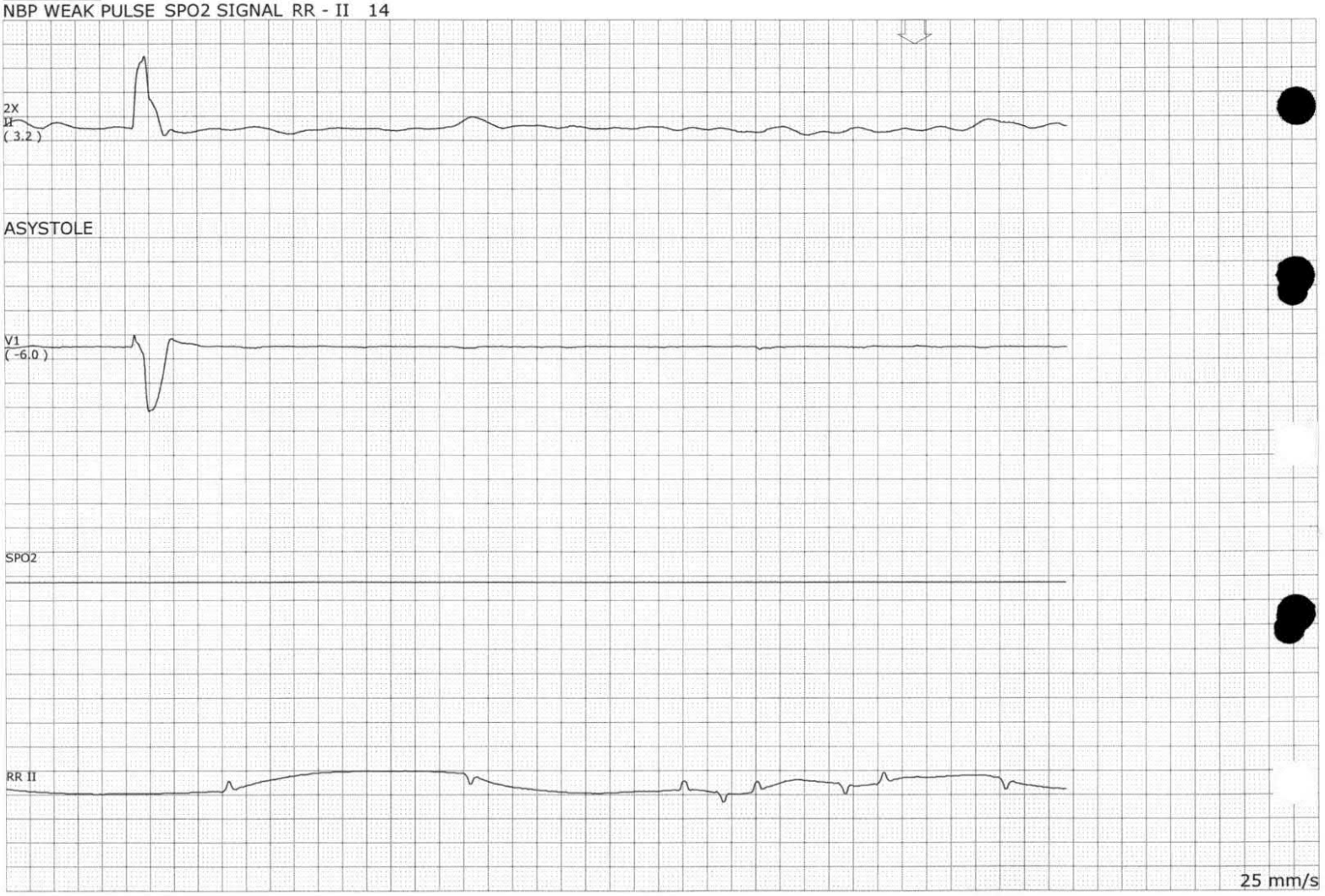


2SEH0972

schara,grace e000365038 13-Oct-2021 19:26:27 ICU|2029

ASYSTOLE HR 0 PVC 1 ST V1 -6.0 mm Alarms Silenced ECG Size: 2X

NBP WEAK PULSE SPO2 SIGNAL RR - II 14

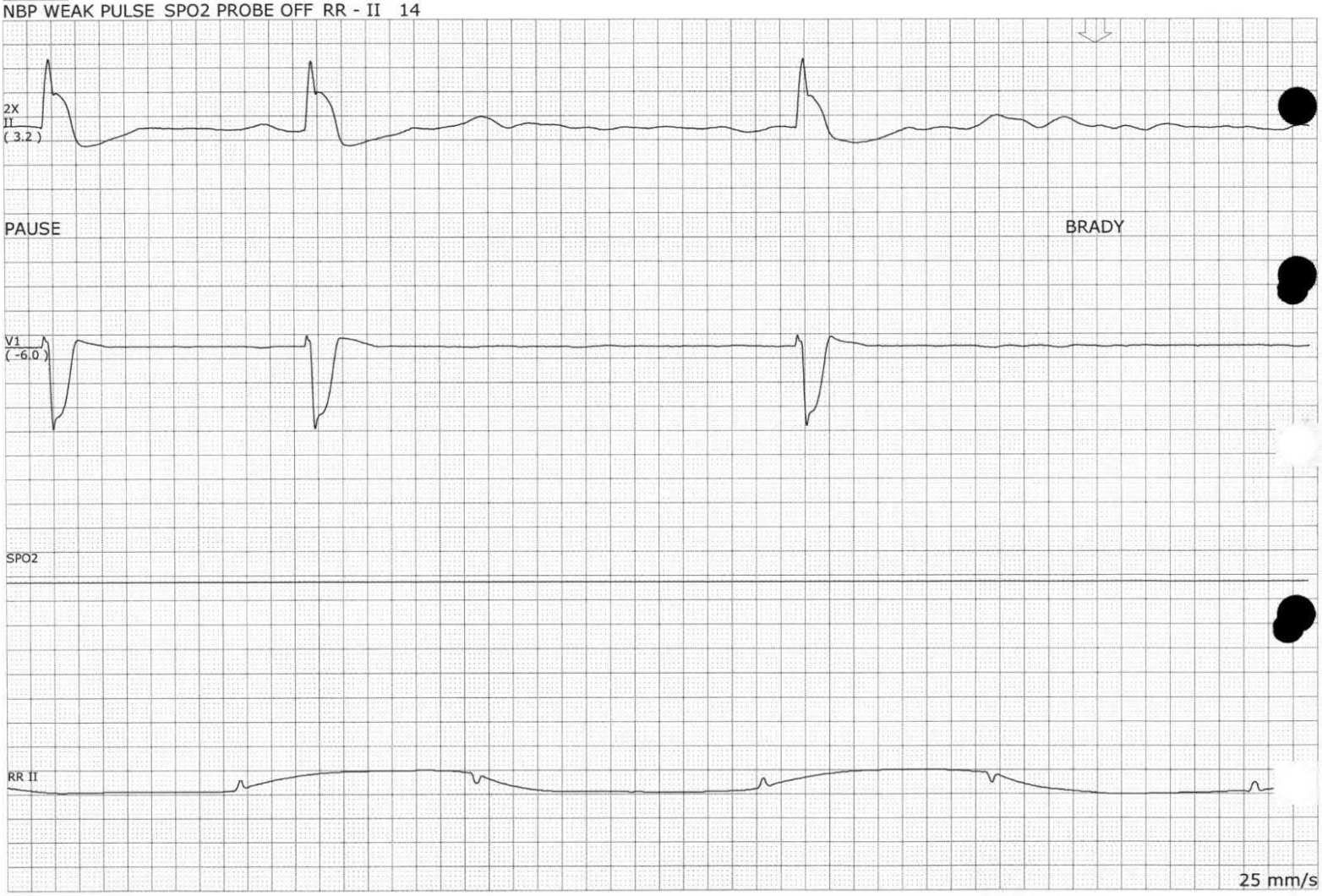


2SEH0973

schara,grace e000365038 13-Oct-2021 19:26:07 ICU|2029

BRADY HR 20 PVC 0 ST V1 -6.0 mm ECG Size: 2X

NBP WEAK PULSE SPO2 PROBE OFF RR - II 14

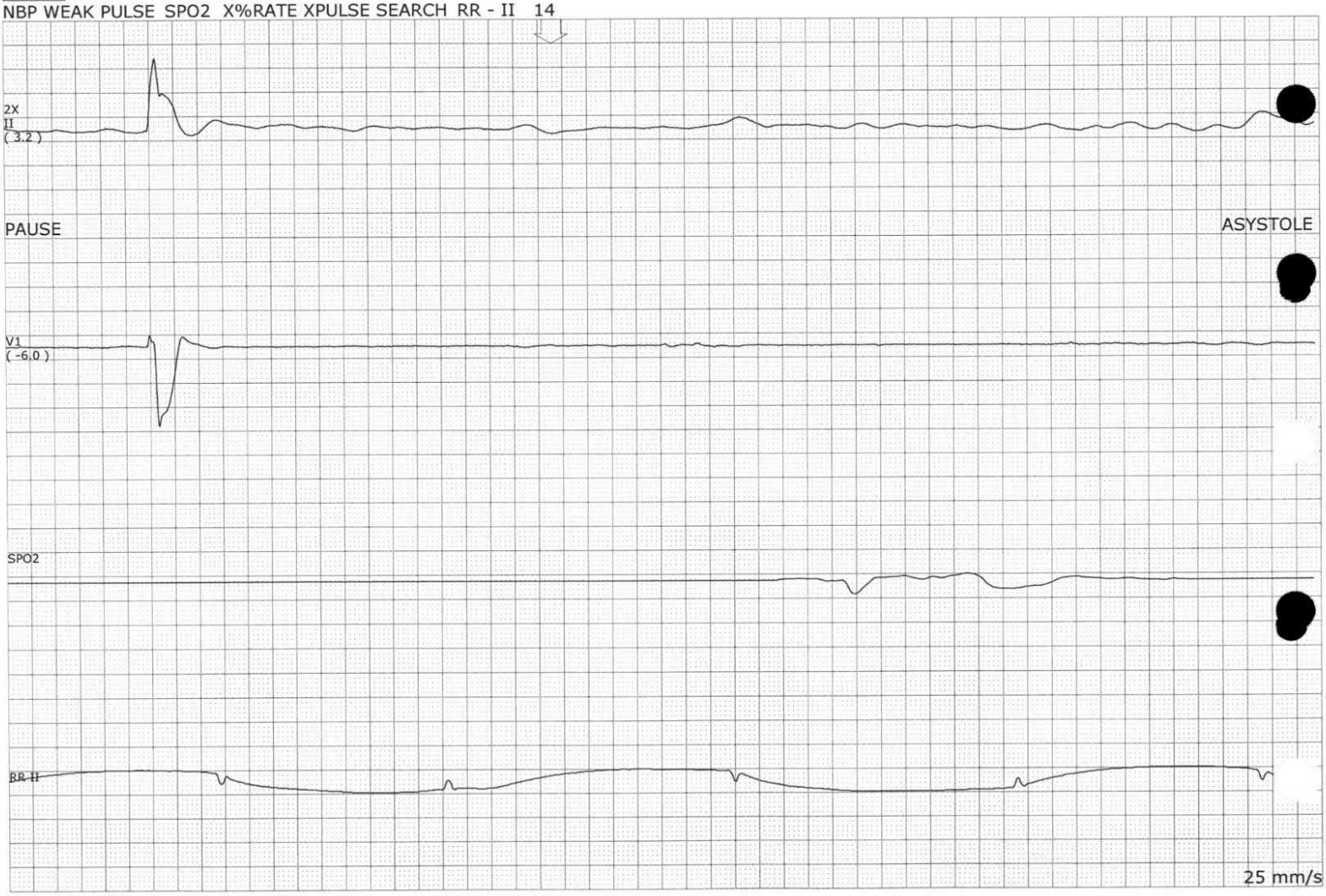


2SEH0974

schara,grace e000365038 13-Oct-2021 19:26:14

PAUSE HR 14 PVC 0 ST V1 -6.0 mm ECG Size: 2X

NBP WEAK PULSE SPO2 X%RATE XPULSE SEARCH RR - II 14



2SEH0975

Equip V60 Date: 4/3/21

Time	0000	0200	0400	0600	0800	1135	1600	1841						
Ventilator Status														
Mode	S/T	S/T	S/T	S/T		S/T	S/T	S/T						
Automode	UN	UN	UN	UN		UN	UN							
VT / VT exh								00						
Spont VT	575	620	540	596		663	696	676						
RR Set / RR Act	14 42	14 39	17 35	14 34		14 47	14 52	17 36						
VE Set / VE exh	339	18.2	9.1	20.9		31.3	37.1	26.1						
FiO2 Set / FiO2 ANA	100	100	100	100	(90)	100	100	100						
PC / PS	5	5	5	5		5	5	5						
Peep / Peep tot														
PIP / Pause	21	21	21	21		21	21	20						
CS / Insp Time %														
Insp Period	2.0	2.0	2.0	2.0		2.0	2.0	2						
Sens / IRT	3	3	3	3		3	3	3						
CPAP Flow														
IPAP / EPAP	20 15	20 15	20 15	20 15		20 15	20 15	20 15						
Alarms														
Low Press / High Press														
Low VE / High VE														
Low O2 / High O2														
Low RR / High RR														
Pt Status														
HR / SpO2	54 95	95	51 98	83 95		74 96	83 94	74 87						
ETCO2 / Leak	32	40	47	6		35	43	4						
Humidity														
Circuit Humidity approp														
HFOV														
ΔP / Power														
MAP / Hz														
Bias Flow														
RT Initial	AW	AW	AW	AW		AW	AW	AW						

Pressure Limit:

Weaning				
RR				
VT				
VE				
VC				
NIF				

Tube Care						
Time						
Size						
Cuff Press						
Location						
Initial						

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:

MR E39547554 19 F
SCHARR GRACE N

E000365036
BECK MD DAVID
NORDSTROM MD MARY E
10/07/21
920-788-0821
09/22/02

2SEH0976

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders

Extubation criteria:

- Clinical condition improving
- RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
- Alert and following commands
- Able to lift head off pillow
- Minimal secretions
- Adequate cough
- Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate

SBT Failure criteria:

- RR > 35/min or < 8/min
- RSBI > 100 for 5 minutes
- Oxygen saturation < 88%
- Respiratory distress, anxiety, agitation, or mental status changes
- Acute cardiac dysrhythmia

2SEH0977

Date: 10-12-21 Pressure Limit:

Equip	VC60													
Time	0004	0311	0700	0920	1105	1400	1615	1846	2000					
Ventilator Status														
Mode	S/T	S/T	S/T	S/T	S/T	S/T	S/T	S/T	S/T					
Automode				UN	UN	UN	UN	UN	UN					
VT / VT exh														
Spont. VT	427	588	392	443	572	426	424	427	680					
RR Set / RR Act	14/34	14/37	14/41	14/45	14/40	14/42	14/41	14/36	14/51					
VE Set / VE exh	166	17.2	14.5	20.8	21.4	18.7	17.3	18.1	19.8					
FiO2 Set / FiO2 ANA	100	100	25	85	85	100	100	100	100					
PC / PS	3	3	3	3	3	(5)	5	5	5					
Peep / Peep tot														
PIP / Pause	16	17	16	16	17	20	20	20	22					
CS / Insp Time %														
Insp Period	1.45	1.45	1.45	1.45	1.45	2.0	2.0	20	2.0					
Sens / IRT	3	3	3	3	3	3	3	3	3					
CPAP Flow														
IPAP / EPAP	15/12	15/12	15/12	15/12	15/12	(20/15)	20/15	20/15	20/15					
Alarms														
Low Press / High Press														
Low VE / High VE														
Low O2 / High O2														
Low RR / High RR														
Pt Status														
HR / SpO2	149/92	89/87	162/98	161/86	164/87	154/86	150/90	152/96	152/86					
ETCO2 / Leak	30	44	86	3	1	13	14	0	90					
Humidity														
Circuit Humidity approp														
HFOV														
ΔP / Power														
MAP / Hz														
Bias Flow														
RT Initial	AW	AW	AP	AP	AP	AP	AP	DW	DW					

Weaning			
RR			
VT			
VE			
VC			
Nif			

Tube Care							
Time							
Size							
Cuff Press							
Location							
Initial							

☐ Ascension Calumet Hospital
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☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0978

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

Date: 10-11-21 Pressure Limit:

Equip	V.60													
Time	0150	411	0620	0900	1205	1480	1640	1803	2134					
Ventilator Status														
Mode	ST	ST	SIT	SIT	SIT	SIT	SIT	SIT	SIT					
Automode			UN	UN	UN	UN	UN	UN	UN					
VT / VT exh														
Spont. VT	379	385	383	391	489	458	431	481	480					
RR Set / RR Act	14 / 32	14 / 31	14 / 34	14 / 31	14 / 29	14 / 36	14 / 34	14 / 27	14 / 46					
VE Set / VE exh	12.3	12.1	12.6	15.1	13.5	16.9	18.8	16.2	20.8					
FiO2 Set / FiO2 ANA	90	90	90	90	90	(85)	(90)	90	100					
PC / PS	3	3	3	3	3	3	3	3	3					
Peep / Peep tot														
PIP / Pause	16	16	15	16	16	16	15	16	16					
CS / Insp Time %														
Insp Period	1.45	1.45	1.45	1.45	1.45	1.45	1.45	1.45	1.45					
Sens / IRT	3	3	3	3	3	3	3	3	3					
CPAP Flow														
IPAP / EPAP	15/12	15/12	15/10	15/12	15/12	15/12	15/12	15/12	15/12					
Alarms														
Low Press / High Press														
Low VE / High VE														
Low O2 / High O2														
Low RR / High RR														
Pt Status														
HR / SpO2	59/98	58/97	61/98	88/94	72/93	80/94	60/92	59/90	61/85					
ETCO2 / Leak		1	1	2	9	0	8	0	1					
Humidity														
Circuit Humidity approp														
HFOV														
△P / Power														
MAP / Hz														
Bias Flow														
RT Initial	D	D	AC	AC	AC	AC	AC	AW	AW					

Weaning			
RR			
VT			
VE			
VC			
Nif			

Tube Care							
Time							
Size							
Cuff Press							
Location							
Initial							

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RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0980

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

Date: 10/10/2021 Pressure Limit:

Equip															
Time	1610	1620	1815												
Ventilator Status															
Mode															
Automode															
VT / VT exh															
Spont. VT															
RR Set / RR Act															
VE Set / VE exh															
FiO2 Set / FiO2 ANA	65	60	75												
PC / PS															
Peep / Peep tot															
PIP / Pause															
CS / Insp Time %															
Insp Period															
Sens / IRT															
CPAP Flow															
IPAP / EPAP															
Alarms															
Low Press / High Press															
Low VE / High VE															
Low O2 / High O2															
Low RR / High RR															
Pt Status															
HR / SpO2															
ETCO2 / Leak															
Humidity															
Circuit Humidity approp															
HFOV															
△P / Power															
MAP / Hz															
Bias Flow															
RT Initial	KLPN	KLPN	KLPN												

Supine

Weaning			
RR			
VT			
VE			
VC			
Nif			

Tube Care			
Time			
Size			
Cuff Press			
Location			
Initial			

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☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0982

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

☐ Ascension Calumet Hospital
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☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 2 of 2)

2/21

Patient Identification:

Date: 10·10·21 Pressure Limit:

Equip	V-60													
Time	0115	0608	0817	0900	0920	0945	1044	1210	1325	1331	1515	1529	1605	
Ventilator Status														
Mode	ST	ST	ST	ST			ST	ST				ST		
Automode														
VT / VT exh														
Spont. VT	401	388	509	426			432	454				361		
RR Set / RR Act	14 / 33	14 / 47	14 / 31	14 / 27			14 / 31	14 / 31				14 / 47		
VE Set / VE exh	13.1	18.2	14.8	13.3			13.6	13.8				17.3		
FiO2 Set / FiO2 ANA	100	100	100	90	90	100	100	100	90	80	75	75	70	
PC / PS	3	3	3	3			3	3						
Peep / Peep tot														
PIP / Pause	16	13	17	16			17	16				15		
CS / Insp Time %														
Insp Period	1.45	1.45	1.45	1.45			1.45	1.45				1.45		
Sens / IRT	3	3	3	3			3	3				3		
CPAP Flow														
IPAP / EPAP	15 / 12	15 / 12	15 / 12	15 / 12			15 / 12	15 / 12				15 / 12		
Alarms														
Low Press / High Press														
Low VE / High VE														
Low O2 / High O2														
Low RR / High RR														
Pt Status														
HR / SpO2	62 / 98	146 / 93	144 / 90	128 / 97			59 / 94	74 / 91				71 / 93		
ETCO2 / Leak	29	1	1	1			0	2				8		
Humidity														
Circuit Humidity approp														
HFOV														
ΔP / Power														
MAP / Hz														
Bias Flow														
RT Initial	KD	MD	MD	AC	KEWEN	KEWEN	MD	MD	KEWEN	KEWEN	KEWEN	MD	KEWEN	

Weaning				
RR				
VT				
VE				
VC				
Nif				

Tube Care								
Time								
Size								
Cuff Press								
Location								
Initial								

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☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0984

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

Date: 10.9.21 Pressure Limit:

Equip	~~D~~													
Time	1840	0350	0730	0945	1140	1355	1515	2230	0830					
Ventilator Status														
Mode	SIT	SS	SIT	SIT	SIT	SIT	Vapo	SS						
Automode					UN	UN		UN						
VT / VT exh														
Spont. VT	497	490	370	395	375	376		426						
RR Set / RR Act	14 / 33	14 / 34	14 / 36	14 / 41	14 / 39	14 / 38		14 / 37						
VE Set / VE exh	10.1	10.1	10.1 / 36	15.0	15.0	15.6		11.6						
FiO2 Set / FiO2 ANA	100	100	100 / 100	100	100	100	40% 100%	100						
PC / PS	5	5	5	~~7~~	7	7		5						
Peep / Peep tot														
PIP / Pause	17	17	15	15	16	15		16						
CS / Insp Time %														
Insp Period	1.45	1.45	1.45	1.45	1.45	1.45		1.45						
Sens / IRT	3	3	3	3	3	3		3						
CPAP Flow														
IPAP / EPAP	15 / 10	15 / 10	15 / 10	15 / ~~10~~	15 / 12	15 / 12		15 / 12						
Alarms														
Low Press / High Press														
Low VE / High VE														
Low O2 / High O2														
Low RR / High RR														
Pt Status														
HR / SpO2	79 / 95	79 / 99	79 / 92	65 / 91	63 / 95	66 / 95	77	64 / ~~88~~						
ETCO2 / Leak	2	6	14	5	3	7		7						
Humidity														
Circuit Humidity approp														
HFOV														
ΔP / Power														
MAP / Hz														
Bias Flow														
RT Initial	~~D~~	~~D~~	AC	AC	AC	AC	AC	~~D~~						

Weaning			
RR			
VT			
VE			
VC			
Nif			

Tube Care							
Time							
Size							
Cuff Press							
Location							
Initial							

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☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0986

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

Date: 10-8-21 Pressure Limit:

Equip	Bipap													
Time		0158	0335	0745	1130	1600								
Ventilator Status	Mode	ST	ST	ST	ST	ST								
	Automode													
	VT / VT exh													
	Spont. VT	578	336	433	403	485								
	RR Set / RR Act	12 34	12 36	14 37	14 35	14 20								
	VE Set / VE exh	18.1	12.9	14.3	10.1	13.8								
	FiO2 Set / FiO2 ANA	100	100	100	100	95								
	PC / PS	4	4	4	5	5								
	Peep / Peep tot													
	PIP / Pause	13	12	17	16	16								
	CS / Insp Time %													
	Insp Period	1.45	1.45	1.45	1.45	1.45								
	Sens / IRT	3	3	3	3	3								
	CPAP Flow													
	IPAP / EPAP	12 8	12 8	12 8	16 10	15 10								
Alarms	Low Press / High Press													
	Low VE / High VE													
	Low O2 / High O2													
	Low RR / High RR													
Pt Status	HR / SpO2	94 96	95 96	73 91	57 93	49 95								
	ETCO2 / Leak	1	1	—	1	—								
	Humidity													
	Circuit Humidity approp													
HFOV	ΔP / Power													
	MAP / Hz													
	Bias Flow													
RT Initial		MM	MM	LHD	LHD	LHS								

Weaning				
	RR			
	VT			
	VE			
	VC			
	Nif			

Tube Care							
	Time						
	Size						
	Cuff Press						
	Location						
	Initial						

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

RESPIRATORY CRITICAL CARE FLOWSHEET
(Page 1 of 2)

2/21

Patient Identification:
10/07/21
E39547554 IN E.2029/1
SCHARA,GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD,DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0988

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

| | | |

Weaning Parameters:

- If SBT passed and other extubation criteria present, contact LIP to consider extubation orders
  Extubation criteria:
  - Clinical condition improving
  - RSBI < 100 for 60 minutes on minimal support (PS 5/PEEP 5)
  - Alert and following commands
  - Able to lift head off pillow
  - Minimal secretions
  - Adequate cough
  - Present of air leak when cuff deflated

- If SBT failed, return to previous ventilator settings. Reassess in 24 hours or sooner if appropriate
  SBT Failure criteria:
  - RR > 35/min or < 8/min
  - RSBI > 100 for 5 minutes
  - Oxygen saturation < 88%
  - Respiratory distress, anxiety, agitation, or mental status changes
  - Acute cardiac dysrhythmia

INITIALS	SIGNATURE (first initial & last name) WITH CREDENTIAL(S)	PRINTED NAME WITH CREDENTIAL(S)	JOB TITLE
MS	Mary PT	Mary Premo PT	PT
DM	Debra Miller	Debra Miller	AN/PE
LR	L. Reynebeau, RDN, CD	Laura Reynebeau, RDN, CD	RDN

☐ Ascension Calumet Hospital
☐ Ascension Mercy Hospital
☒ Ascension St. Elizabeth Hospital

INITIAL / SIGNATURE IDENTIFICATION FORM

10/05

Patient Identification:

10/07/21
E39547554 IN E.2029/1
SCHARA, GRACE N
N4833 MISTY MEADOWS DR SEYMOUR
BECK MD, DAVID
09/22/02 920-788-0829
MRE000365038 19/F CHNP

2SEH0992

FINAL **Patient Care Report**

Gold Cross Ambulance Service, Inc.
Expert Care in a Heartbeat

Gold Cross Ambulance Service Inc.
1055 WITTMANN DR
MENASHA, WI 54952-3606
(920) 727-3020 Ext.

Run Number:	23387
Date of Service:	10/06/2021
Patient Name:	Grace Schara
Medical Rec #:	365038

WI Ambulance Provider # 60-01331

CREW INFO

Vehicle : GC5
Crew #1: Stahl, Mariah
Crew #2: Reinke, Adam

Doc'd By: Stahl, Mariah
Assisted By: RN

RESPONSE INFO

Med/Trauma: Medical
Call Type: Medical Transport
Response Priority: Non Emergency
Nature Of Call: Transfer/Interfacility
Start Mileage: 197,970.2
Resp. Delay: Radio Malfunction
<None>
<None>
Trans. Delay: <None>
<None>
<None>

Location: Affinity Hlth Sys(App/Rich)
3329 N RICHMOND ST
APPLETON, WI 54911

DISPOSITION

Outcome: Treated/Transported by EMS
Dest. Reason: Family Choice
Transport Priority: Non Emergency
Emergent TX Reason:
At Scene Mileage: 197,972.4
At Dest. Mileage: 197,976.1
Condition at Dest.:
Barriers to Care: Developmentally Impaired
None
None
Pt. Transported:
Scene Delay : None/No Delay
Destination: St Elizabeth Hospital
1506 S ONEIDA ST
APPLETON, WI 54915
Transporting Agency:
Transporting Unit:

TIMES

Recvd:	13:27 10-06-21
Dispatch:	13:28 10-06-21
En route:	13:28 10-06-21
At patient:	13:37 10-06-21
At scene:	13:38 10-06-21
Transport:	13:51 10-06-21
At dest.:	14:04 10-06-21
In service:	14:29 10-06-21
At base:	14:29 10-06-21

PATIENT INFORMATION

Name : Grace Schara
SSN : 000-00-0000
Sex : Female
Race : White

Phone :
DOB : 9/22/2002
Home Addr. : N4833 MISTY MEADOW RD
SEYMOUR, WI 54165

DL Info :
Weight : 200 lbs
Mailing Addr. :

INSURANCE

no insurance information entered

HISTORY

Allergies:
No Known Environmental/Food Allergies

Chief Complaint:
Breathing Problem

Past Medical History:
Neuro-Down's Syndrome

ASSESSMENTS

10/06/2021 13:43:00 By: Stahl, Mariah

Body Area	Assessment	Body Area	Assessment
Airway	Patent	Blood/Fluid Loss	None Noted
Breathing	Normal Respirations	Circulation	Pulses - Radial - Normal (2+)
External/Skin	Warm	Mental Status	Normal Baseline for Patient
Neurological	Normal Baseline for Patient		

IMPRESSIONS

Primary Impression: Pneumonia

TRAUMA

no trauma entered

2SEH0993

FINAL **Patient Care Report**

Gold Cross Ambulance Service, Inc.
Expert Care in a Heartbeat

Gold Cross Ambulance Service Inc.
1055 WITTMANN DR
MENASHA, WI 54952-3606
(920) 727-3020 Ext.

Run Number: 23387
Date of Service: 10/06/2021
Patient Name: Grace Schara
Medical Rec #: 365038
WI Ambulance Provider # 60-01331

VITAL SIGNS

Time	BP	Pulse	Cap Refill	Respiratory	Left Lung	Right Lung	GCS	SPO2	EtCO2
13:48	100/70	98, Strong, Regular	Less than 2 seconds	18 Rapid	Rales	Rales	E4 + V5 + M6 = 15	91%	

Skin Temp=Warm Skin Color=Normal Skin Moisure=Normal
Pupil size: Left=3-mm, Right=3-mm Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Pain Scale=0; Arm Movement: Left=Spontaneous, Right=Spontaneous; Leg Movement: Left=Spontaneous, Right=Spontaneous
Completed By: Stahl, Mariah

Time	BP	Pulse	Cap Refill	Respiratory	Left Lung	Right Lung	GCS	SPO2	EtCO2
14:01	104/76	102, Strong, Regular	Less than 2 seconds	20 Normal	Rhonchi / Wheezing	Rhonchi / Wheezing	E4 + V5 + M6 = 15	91%	

Temp=100.1 F Skin Temp=Warm Skin Color=Normal Skin Moisure=Normal
Pupil size: Left=3-mm, Right=3-mm Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Pain Scale=0; Arm Movement: Left=Spontaneous, Right=Spontaneous; Leg Movement: Left=Spontaneous, Right=Spontaneous
Completed By: Stahl, Mariah

SCORES

no scores entered

TREATMENT SUMMARY

Time	PTA	Treatment	Who performed	Comments
13:48		**Pulse Ox**	Stahl, Mariah	
		Type=Adult		
		Attempts=1		
		Successful?=Yes		
13:49		**Oxygen**	Reinke, Adam	
		Delivery Device=Oxygen by Nasal Cannula		
		Rate=5		
		Indication=Low SPO2		
		Result=Increased O2 Sat		

2SEH0994

FINAL **Patient Care Report**

Gold Cross Ambulance Service, Inc.
Expert Care in a Heartbeat

Gold Cross Ambulance Service Inc.

1055 WITTMANN DR
MENASHA, WI 54952-3606
(920) 727-3020 Ext.

Run Number:	23387
Date of Service:	10/06/2021
Patient Name:	Grace Schara
Medical Rec #:	365038

WI Ambulance Provider # 60-01331

NARRATIVE

R- Medic 7 was dispatched out for an interfacility transport from Affinity Hill clinic to St. Elizabeth's hospital. It was an emergent response with no lights or sirens and no delays.

C- Patient's chief complaint was difficulty breathing and a cough.

H- Patient tested positive for Covid last Friday and has had increased difficulty breathing and weakness associated with a cough. Patient's cough and breathing get's worse upon movement and standing. Patient has been running a temperature as well, so patient's parents elected to get her checked today. Clinic took a chest x-ray that looked like pneumonia or a possibly pulmonary embolism. Clinic also discovered patient had some elevated lab results with low oxygen levels, so she needed to get checked out at the hospital.

A/R- Upon the crew's arrival at the scene, the patient was laying supine on the clinic bed with a patient airway, a non rebreather on and good circulation. Patient had no obvious signs of trauma or bleeding. Patient was at normal neurological baseline with a GCS of 15. Upon assessment, the clinic told the crew that the patient had been doing nebulizer treatments at home with just oxygen that was not helping the patient's breathing. Clinic nurse also told crew that the patient's mother tested positive for covid as well. The patient told the crew that her breathing was manageable in a supine position, and the patient's oxygen levels were 92% on supplemental oxygen. Patient said that her cough and increased difficulty breathing was what was bothering her the most. Patient denied any chest pain or blurry vision. Patient did have a low grade fever of 100.1 degrees tympanic but was not diaphoretic. Patient's respirations were slightly tachypneic at 18-20/minute and had some slight wheezing in both lungs. No other abnormalities were found. Patient was then assisted to her feet with the help of the crew and patient's father. Patient was then able to sit on the cot on her own and was secured onto the cot. Patient was then secured into the ambulance and a set of vitals were taken. Patient was also put on a nasal cannula at 5 lpm. Patient was resting comfortably in a supine position and transport to St. Elizabeth's hospital was initiated.

T- While en route to the hospital, a field report was given to the emergency department to let them know what was coming in and if they had any other interventions, which they did not. Another set of vitals were done and reassessment revealed no new changes. Upon arrival at the hospital, a new report was given to the emergency department nurse. Patient was then transferred to the emergency department bed via a blanket lift and patient care was transferred.

S- Patient's father signed for patient, and signature was obtained electronically.

Mariah Stahl
EMT 4306

HIPAA

no signatures entered

SIGNATURES

Time	Type	Who signed	Why patient did not sign
10/6/2021 12:00:00AM 14	Section 1 - Patient Signature/Parent/Legal Guardian of	Guardian - Schara, Scott	Signed-Not Patient

Privacy Practices Acknowledgment:
By signing below, the signer acknowledges that Stahl, Mariah, Reinke, Adam provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

x

Patient Authorization:
I, Grace Schara, authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by GCA now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by GCA, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to GCA any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to GCA. I authorize GCA to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to GCA and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by GCA, now, in the past, or in the future. I also authorize GCA to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

Note: A copy of this form is as valid as an original.

2SEH0995

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CREW INFORMATION

Start Date/Time : 10/6/2021 12:00:00AM 07:09

Crew #	Name	Crew #	Name	Crew #	Name
689	Stahl, Mariah	7020767	Reinke, Adam		

x

x

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