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