

Voice Care Updates

Many issues have been brought forward about voice care, so a few changes and suggestions have been made. Shift to shift report tends to be long. *Remember*, you want to give a brief synapse and/or picture of what happened during your shift. Much of the needed information can be obtained from the overview tab. Report should be brief, yet thorough and informative.

Reminders

- Name and safety Alert: Include *Admit date, Physician, Diagnosis, CMS Pathway, and SCIPS*
- Significant date: Include *restraints*
- History: Explain the events that lead up to their admission and any important *co-morbidities that impact hospitalization*. An example would be to include that they are a diabetic, because we would be monitoring blood sugars. Another example would be that they have a left below the knee amputation. Special needs include *ACE* patients.
- Assessment: Include *DNR/Variant Code* and *telemetry* patient
- Treatments: Include *neuro, CIWA, observations, post-falls, dressings, (wounds/IV's)*
- Testing: Include *preps needed*.
- Use the number 5 button to “pause” when you are searching for thoughts or find yourself saying “Um” .
- Do not record their entire “head-to-toe” assessment. Please state “Systems WDL” except.... and state abnormal systems.
- Let the next RN know to reassess for pain, and if a medication was given at shift change.
- Do not list all resulted labs or exams from that day if they are WDL, list only abnormal
- Physician consult paged, not yet returned call. Or, GI consult pending, physician aware and should be here today. This will allow staff to monitor and track consults.
- ER Staff: use the “history” section just for history, not report
- Use the Report Guidelines if you are not sure where something should be reported.

REPORT TEMPLATE

NAME (2 patient identifiers required) and SAFETY ALERT:

- Name / Date of Birth/Age/Admit Date/Physician/Diagnosis/CMS Pathway
- Significant safety data (MRSA, VRE, latex allergy, falls, restraints, etc)

Press # after

HISTORY:

- Events leading up to admission/Co-morbidities that impact hospitalization
- Special needs (language, vision, hearing, mobility, ACE, etc.)
- Functional level/living situation/pertinent social history

Press # after recording

REPORT: IF WITHIN NORMAL LIMITS, NO NEED TO REPORT

These are suggested categories for reporting but are not required nor are they all-inclusive.

Assessments (abnormal/pertinent findings only)

- * Code status (DNR/Variant), telemetry
- Vital signs
- Body systems
- Psychosocial

Treatments:

- Pain: Location, quality, pain scale, interventions, patient response, time due to reassess
- Medications: PRNs,, medications not given to be followed up on, IV infusions/CIV,
- Time Monitoring Tasks: Restraints, PCA/PCEA, Neuro, CIWA, Observation, Post-falls, Dressings (wounds/IV's)
- Tubes: Type / drainage appearance
- Activity/Functional Status

Testing:

- Blood work/radiology exams/Preps Needed
- Critical results-notification and outcome
- When test was ordered and whether completed (if significant deviation from norm)

Recommendations:

- Plan of Care/Patient Education
- Discharge plan/disposition
- Outstanding issues that must be addressed (examples):
 - **CMS-ACTION LIST ITEMS TO BE COMPLETED**
 - Advanced Directives
 - Call placed for physician, return call pending
 - Consent that needs to be signed
 - Vaccinations to be administered