WELCOME

Welcome to the Kansas City VA Medical Center!

Congratulations! You have been selected as one of the most distinguished candidates for the VALOR Program.

For over 15 years, the Kansas City VA Medical Center has offered the VALOR Program, a VA Learning Opportunities Residency Program, tailored to outstanding registered nursing students who have completed their junior year in an accredited clinical program. The VALOR Program is designed to aid students in the development of their clinical nursing competencies within a VA-approved health care facility. Students are appointed a 400-hour learning experience during the summer months under the supervision of a qualified registered nurse preceptor. All 400-hours must be completed by September 30th, 2019. After the new fiscal year, students may be granted additional hours that continue during their senior year on a part-time basis.

PROGRAM OVERVIEW

Each VALOR student is designated to a specialty unit: MICU, SICU, PCU, 5 West, 8 East, 8 West, or ER. Throughout the course of the program, each student has opportunity to visit other inpatient units up to two weeks of their 400-hours. Floats to other units will be coordinated between VALOR student and preceptor.

- The VALOR Program is a 12-14 week paid summer program
- The first two weeks include hospital orientation and computer training
- VALOR students will work 80-hour pay periods (every 2 weeks) following along their preceptor's schedule
- Students will complete the "VALOR Skills Check-off" and return to VALOR Coordinator, Sharon Shade, at the end of the program.
- There will be weekly evaluations between preceptor/preceptee to discuss VALOR's progress
- There will be monthly meetings with Sharon Shade and students. During these meetings, students will discuss their experiences and guest speakers will come and educate students on a variety of nursing specialties.
- It is highly encouraged, based on preceptor evaluation, for VALOR students to transition into the KCVA Nurse Residency Program after graduation and passing of the NCLEX.
- At the end of the program, each VALOR student will have completed and returned the "KCVA Weekly Clinical Evaluation Tools," "Preceptor's Evaluation of Orientation," "Orientee's Evaluation" and binder.

Our goal is to help you develop your clinical nursing skills, provide hands-on experience, and successful orientation into the KCVA system. This binder will have all the evaluations, resources, and contact information you will need – make sure you bring it with you each clinical day and to monthly meetings. Additional copies of evaluations will be uploaded on the KCVA SharePoint website.

We are looking forward to working with you!

Warm Regards,

Sharon Shade
VALOR/RN Resident Coordinator
Sharon.Shade@va.gov
816.861.4700 Ext. 56551

TABLE OF CONTENTS: ER VALOR

KANSAS CITY VA MEDICAL CENTER

ESSENTIALS

ER QUICK GUIDE

ER CODES					
BLOOD BANK	Ext. 56104	LAB	Ext. 56200	RAPID RESPONSE	Ext. 54444
BREAK RM	N/A	LOCKER RM	N/A	RT	PGR 651
CLEAN CLOSET	1322	MED RM	1391	SUPPLY	4235
CT (M2-269)	PGR 742	POLICE	Ext. 52875	TRIAGE	56554
DIRTY CLOSET	132	PRINTER	PTN215	X-RAY (M2-421)	PGR 180

PAGING:
KCVA: Dial "9," EXCLUDE area code, and then 7-digit phone number
For example: if your phone # is 816-374-4025 → 9-374-4025
When it asks, "Leave a numeric number": Dial unit extension + pound key
For example: 56325#
KU Pager: Dial "9," INCLUDE area code, and then 7-digit phone number
For example: if your phone # is 913-374-4025 → 9-913-374-4025
When it asks, "Leave a numeric number": Dial unit extension + pound key
For example: 56325#
3-Digit Pager Number: Dial "5BEEP" or [5-2337]
Dial 3-digit pager number + pound key: Example "563#"
Enter extension of receiving phone to page + pound key, example "56325#"

DAILY ED REQUIRED NOTES:
ED CPRS TEMPLATES:
- *KC-Triage* – completed by Triage RN
- *KC-Emergency Department Nurse Intake* – addendum with interventions `
- *KC-SBAR*

ER DISCHARGES:
CPRS:
- *KC-Emergency Dept Nurse Discharge Summary*
  -Print Krames On-Demand/UpToDate education regarding diagnosis
  -Print *Daily Plan (ED)*

ED PAPER DOCUMENTATION
- Restraint checks
- AMA form
- Employee Injury Form
- Patient Belongings Inventory
- Consents:
  - For treatment: I&D, sutures, staples, etc.
  - Facility transfer
  - Blood transfusion

EXPECTATIONS WHEN MANAGING:

SUICIDAL/HOMICIDAL PATIENTS:

- Remove clothing/belongings and complete inventory
- Place on 1:1 observation
- Draw labs and collect urine

CHEST PAIN/STEMI:

- Apply telemetry/CV monitor
- Apply O2 if indicated
- Start IV and draw labs, and run POC troponin
- Complete EKG and hand to physician
- Place patient in a gown
- If a STEMI start 2nd IV obtain STEMI kit from Pyxis room and complete checklist

ABDOMINAL PAIN/GI BLEED:

- Apply telemetry/CV monitor
- Start IV and draw labs
- Start 2 large bore IVs
  - Draw Type and Screen if GI bleed is suspected
- Obtain UA
- Place patient in a gown

SOA/COPD:

- Apply telemetry/CV monitor
- Apply O2 if indicated
- Complete EKG and hand to physician
- Start IV and draw labs, run POC troponin
- Administered albuterol nebulizer treatment if indicated
- Place patient in a gown

NEURO-CVA/SEIZURE:

- Apply telemetry/CV monitor
- Complete EKG and hand to physician
- Start IV and draw labs, run POC troponin
- Perform an Accu-check
- Pad bedrails for seizure patient
- Place patient in a gown
- If suspect CVA:
  - Perform NIH Stroke Scale
  - Prepare for immediate CT

PENUMONIA/SEPSIS:

- Apply telemetry/CV monitor
- Apply O2 if indicated
- Complete EKG and hand to physician
- Start IV and draw labs including lactic acid + 1st set of blood cultures
- Draw 2nd set of blood cultures from 2nd site
- Place patient in gown

ORTHO INJURIES:

- Prosthetics
- Orthoglass splints

PATIENT DEATH:

- Leave all tubes/lines in place if a coroner case
- Contact Jackson County Medical Examiner: (816) 881-6600
- Contact Midwest Transplant Network: 1(800) 366-6792
- Complete belonging inventory
- Complete KC-Death Note-Nursing
- Transport to morgue within 2 hours of death
  - Drape body with American flag prior to transport

CONTACT INFORMATION

VALOR PROGRAM						
LAST NAME	**FIRST NAME**	**TITLE**	**LOCATION**	**EMAIL**	**EXTENSION**	**PAGER**
Shade	Sharon	VALOR/RN Resident Program Director	M7.244	Sharon.Shade@va.gov	56551	156

INPATIENT						
LAST NAME	**FIRST NAME**	**TITLE**	**LOCATION**	**EMAIL**	**EXTENSION**	**PAGER**
Ashford	Viana	Nurse Manager	ER	Viana.Ashford@va.gov	52110	230
Barnes	Laura	CNL	Critical Care	Laura.Barnes@va.gov	57180	171
Bond	Leanna	CNL	ER	Leanna.Bond@va.gov	55330	---
Buntz	Cheryl	Nurse Manager	MICU	Cheryl.Buntz@va.gov	57766	791
Czir	Julie	CNL	PCU	Julie.Czir@va.gov	56568	544
Duckstein	Michele	Nurse Manager	10E	Michele.Duckstein@va.gov	56697	226
Evans	Shaun	Nurse Manager	5W	Shaun.Evans2@va.gov	57333	2565
Hunter	Debra	Nurse Manager	8E	Debra.Hunter2@va.gov	57805	992
Judy	Jessica	Nurse Manager	SICU	Jessica.Judy@va.gov	52309	269
Licklider	Amber	Clinical Nurse Educator	5W	Amber.Licklider@va.gov	52361	508
Perisho	Rachel	Nurse Manager	PCU	Rachel.Perisho@va.gov	56522	484
Schletzbaum	Tracy	Nurse Educator	Critical Care	Tracy.Schletzbaum	52274	245
Squires	Tina	Nurse Educator	8W	Tina.Squires@va.gov	57278	517
Williams	Jacquelyn	Nurse Educator	8E	Jacquelyn.Williams2@va.gov	52067	2547
Wilson	Benjamin	Nurse Manager	8W	Benjamin.Wilson@va.gov	56387	571

OUTPATIENT						
LAST NAME	**FIRST NAME**	**TITLE**	**LOCATION**	**EMAIL**	**EXTENSION**	**PAGER**
Dooly	Tisha	Nurse Manager	Cath Lab	Tisha.Dooly@va.gov	57807	---
Wood	Jeanine	Nurse Manager	GI Lab	Jeanine.Wood@va.gov	56468	803

COMMON KCVA NURSING ABBREVIATIONS

A

A/O: Alert and oriented
ABD: Abdomen
ABG: Arterial blood gas
ABP: Arterial blood pressure
AC: Before meals
AD LIB: Freely, as desired
ADL: Activities of daily living
AKA: Above knee amputation
AMA: Against Medical Advice
ASAP: As soon as possible

B

BID: Twice a day
BKA: Below knee amputation
BLE: Bilateral lower extremity
BM: Bowel movement
BRP: Bathroom privileges
BUE: Bilateral upper extremity
Bx: Biopsy

C

C with line above: Without
C/D/I: Clean, dry, and intact
C/O: Complaint of
CAD: Coronary artery disease
CBC: Complete blood count
CHF: Congestive heart failure
CKD: Chronic kidney disease
COPD: Chronic obstructive pulmonary disease
CRNA: Certified Registered Nurse Anesthetist
CRRT: Continuous Renal Replacement Therapy
CVA: Cerebrovascular accident
CXR: Chest x-ray

D

D/C: Discharge
DJD: Degenerative joint disease
DM: Diabetes mellitus
DNR: Do not resuscitate
DOA: Dead on arrival
DRSG: Dressing
DVT: Deep vein thrombosis
DX: Diagnosis

E

ECG/EKG: Electrocardiogram
ENT: Ear, Nose, Throat
ESR: Erythrocyte sedimentation rate
ESRD: End-Stage Renal Disease
EUD: External urinary device

F

F/U: Follow-up

G

GI: Gastrointestinal
GERD: Gastroesophageal reflux disease
GU: Genitourinary

H

HFNC: High flow nasal cannula
H/O: History of
HOB: Head of bed
HS: At bedtime
HTN: Hypertension
HYPER: Prefix, above/high
HYPO: Prefix, below/low

I

IVF: IV Fluids

K

KUB: x-ray of abdomen – kidneys, ureters, and urinary bladder

L

LLE: Left lower extremity
LLQ: Left lower quadrant
LOC: Level of consciousness
LUE: Left upper extremity
LUQ: Left upper quadrant
LYTES: Electrolytes

M

MAE: Moves all extremities

N

NC: Nasal Cannula
NGT: Nasogastric tube
NKDA: No known drug allergies

O

OGT: Orogastric tube
OOB: Out of bed

P

PCA: Patient controlled analgesia
PVD: Peripheral vascular disease

R

RA: Room air
RBC: Red blood cells
RLE: Right lower extremity
RLQ: Right lower quadrant
R/O: Rule out
ROM: Range of motion
RRN: Rapid response nurse
RUE: Right upper extremity
RUQ: Right upper quadrant

S

SOA/SOB: Shortness of air/breath
S/P: Status-post
S/S: Signs and symptoms
STAT: Immediately

T

TID: 3-times a day; q8hours
TKO: To keep open

W

WBC: White Blood Cells
WNL: Within normal limits

SAMPLE SBAR

ROOM #: NAME (AGE) **CODE STATUS**
LAST 4 SS# **PRIMARY TEAM**
ALLERGIES?
ISOLATION
FSBS?

ADMIT: Date/Diagnosis/background

HX:

PAIN: AVAIL. PAIN MEDS

NEURO:
Alert and oriented
Upper/Lower Strength: Weak, Mod, Strong
Upper/Lower Weakness?
Numbness/tingling?
Gait: Steady/Unsteady/Slow; Walker/Ad lib?

RESPIRATORY:
Lung Sounds
Respiratory Device? RA/NC/Vent?
Any Secretions? Small, med, copious, color

CARDIOVASCULAR:
HR: Regular/Irregualr/Murmur? PULSES
BP EDEMA
ABP

GI (GASTROINTESTINAL):
ABD TONE: Soft, tender, firm?
BOWEL SOUNDS: Absent, Hypo, Hyper
NGT/OGT? Which nare?
DIET
LAST BM

GU (GENITOURINARY):
URINARY METHOD: Void/ EUD
Foley: Size? Color of urine? Reason for foley?
Suprapubic cath/ ileal conduit: Stoma color?
Bladder scan

SKIN: Surgical incisions, abrasions, bruising, pressure ulcers & location

IV: PIV/Midline? Catheter gauge/site appearance/insertion date/fluids running?

IVF & Rate: i.e. NS @ 100ml/hr

#1: SMITH, JOHN (70) 5555 FC
MICU

ADMIT: 5/12 – Respiratory Failure – Penicillin
EMS brought in from home Standard
SOA x3 days, h/o CHF AC/HS

Hx: DM, CHF, HLD, chronic leg pain

PAIN: 4/10 – R leg - PRN Oxycodone 5 mg q3H
Last given: 0330

N: A/O x4, MAE, Mod Strength upper/lower
Denies n/t; up with assist/walker
Walked: Up to chair:

R: LS CTA, Decreased bases
Room air, SpO2 – 97%
Cough: Present
No secretions

C: HR- 70-80 SR, occas. PVCs
BP: 120-130/80-90 2/2/2
ABP: 130-140/90 Trace edema BLE

GI: Abdomen soft, nontender
Active (+) BS
Regular diet – 100% dinner
Last BM: 5/12 – brown, soft-formed

GU: Voids per urinal – clear yellow

SKIN: Bruising noted to upper extremities
Abrasion to left skin
Stage I Pressure ulcer on coccyx

IV: Left forearm #20 G – placed 5/12 – Saline locked

08	LIST NEW ORDERS
09	
10	
11	
12	17
13	18
14	19
15	
16	

_____

_____

ADMIT: _____

_____

H/O:

PAIN:

N:

R:

C:

GI:

GU:

SKIN:

IV:

08	LIST NEW ORDERS
09	
10	
11	
12	17
13	18
14	19
15	
16	

_____

_____

ADMIT: _____

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H/O:

PAIN:

N:

R:

C:

GI:

GU:

SKIN:

IV:

08	LIST NEW ORDERS
09	
10	
11	
12	17
13	18
14	19
15	
16	

ROOM #: _____

ADMIT: _____

HX:

P

N:

R:

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GI:

GU:

SKIN:

IV:

08	13	NEW ORDERS:
09	14	
10	15	18
11	16	19
12	17	20

ROOM #: _____

ADMIT: _____

HX:

P

N:

R:

C:

GI:

GU:

SKIN:

IV:

08	13	NEW ORDERS:
09	14	
10	15	18
11	16	19
12	17	20

SCHEDULE

VALOR HOURS

Week	Date	Unit	Preceptor	Hours Worked	Total Hours
1					
2					
3					
4					
5					
6					
7					

VALOR HOURS

Week	Date	Unit	Preceptor	Hours Worked	Total Hours
8					
9					
10					
11					
12					
13					
14					

MONTHLY CALENDAR

MONTH/YEAR:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—

MONTHLY CALENDAR

MONTH/YEAR:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—

MONTHLY CALENDAR

MONTH/YEAR:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—

MONTHLY CALENDAR

MONTH/YEAR:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—

SKILLS

VALOR Skills Checklist

VALOR Student Name _____ Unit: _____

The VALOR student will always be under the direct supervision of an RN. The supervising RN is accountable and responsible for assigning specific duties to VALOR's either in writing or verbally, once competency has been validated. The patient's status and health care needs will be assessed by the supervising RN prior to delegation to the VALOR, taking into consideration the complexity of the patient's physiological and psychological instability. The VALOR student's work assignment is interdependent with the preceptor's assignment. Turn in completed orientation checklist to Sharon Shade by end of orientation.

Preceptor and VALOR to complete this orientation checklist	Learning Options	P / PI	Preceptor Instruction Date/Initial	Demonstrated Competency Date	Preceptor Signature
General					
1. Admission of patients	Review Admission Policy. Performs with supervision from RN. **Database must be co-signed by RN.**	PI			
2. Patient transfers	Review transfer policy. Provides report to receiving unit with RN supervision.	PI			
a. Within hospital	Performs with supervision from RN. **Must be co-signed by RN.**	PI			
b. To another facility	Performs with supervision from RN. **Must be co-signed by RN**	PI			
3. Discharge	Performs with supervision from RN. **Must be co-signed by RN.**	PI			
4. Patient death	Review policy on post-mortem care & organ donation. Cite RN responsibilities for organ donation.	PI			
5. Nursing staff responsibilities	Review practice guidelines for RN, LPN, HT/CNA, SNT/VALOR	P			
6. Charge nurse responsibilities	Review charge nurse responsibilities. Review Charge Nurse policy.	PI			
7. Patient classification system	Determines patient classifications with supervision from preceptor. Review policy.	PI			

P = Student may perform
PI = Student may participate-in with preceptor

8. Tour duties	Review unit guidelines	P			
9. Code Blue/Rapid Response	Maintain current BLS certification. Perform crash cart check under direct RN supervision. (Requires RN co-signature) Demonstrate correct calling of Rapid Response Team and Code Blue. Accompany preceptor in responding to Code Blue.	PI			
10. Code Yellow	Review procedure. Discuss with preceptor. Accompany preceptor in responding to Code Yellow.	PI			
11. Management of aggressive patients/Restraints	Review policy. Demonstrate competency in application of restraints and proper documentation under RN supervision. May perform documentation independently after competency validation by RN.	P			
12. Infection Control	Review Infection Control Policies. Review isolation cart contents and their proper use. Obtain MRSA Swab.	P			
13. Float	Review Float policy. (Valor will only float with designated preceptor.)	P & PI			
Documentation					
1. Admission Data Base and assessment	Performs with supervision from RN. Review standards of care for documentation. **Must be co-signed by RN**	PI			
2. Interdisciplinary Plan of Care	Performs with supervision from RN. May contribute & collaborate with the health care team to identify patient problems & expected outcomes/goals. May prescribe nursing orders under RN supervision. **Must be co-signed by RN**	PI			
3. Bedside flow sheets	May complete I&O, vital signs, other flow sheet after initial instruction & competency assessment by RN	P & PI			
4. Shift Note/ Nursing Note	Documents with supervision from RN. **Must**	PI			

P = Student may perform
PI = Student may participate-in with preceptor

	be co-signed by RN				
5. Patient Education - Parent	Documents parent note with supervision from RN. May complete child note independently after demonstrated competency. **Must be co-signed by RN**	P & PI			
6. Orders	Review Policy and observe RN preceptor. VALOR **will not** take verbal orders, verify orders, or complete 24 hour chart checks.	PI			
7. BCMA/Medication Administration	**Observe** medication administration by RN. Review medications and their actions and effects with preceptor. VALOR **will not** administer any medications or IV fluids.	PI			
8. Discharge Instructions	Performs with supervision from RN. **Must be co-signed by RN**	PI			
9. Specialized forms/documentation a. AMA b. Consents c. Blood transfusion d. Fall risk e. Neuro checklist f. Restraint g. Skin care	Review with RN.	PI			
Monitors and Equipment					
1. Equipment	Reviews equipment maintenance policy and procedure for both acquisition and repair.	P & PI			
2. Alarms	Will recognize alarms & initiate appropriate action (notify RN, check patient and initiate emergency care if needed).	P & PI			
3. Telemetry monitoring	Review nursing responsibilities for telemetric monitoring, review EKG standards.	PI			
Skills					
1. 12 lead EKG	Perform with preceptor assistance. May	P & PI			

P = Student may perform
PI = Student may participate-in with preceptor

	complete independently after competency checklist completed.				
2. GI Tubes: NGT, gastrostomy, jejunostomy—check residuals, manage feedings	Demonstrate competency under RN supervision then may manage with supervision. May insert NG/OG **under direct supervision. May not insert small-bore feeding tubes**	P & PI			
3. Feeding pump	**Under direct supervision of RN**, may hang new feeding bag and change or initiate feeding through existing feeding tube and check residuals.	PI			
4. PCA pump	**Must have RN review co-signature** for documentation of narcotic shift checks.	PI			
5. Urethral Catheters	Demonstrate competency of insertion and discontinuation under RN supervision then may perform independently.	P			
6. Medications	Participate in medication administration by **observing** RN preceptor. VALOR **will not** administer medications.	PI			
7. Vital signs	Demonstrate proper procedure in obtaining blood pressure, pulse, RR, & pulse oximetry under supervision by RN. When competency assured, may perform & document independently	P			
8. Chest Tubes	Review care of patient with chest tube; may measure CT output and assess for function under **direct supervision of RN**	PI			
9. Accu-check	May complete and document after RN validates competency	P			
10. Dressings: Sterile & clean	May perform after demonstrated competency assessment by RN preceptor	P			
11. Dressings: Central line	May complete central/arterial line dressing changes under **direct supervision of RN**	PI			

P = Student may perform
PI = Student may participate-in with preceptor

12. Peripheral IV Insertion	May initiate IV access under **direct supervision of RN. Documentation must be co-signed.**	PI			
13. Suctioning: Nasotracheal, oral, via trach (including pre-oxygenation)	May perform after demonstrated competency under RN supervision	P & PI			
14. Oxygenation: Application and changes in concentration of O2 via nasal cannula, venti-mask, non-rebreather mask	May perform after demonstrated competency under RN supervision	P & PI			
15. Tracheostomy/laryngectomy care	May perform routine care after demonstrated competency under RN supervision	P & PI			
16. Phlebotomy: Peripheral and central line draws	May draw peripheral blood specimens after completion of phlebotomy class and demonstrated competency under RN supervision. May obtain central line blood specimens under direct supervision of RN. **RN must co-sign.**	P & PI			
17. Blood administration	May assist RN with blood transfusions. **RN must complete all documentation.**	PI			
Assessment (Review physical assessment course content)					
1. Neurologic	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
2. Pulmonary	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
3. Cardiovascular	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
4. GI/ GU	Perform assessment & verify findings with RN preceptor. May document but must be co-	PI			

P = Student may perform
PI = Student may participate-in with preceptor

	signed				
5. Peripheral Vascular	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
6. Psychosocial	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
7. Educational Needs	Assess educational needs & learning styles of patients. Provide appropriate teaching with supervision of RN preceptor. Demonstrate use of Micromedex & location of patient education materials	PI			
8. Post-Operative/Recovery from anesthesia	Refer to Standard of Care for surgical patients. May perform vital signs & patient assessment under supervision of RN. Assessment must be co-signed. Review conscious sedation policy.	PI			
9. Integumentary	Perform assessment & verify findings with RN preceptor. May document but must be co-signed	PI			
10. Lab values	Review patient's lab values with RN each am and determine appropriate course of action	PI			

Comments:

VALOR Signature Date

Preceptor Signature Date

P = Student may perform
PI = Student may participate-in with preceptor

EVALUATIONS

DAILY GUIDE (OPTIONAL)

DATE:

DAILY EXPECTATIONS:

POLICIES REVIEWED:

LIST TWO GOALS TO ACCOMPLISH TODAY:

SKILLS COMPLETED:

REFLECTION: Positives experiences? Negatives experiences? What would you change/do differently? Accomplishments?

WEEKLY PROGRESS (OPTIONAL)

DATE: _____

PROGRESS CHECK	PLAN / GOALS FOR NEXT WEEK:
VALOR: ☐ I feel I am making progress, _____ _____ _____ _____ _____ ☐ I feel I am a little behind and need to work on the following: _____ _____ _____ _____ _____	Measureable goals for the next week – – – –
PRECEPTOR/EDUCATOR: ☐ VALOR is making progress. _____ _____ _____ _____ _____ ☐ VALOR is a little behind and we need to work on the following: _____ _____ _____ _____ _____	Outcomes from the previous week of goals: – – – –

KCVA Weekly Clinical Evaluation Tool (Required)

VALOR Name: _____ **Weekly Clinical Progress Summary & Goals From Previous Week** **Preceptor Name**: _____	**Week 1** Date: Preceptor Initials:	**Week 2** Date: Preceptor Initials:	**Week 3** Date: Preceptor Initials:	**Week 4** Date: Preceptor Initials:	**Week 5** Date: Preceptor Initials:
Recognizes the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs	D A S I	D A S I	D A S I	D A S I	D A S I
Prioritizes care, manages time and delegates appropriately.	D A S I	D A S I	D A S I	D A S I	D A S I
Establishes rapport, communicates with, and educates patient/family about daily plan of care; provides updates as appropriate and includes them in the plan of care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Uses a systematic process to assimilate information, analyze data, and make decisions regarding patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Integrates best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Functions effectively within nursing and inter-professional teams, fostering open and effective communication, mutual respect, and shared decision-making to achieve quality patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Effectively communicates within healthcare team utilizing defined processes i.e., handoff navigator, EMR, notes, SBAR, etc.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Minimizes risk of harm to patients and providers through the use of defined processes and compliance with hospital safety and infection control standards	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Projects professional image, attitude and values of caring, ethics, respect, communication, civility, accountability, professional engagement.	D A S I	D A S I	D A S I	D A S I	D A S I
Identifies knowledge deficits, demonstrates initiative, and seeks out appropriate learning resources, takes action based on constructive feedback.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					

DESCRIPTION of EXPECTED LEVEL (modified from Bondy KN: Criterion-referenced definitions for rating scales in clinical evaluation, J Nurs Ed 22(9): 376, 1983)
D=Dependent: Unskilled, inefficient, shows considerable expenditure of energy. Performs within a prolonged time period**. Continuous verbal and frequent physical cues required**.
A= Assisted: Skillful in parts of behavior; shows some inefficiencies/uncoordination. Performs within a delayed time period**. Requires verbal and occasional physical directive cues**
S= Supervised: Efficient, coordinated, confident. Shows some excess energy expenditure; performs within a reasonable time period. **Requires occasional supportive cues from preceptor**
I= Independent: Proficient, coordinated, confident. Shows occasional excess energy expenditure; performs in an expedient time period**. Does not require supportive cues from preceptor.**

KCVA Weekly Clinical Evaluation Tool

VALOR Name: _____ **Weekly Clinical Progress Summary & Goals From Previous Week** **Preceptor Name**: _____	**Week 6** Date: Preceptor Initials:	**Week 7** Date: Preceptor Initials:	**Week 8** Date: Preceptor Initials:	**Week 9** Date: Preceptor Initials:	**Week 10** Date: Preceptor Initials:
Recognizes the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs	D A S I	D A S I	D A S I	D A S I	D A S I
Prioritizes care, manages time and delegates appropriately.	D A S I	D A S I	D A S I	D A S I	D A S I
Establishes rapport, communicates with, and educates patient/family about daily plan of care; provides updates as appropriate and includes them in the plan of care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Uses a systematic process to assimilate information, analyze data, and make decisions regarding patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Integrates best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Functions effectively within nursing and inter-professional teams, fostering open and effective communication, mutual respect, and shared decision-making to achieve quality patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Effectively communicates within healthcare team utilizing defined processes i.e., handoff navigator, EMR, notes, SBAR, etc.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Minimizes risk of harm to patients and providers through the use of defined processes and compliance with hospital safety and infection control standards	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Projects professional image, attitude and values of caring, ethics, respect, communication, civility, accountability, professional engagement.	D A S I	D A S I	D A S I	D A S I	D A S I
Identifies knowledge deficits, demonstrates initiative, and seeks out appropriate learning resources, takes action based on constructive feedback.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					

DESCRIPTION of EXPECTED LEVEL (modified from Bondy KN: Criterion-referenced definitions for rating scales in clinical evaluation, J Nurs Ed 22(9): 376, 1983)
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KCVA Weekly Clinical Evaluation Tool

VALOR Name: _____ **Weekly Clinical Progress Summary & Goals From Previous Week** **Preceptor Name**: _____	**Week 11** Date: Preceptor Initials:	**Week 12** Date: Preceptor Initials:	**Week 13** Date: Preceptor Initials:	**Week 14** Date: Preceptor Initials:	**Week 15** Date: Preceptor Initials:
Recognizes the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs	D A S I	D A S I	D A S I	D A S I	D A S I
Prioritizes care, manages time and delegates appropriately.	D A S I	D A S I	D A S I	D A S I	D A S I
Establishes rapport, communicates with, and educates patient/family about daily plan of care; provides updates as appropriate and includes them in the plan of care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Uses a systematic process to assimilate information, analyze data, and make decisions regarding patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Integrates best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Functions effectively within nursing and inter-professional teams, fostering open and effective communication, mutual respect, and shared decision-making to achieve quality patient care.	D A S I	D A S I	D A S I	D A S I	D A S I
Effectively communicates within healthcare team utilizing defined processes i.e., handoff navigator, EMR, notes, SBAR, etc.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Minimizes risk of harm to patients and providers through the use of defined processes and compliance with hospital safety and infection control standards	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					
Projects professional image, attitude and values of caring, ethics, respect, communication, civility, accountability, professional engagement.	D A S I	D A S I	D A S I	D A S I	D A S I
Identifies knowledge deficits, demonstrates initiative, and seeks out appropriate learning resources, takes action based on constructive feedback.	D A S I	D A S I	D A S I	D A S I	D A S I
Comments:_____					

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PRECEPTOR'S EVALUATION OF ORIENTATION (Required)

Name: _____ Date: _____

Please answer the following using the numerical scale below:
1- Did not meet my needs
2- Met some of my needs
3- Met most of my needs
4- Met all of my needs

1) Orientation process: timeline, structure, & binder	1	2	3	4
2) Peer support was available (Nurse Manager, Educator, CNL, & peers).	1	2	3	4
3) I was able to provide needed learning opportunities.	1	2	3	4
4) VALOR was open to my/my peers' feedback.	AGREE		DISAGREE	
5) Overall, VALOR did well with the learning opportunities and assignments presented	AGREE		DISAGREE	

Do you have any suggestions to make the Valor Program more valuable? Anything you would change?

In what way(s) have you benefited from being a preceptor in the Valor Program?

What are your final thoughts about your Valor program experience?

VALOR EVALUATION (Required)

Name: _____ Date: _____

Please answer the following using the numeric scale below:

1- Did not meet my needs
2- Met some of my needs
3- Met most of my needs
4- Met all of my needs

1) Feedback received	1	2	3	4
2) Learning opportunities and assignments	1	2	3	4
3) Orientation process: timeline, structure, packet	1	2	3	4
4) Peer support	1	2	3	4
5) Availability of resources	1	2	3	4

How many preceptors did you have and was the number of preceptors beneficial or disadvantageous to your experience?

Please list strengths of the orientation process you experienced.

Please list weaknesses of the orientation process that you experienced.

What could we have done differently to make the process more valuable?

What qualities did you find valuable in your preceptor?

What would you keep from the orientation program and what would you change and why?

Please provide additional comments:

RESOURCES

POLICIES, PROCEDURES, AND PROFESSIONAL DEVELOPMENT

As you peruse your orientation packet, you will see mention of Lippincott Procedures and Lippincott Professional Development as a reference for procedures as well as a means by which KCVA critical careunits establish competency. To access these programs, please follow these links:

- Procedures: http://procedures.lww.com
- Your log in information: Log-in name: _____ Password: _____

Utilizing Lippincott Procedure, you are able to search for a specific procedure, read the procedure, printoff a skills check list, watch a video etc. If you choose to demonstrate your competency in a certain procedure, you can either choose 1) Return Demonstration: print off the skills check list and demonstrate the procedure while your preceptor watches and ensures that you follow the checklist or 2) Text/Exam: request your CNL or nurse manager to assign you the test associated with the procedure. Once you read and are familiar with the procedure, you can then take the test independently to demonstrate your competency.

- Professional Development: http://competency.lww.com
- Your log in information: log-in name: _____ Password: _____

The Professional Development program from Lippincott allows you to further your knowledge as a nurse by watching scenarios and taking competencies in topics such as “heart failure”, “patient falls”, “CAUTI prevention” and even Joint Commission required topics. If you wish to demonstrate your clinical competency using the Professional Development program, request the specific competency from your nurse manager or CNL, participate in the scenario and take the associated competency validation tests.

- Policies: https://vaww.visn15.portal.va.gov/kan/Policies/

Policies associated with each specific item have been conveniently added to the orientation packet. To locate and read the policies in entirety, go to the Policy section of the intranet homepage. Use the packet to guide you with the exact terminology of the Policy name, or search for the policy by pressing “Ctrl” and the letter “F” on the key board and typing in the keyword to search the webpage. Ask your preceptor for further assistance.

IMPORTANT HOSPITAL POLICES TO REVIEW

POLICY NAME	POLICY #
ADMINISTRATION OF INTRAVENOUS MEDICATIONS BY RN	11-118-032
BLOOD TRANSFUSION	118-10
CAPNOGRAPHY MONITORING	11-118-098
CARDIAC OR RESPIRATORY ARREST POLICY	11-111-032
CARE OF THE PATIENT RECEIVING GLYCOPROTEIN IIB/IIIA THERAPY	111C-027
CHEST PERCUSSION/VIBRATION/POSTURAL DRAINAGE	111-R11
CHLORHEXIDINE PRE-SURGICAL BATH"	11-112-035
CLINICAL ALARM MANAGEMENT POLICY	00-118-017
CRITICAL LABORATORY RESULT NOTIFICATION	11-113-056
DOCUMENTATION OF PATIENT/FAMILY EDUCATION	00-003-127
ELECTIVE CARDIOVERSION	118C-9
FALL PREVENTION AND MANAGEMENT	11-118-132
FEMOSTOP	SOP - Femstop
HIGH ALERT MEDICATIONS	11-119-069
INDUCED HYPOTHERMIA AFTER CARDIAC ARREST	11-118-095
INSULIN INFUSION POLICY	11-118-081
INTRA AORTIC BALLOON PUMP (IABP): STANDARDS OF CARE	111C-026
LEAD SKIN PREP	111C-009
MALIGNANT HYPERTHERMIA MANAGEMENT	11-112H-009
MANAGEMENT OF ALCOHOL WITHDRAWALS	11-118-096
MANAGEMENT OF PATIENTS RECEIVING MODERATE (CONSCIOUS) SEDATION/ANALGESIA	11-112H-042
MANAGEMENT, REMOVAL AND POST-PROCEDURE CARE OF ARTERIAL/VENOUS SHEATHS	11-111-110
NARCOTIC PARENTERAL INFUSION THERAPY	11-118-063
NASOTRACHEAL SUCTION	111-R03
NEUROMUSCULAR BLOCKADE	118N-6
OPTI-FLOW/MAX-VENTURI/HUMIDIFIED HIGH FLOW NASAL CANNULA	111-R06
ORGAN & TISSUE DONATION AFTER CIRCULATORY DEATH	11-111-078
ORGAN, TISSUE AND EYE DONATION	11-111-079
PULMONARY ARTERY CATHETER	118S-12
RAPID RESPONSE TEAM	11-111-090
SEDATION IN INTENSIVE CARE UNITS (ICU) PATIENTS RECEIVING MECHANICAL VENTILATION	11-111-008
SKIN CARE PROTOCOL FOR PREVENTION AND TREATMENT OF PRESSURE ULCERS	118S-15
THE USE OF INTRAOSSEOUS (IO) DEVICE	11-111-068
TOTAL PARENTERAL NUTRITION	118T-7
TREATMENT OF ACUTE ISCHEMIC STROKE (AIS)	11-111-005
TREATMENT OF HYPOGLYCEMIA IN PATIENTS WITH DIABETES MELLITUS	11-118-050
USE OF RESTRAINTS AND ALTERNATIVES FOR HEALTH CARE PURPOSES	11-118-008

LIPPINCOTT PROCEDURES

Airway Suctioning
Arterial Line Placement
Arterial Puncture
Aspiration Precautions
Assisting with Central Venous Catheter Insertion
Cardiac Output Measurement
Central Venous Catheter Site Care
Central Venous Pressure Measurement
Chest Tubes
Colostomy Care
Colostomy Irrigation
Defibrillation
Enteral Tube Feeding
Fecal Management System
Gastric Lavage
Ileal-Conduit Care
Ileostomy Care
Intra-abdominal Pressure Monitoring
Nephrostomy Tube Care
NG/OG Tube insertion
Oral Care
Peripheral Nerve Stimulation
Post-Mortem Care
Seizure Precautions
Sterile Dressing Change
Tracheostomy Care
Treatment for Occluded Central Line Catheters

PATIENT EXPIRATION

THE DYING PATIENT

This situation may happen after many days of intensive therapy or just a few hours. After all has been done for the patient, the best Intensive Care can do is to offer the patient as dignified and peaceful a death as possible. Such a decision is never made lightly or without extensive discussion with the family. It is with utmost importance that this situation be handled with care and sensitivity to not only the patient, but also the family. At this time, emphasis is placed on:

- Allowing the family time and space to deal with their grief
- Applying care to the patient's physical, emotional and spiritual comfort
- Utilizing the Chaplain and social services if needed
- Keeping the patient comfortable
- Contact Midwest Transplant Network (refer to "Documentation Expectations"

CARE OF THE PATIENT POST-MORTEM

- The doctor will notify the family if they are not present
- Clean the body, dress any oozing wounds, and remove tubes if no autopsy is to be performed. Do not delay the family for these tasks if they had not seen the patient prior to death
- Obtain the Flag
- Obtain the Morgue key

COURTESY

When patients are admitted to the Critical Care areas, they are often under considerable emotional as well as physical stress. Their sensibilities are usually heightened so that even insignificant or imagined discourtesies by staff can become magnified. The unit is one area in the hospital where it is vitally important to observe courtesies, show respect for patients and be ultra-professional in your actions. Please consider the following:

- Courtesy: Most patients' complaints involve attitudes, not actual treatment. Every effort should be made to preserve the dignity of the patient as an individual, even in the most stressful situations. All communications, silent and aloud, should indicate respect.
- Privacy: carry out physical exams according to correct procedures, making sure to have curtains drawn properly.

PATIENT HYGIENE AND SKIN CARE

PATIENT HYGIENE

- Bathing should be every 24 hours and with chlorhexidine wipes and at time of death
- Oral care for ventilated patients is every 2 hours, otherwise twice daily and as per patient request if alert
- Wash hair once weekly and as needed, brush daily
- Shave daily if able and is per patient norm (if not anticoagulated and platelets stable and within
- range)
- Reposition every two hours and as needed. Assess skin for breakdown, light wash if dirty.
- For the incontinent or sedated/comatose patient, assess for bowel and/or urinary incontinence a minimum of every two hours, see above for cleansing if soiled
- Perineal care is to be completed each shift, apply barrier cream as needed
- Head of bed at minimum of 30 degrees when ventilated

PATIENT COMFORT

It is an unwritten policy to try to make the patients as comfortable as possible. It is important for the nurse to identify stimulants that may add to a patient's discomfort. These include:

- Lack of sleep
- Lights
- Heat
- Cold
- Noises inside/outside the room
- Being ignored
- Sweaty
- Bowel issues
- Odor

This list of course could be extended. Think of this section as a reminder to treat the patient as a person. What is upsetting them may be more or less than pain. This stress and anxiety is commonly heightened when communication is at a higher challenge for patients.

PROPER CLEANING OF FREQUENTLY USED EQUIPMENT

Before/After each use, always wring excess fluid from wipes prior using and allow device to completely dry before using:

- THERMOMETER: Use PolySat (70/30) wipes or Dispatch wipes
- INTELLIVUE MONITOR: PolySat (70/30)
- COWS: use PolySat (70/30) wipes, avoid contact with energized components
- BLADDER SCANNER: Completely wipe off all gel from probe with Sani-Cloth (purple top)
- GLUCOMETER: Sani-Cloth (purple top)
- EKG MACHINE WIRES: Dispatch wipes
- BAIR HUGGER: Sani-Cloth (purple top)
- HOVERMATT AIR CAN: Wipe down using a damp cloth with soap and water or mild neutral detergent. Dry using a clean, dry cloth or disposable paper towel.
  - *Do not spray cleaners or liquids directly on the Air Supply*
- WALKERS: Sani-Cloth
- SLIDE BOARDS: Sani-Cloth
- DOPPLERS: Clear all gel from device, PolySat (70/30) wipes

Once a month or sooner if needed:

- EKG machine will need exterior surfaces and peripheral devices cleaned with Dispatch wipes, let dry 30 minutes

VENTILATOR RESOURCES

VAP - VENTILATOR ASSOCIATED PNEUMONIA BUNDLE

Document the following EVERY shift for each patient on the ventilator:

- Head of bed at least 30 degrees
- Hourly RASS score
- Daily sedation vacation – if physician orders otherwise, please document
- Review weaning protocol daily for all patients on ventilators
  - Collaborate with respiratory therapy regarding trial initiation
  - RT/RN initiate trial and document patient's tolerance of trial (no physician order needed to trial patient if criteria met per weaning protocol)
  - KCVA Weaning trials between 0800-1000

WEANING TRIAL PROTOCOL

All ICU patients on mechanical ventilation will be assessed daily by RT and RN to determine eligibility for weaning trial.

A weaning trial will be performed on eligible patients by RT between 0800-1000 each morning. Patients must meet **ALL** of the following criteria for a weaning trial:

- FIO2 < 50%
- PEEP < 7 cm H2O
- Arterial oxygen saturation> 92% or PaO2> 65 mm Hg
- Respiratory rate< 30 breaths per minute
- Hemodynamically stable (HR < 110/min, MAP> 60 mm Hg or order from primary team if not within these parameters)
- ABG pH> 7.3
- Able to follow commands
- Gag and cough present, able to clear secretions. Doctors will occasionally ask the patient to lift their head off the bed

Patients must **NOT** undergo a weaning trial if they are:

- Unresponsive to stimuli
- Receiving continuous neuromuscular blockade (paralytic)
- Receiving vasopressor infusion (dopamine, phenylephrine, norepinephrine, or epinephrine)

If the patient is a **DNR status, do not wean unless provider ordered**

WEANING PARAMETERS:

All patients will be placed on spontaneous mode for 3 minutes in preparation of obtaining weaning parameters. Patients receiving PSV will have pressures support turned off for these measures. CPAP 5cm H2O may be maintained during this time. RT will access and record the following weaning parameters:

- Spontaneous respiratory rate (RR)
- Spontaneous tidal volume (Vt)
- Spontaneous minute volume (VE)
- Calculate rapid shallow breathing index (RSBI) = RR/Vt
- Vital capacity (VC), only if requested
- Weaning Trial

Unless otherwise ordered, a weaning trial will be performed for no more than 2 hours. The weaning trial will be performed on PSV 5cm H2O and CPAP 5cm H2O. The weaning trial will be stopped if any of the following occur for >3 minutes:

- The patient appears clinically uncomfortable, diaphoretic, anxious, agitated or shows signs of respiratory muscle fatigue (i.e. – use of accessory muscles, paradoxical respirations)
- Arterial oxygen saturation below 90%
- Above weaning parameters change (RR>)

RICHMOND AGITATION SEDATION SCALE (RASS)

SCORE	TERM	DESCRIPTION
+4	**Combative**	Overtly combative, immediate danger to staff
+3	**Very Agitated**	Pulls or removes tube(s) or catheter(s); aggressive
+2	**Agitated**	Frequent non-purposeful movement, fights ventilator
+1	**Restless**	Anxious, but movements are not aggressive or vigorous
0	**Alert and Calm**	
-1	**Drowsy**	Not fully alert, but has sustained awakening (eye-opening/contact)
-2	**Light Sedation**	Briefly awakes with eye contact to voice (< 10 seconds)
-3	**Moderate Sedation**	Movement or eye opening to voice (no eye contact)
-4	**Deep Sedation**	No response to voice, but movement/eye opening to physical stimulation
-5	**Unarousable**	No response to voice or physical stimulation

RASS ASSESSMENT

- Observe patient
  - Patient is alert, restless, or agitated (score 0 to +4)
- If not alert, state patient's name and say to open eyes and look at speaker
  - Patient awakens with sustained eye opening and eye contact (score -1)
  - Patient awakens with eye opening and eye contact, but not sustained (score -2)
  - Patient has any movement in response to voice but no eye contact (score -3)
- When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum
  - Patient has any movement to physical stimulation (score -4)
  - Patient has no response to any stimulation (score -5)

RASS Goal: Target RASS score in ventilated patients is usually 0 to -2, although scores of -3 and -4 may be acceptable. *DOCUMENT RASS HOURLY*

HYPERGLYCEMIA – DKA - HHNS

	HYPERGLYCEMIA	DKA	HHNS
QUICK PATHOLOGY	✓ Lack of insulin ✓ Fluid and electrolyte imbalances ✓ Stress response (surgical patients) ✓ Use of steroids	✓ Type I diabetics ✓ Precipitated by infection, stress, or noncompliance ✓ pH <7.35 ✓ Osmotic diuresis ✓ Volume depletion ✓ Anion gap acidosis (>12mEq/L) ✓ + Urine and serum ketones ✓ Initial hyperkalemia followed by hypokalemia	✓ Type II diabetics ✓ Precipitated by infection, MI, sepsis, stroke, or noncompliance ✓ pH >7.35 ✓ Severe volume depletion; often losing 15-25% of body fluid ✓ Seizures
INITIAL GLUCOSE	>150 mg/dl	>300 mg/dl	>800 mg/dl
TARGET GLUCOSE	80-150 mg/dl	<200 mg/dl	<200 mg/dl
USE OF INSULIN	IV insulin infusion per ICU infusion protocol; with eventual transition to sliding scale	Initial bolus followed by insulin infusion with titration **Decreasing blood glucose 50-100mg/dl/hr**	IV insulin given at rate of 10 units/hr is usually required to reduce blood glucose levels or 10% per hour of the blood glucose level
IV FLUID RESUSCITATION	Not applicable	✓ 0.9% Normal Saline ✓ Once glucose reaches 250ml/dl add 5% dextrose (to prevent hypoglycemia) ✓ As K+ reaches 4.5 add K+ to fluids	✓ 0.9% Normal Saline @ 1L/hr until CVP/urine output/BP stabilize
GOAL OF INSULIN THERAPY	Maintain blood glucose within target range (as evidence shows this to decrease morbidity and mortality)	With insulin infusion the goal is the reversal of academia and closure of anion gap NOT euglycemia (glucose in range)	Completely rehydrate and obtain normal blood glucose levels within 36-72 hours
IMPORTANT PEARLS OF KNOWLEDGE	<u>Importance of glucose control in the ICU:</u> ↓ Nosocomial infections ↓ Onset of acute renal failure ↓ LOS ↑ Tissue Healing ↑ Osmotic Diuresis	The main problem in DKA is NOT hyperglycemia, it is ketoacidosis. The insulin drip is to treat the anion gap (i.e. the ketoacidosis), NOT the hyperglycemia. If the patient has a high anion gap and normal glucose, continue the insulin and add glucose. **Failure to follow this strict protocol can result in cerebral edema and DEATH.**	The onset of HHNS is slow and may not be recognized thus the older client typically seeks medical attention later.

TIKOSYN ADMINISTRATION

INDICATION:

Tikosyn is a class III antiarrhythmic for the use of cardioversion or maintenance of regular sinus rhythm in patients with atrial fibrillation or flutter

CONTRAINDICATIONS:

Known hypersensitivity to Tikosyn; Creatinine clearance < 20 ml/min; baseline QTc >440 msec (or 500 msec with ventricular conduction abnormalities); Verapamil, hydrochlorothiazide, cation transport inhibitors (cimetidine, ketoconazole, trimethoprim, prochlorperazine, megestrol, and dolutegravir). Always verify no medication interactions prior to dosing.

CONSIDERATIONS:

Patients are at greatest risk for Torsades de Pointes (due to prolonged QT interval and possible R-on-T phenomenon) during initiation of Tikosyn, requiring monitoring of the first 5 doses; medication changes directed by the Cardiologist or Cardiology Fellow but order may be placed by resident. Patients MUST remain on telemetry monitoring at ALL TIMES, NO EXCEPTIONS throughout Tikosyn initiation. ACLS certified RN will accompany patient with monitor if off unit testing is ordered.

PRIOR TO ADMINISTRATION:

Baseline weight, creatinine clearance, potassium, magnesium and QTc must be documented (utilize lead II, V5 or V6 on 12 lead EKG only, not Phillips monitor, whichever is longest and document which used). Potassium <4.0 and Magnesium < 2.0 to be treated prior to first dose of Tikosyn, notify cardiology Fellow of abnormals. Please verify anticoagulation status and last dose of previous antiarrhythmic therapy (to ensure proper clearance of previous therapy has occurred).

ADMINISTRATION:

Dosing is provided on an every 12 hour schedule, times are 0600 and 1800. EKGs will be completed 2 hours post Tikosyn administration: 0800, 2000 (maximum time allowed for EKG completion is 3 hours). QTc will be measured, calculated and reported to the Cardiologist or Cardiology Fellow (not resident) no later than 3 hours post dose. Only calculation method to be utilized is Frederica. This may be calculated via Qx Calculate App or https://www.medcalc.org/clinicalc/correctedqt- interval-qtc.php; you must verify correct method of calculation is utilized. Any questions regarding these formulas please notify the Critical Care Educator for review. It is ultimately the responsibility of the physician to ensure the accuracy of the QTc measurement. It is the responsibility of the RN to document all communication regarding measurements, labs, changes in patient condition with the physician and to who was spoken to. If Fellow or Cardiologist is unavailable, you must page the fellow, obtain fax number to send EKG for their review. If changes are needed, the fellow can provide those to the resident for placement. RNs are NOT to take verbal orders.

CHANGES:

If initial dosing provides >15% increase in measurement, expect a decrease of medication per chart on flowsheet. If measurement exceeds 500 msec (or 550 msec for ventricular conduction delay) medication should then be stopped. Only allow one decrease in dosage, never twice.

TELEMETRY "CHEAT SHEET"

NAME	RHYTHM	RATE	P WAVE	P:QRS RATIO	PR INTERVAL	QRS	OTHER
SINUS RHYTHM	Regular	60-100	Same, Smooth, Rounded	P=QRS	0.12-0.20	<0.12	
SINUS TACH	Regular	101-150	Same, Smooth, Rounded	P=QRS	0.12-0.20	<0.12	Gen. not >150 Treat underlying cause
SINUS BRADY	Regular	<60	Same, Smooth, rounded	P=QRS	0.12-0.20	<0.12	Treat when symptomatic
SINUS ARRYTHMIA	Irregular	60-100	Same, Smooth, Rounded	P=QRS	0.12-0.20	<0.12	Rhythmic Changes
SINUS PAUSE	Irregular	60-100	Same, Smooth, Rounded	P=QRS	0.12-0.20	<0.12	Dropped Beats
PAC	Irregular	Depends Underlying Rhythm	Presence of P'	P=QRS	0.12-0.20 PR may be abnormal	<0.12	Not a Rhythm Determine & treat the cause
NON-CONDUCTED PAC	Irregular	Depends Underlying Rhythm	Presence of P'	P>QRS	0.12-0.20 No PR interval	<0.12	Watch T waves Determine & eliminate cause
ATRIAL TACH/PAT	Regular	140-250	Abnormal	P=QRS	Tends to be short	<0.12	Angry P waves; Valsalva's maneuvers
A. FLUTTER	Maybe Irregular	Atrial 250-300 Vent onset controlled 60-100	Not present – F waves	N/A	N/A	<0.12	Saw-tooth flutter waves
A. FIB	Irregular	Atrial Indiscernible Vent 150 onset Controlled 60-100	Chaotic Baseline	Indiscernible	Indiscernible	<0.12	
WAP	Irregular	60-100	Variable	P=QRS	Variable Like P waves have like PR intervals	<0.12	Minimum of 3 distinct P waves One intrinsic P wave & at least 2 other P'
MAT	Irregular	>100	Variable	P=QRS	Variable	<0.12	Minimum of 3 distinct P waves One intrinsic P wave & at least 2 other P'
SVT/PSVT	Typ. Regular	150-250	Indiscernible	Indiscernible	Indiscernible	<0.12	Treat underlying, vagal maneuvers
PJC	Irregular	Depends Underlying Rhythm	P' before, after, or buried in early QRS, inverted in II,	P=QRS	P'R generally 0.04-0.12 if seen	<0.12	Not a Rhythm ID & treat cause

			III, aVf				
JUNCTIONAL	Regular	40-60	P' before, after, or buried in early QRS, inverted in II, III, aVf	P=QRS	P'R generally 0.04-0.12 if seen	<0.12	Treat if symptomatic
ACCEL. JUNCTIONAL (AJR)	Regular	60-100	P' before, after, or buried in early QRS, inverted in II, III, aVf	P=QRS	P'R generally 0.04-0.12 if seen	<0.12	Correct underlying cause
JUNCTIONAL TACH	Regular	>100	P' before, after, or buried in early QRS, inverted in II, III, aVf	P=QRS	P'R generally 0.04-0.12 if seen	<0.12	If rate >150, may be called SVT as P' hard to identify
BBB	Depends Underlying Rhythm	Depends Underlying Rhythm	Depends Underlying Rhythm	Depends Underlying Rhythm	Depends Underlying Rhythm	>0.12	Not a Rhythm
PVC	Irregular	Depends Underlying Rhythm	No P prior to early QRS	P>QRS	None for early beat	>0.12 for Early QRS	Wide & Bizarre QRS; Not a rhythm
IR	Regular	Atrial None Vent 10-40	Absent	P<QRS	N/A	>0.12 Wide & bizarre	**LETHAL**; Dying Heart, CPR
AIR	Regular	Atrial Non Vent 41-100	Absent	P<QRS	N/A	>0.12 Wide & bizarre	If symptomatic, Atropine may restore SA node
V-TACH	Regular	Atrial None Vent >100	Absent	P<QRS	N/A	>0.12	Torsades is a form of VT & is irregular; **LETHAL**
V-FIB	Irregular	Indeterminate	Absent	P<QRS	N/A	>0.12	Course baseline only-irregular Defibrillation **LETHAL**
ASYSTOLE	Irregular	None	Absent	N/A	N/A	Absent	Flat line, may have just P waves; **LETHAL**
1°AVB	Depends Underlying Rhythm	Depends Underlying Rhythm	Depends Underlying Rhythm	Depends Underlying Rhythm	>0.20 Constant	Depends Underlying Rhythm	State underlying rhythm
2°AVB, TYPE I WENCKEBACH	Regular Atrial Irregular Ventricular	Usually 60-100	Same, Smooth Rounded	P>QRS	Lengthening PR Progressive	<0.12	May have a pattern "foot prints"
2°AVB, TYPE II	Regular	Atrial usually 60-100; Vent may be slower	Same Smooth, Rounded	P>QRS	Usually 0.12-0.20 but may be prolonged; Constant	Prolonged or WNL	
3°AVB CHB	Regular	Atrial usually 60-100; Vent usually <60	Same, Smooth, Rounded	P>QRS	Highly variable; No pattern	Generally >0.12	**LETHAL**

COMPLETED FORMS

SEE M-8, PART II, CHAPTER 2 FOR INSTRUCTIONS

Veterans Administration

CLINICAL INSTRUCTOR PROFILE

NOTE: This form should be used for either a VA instructor or, if applicable, the instructor from the affiliating school.

1. VA FACILITY	DATE

2. PROGRAM	3. AFFILIATING INSTITUTION
4a. INSTRUCTOR	4b. PRESENT POSITIONS
5a. REGISTRATION/LICENSURE: (State) /	5b. EXPIRATION DATE

6. EDUCATIONAL PROFILE

NAME OF INSTITUTION	PROGRAM	DEGREE AND YEAR AWARDED
a.		
b.		
c.		
d.		

7. ADVANCED EDUCATIONAL PREPARATION FOR LAST 2 YEARS *(List courses, continuing education activities, etc.)*

S

8. PUBLICATIONS LIMITED TO LAST 2 YEARS *(Doctoral programs only) (Attach paper if additional space is needed.)*

9. PROFESSIONAL EXPERIENCE *(Limit to last 5 years)*

DATE(S)	POSITION	TITLE	PLACE OF EMPLOYMENT
a. *(Present)*			r
b. -			
c. -			
d. -			
e. -			