#### ATTACH Patient LD LABEL

### CRITICAL CARE NURSING ASSESSMENT FORM

	Safety Check: Resus.bag Suction & correct setup Alarms & limits Bed rails
	U.P.S (vent/cmt/monitor)  U.D band
Neurological	See Critical Care Flow Chart for Neurological Assessment & Sedation/Analgesia Infusions Mental Status:
	GCS: Eye Verbal Motor Pupils: L(mm) R(mm) Reaction L R           Restraints:
Respiratory	See Critical Care Flow Chart for Oxygen Therapy & Ventilator Settings   Ainway:   Maintains Own   BPAP /CPAP     ETT: Size:   Length at teeth/gums   cm   Cuff pressure:   cmvH20     Tracheostomy: size:   Breath     Sounds   Sounds   Coler     Cral Mucosa:   Intact   Other   Sounds     Lip Condition:   Intact   Other   Coler     Tracheal stoma: Describe:   Decreased   Wheak   Absent     Strong   Moderate   Weak   Absent   Crep's     Cough:   Strong   Moderate   N.I.V   Non-ventilated   Crep's     Easy/Regular   Deep   Shallow   A Absent     Chest Expansion:   Symmetrical   Asymmetrical   Intercostal use   Other     Paradoxical   Tracheal tug   Expiratory     Trachea:   Midline   Deviated left   Deviated right     Other (description)
	☐ Chest tube #1 to: ☐ Chest tube #2 to: ☐ Suction cm H2O ☐ Underwater seal only Oscillation: ☐ Present ☐ Absent Oscillation: ☐ Present ☐ Absent Air Leak: ☐ Present ☐ Absent Air Leak: ☐ Present ☐ Absent Drainage: ☐ Chest tube #2 to: ☐ Chest
Cardovascular	□ See Critical Care Flow Chart for Wital Signs, Haemodynamics, and Neurovascular Assessment  ECG: Lead: Rate: PR: QRS: QT: ST Segment: Twave  Interpretation:  Skin (peripheral): Pink Pale □ Jaundiced □ Flushed □ Mottled □ Cyanotic □ Diaphoretic
	Oedema: Generalised Localised to: Dry Moist (sacral, ankle etc)
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## **Table of Contents Respiratory Therapy Documentation Forms**

- 1. Understanding the eBook Respiratory Therapy Documentation Forms
  - The Rise of Digital Reading Respiratory Therapy Documentation Forms
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Respiratory Therapy Documentation Forms
  - Exploring Different Genres
  - $\circ\,$  Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Respiratory Therapy Documentation Forms
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Respiratory Therapy Documentation Forms
  - Personalized Recommendations
  - Respiratory Therapy Documentation Forms User Reviews and Ratings
  - Respiratory Therapy Documentation Forms and Bestseller Lists
- 5. Accessing Respiratory Therapy Documentation Forms Free and Paid eBooks
  - Respiratory Therapy Documentation Forms Public Domain eBooks
  - Respiratory Therapy Documentation Forms eBook Subscription Services
  - Respiratory Therapy Documentation Forms Budget-Friendly Options
- 6. Navigating Respiratory Therapy Documentation Forms eBook Formats
  - o ePub, PDF, MOBI, and More
  - Respiratory Therapy Documentation Forms Compatibility with Devices
  - Respiratory Therapy Documentation Forms Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Respiratory Therapy Documentation Forms
  - Highlighting and Note-Taking Respiratory Therapy Documentation Forms
  - Interactive Elements Respiratory Therapy Documentation Forms
- 8. Staying Engaged with Respiratory Therapy Documentation Forms

- Joining Online Reading Communities
- Participating in Virtual Book Clubs
- Following Authors and Publishers Respiratory Therapy Documentation Forms
- 9. Balancing eBooks and Physical Books Respiratory Therapy Documentation Forms
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Respiratory Therapy Documentation Forms
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Respiratory Therapy Documentation Forms
  - Setting Reading Goals Respiratory Therapy Documentation Forms
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Respiratory Therapy Documentation Forms
  - Fact-Checking eBook Content of Respiratory Therapy Documentation Forms
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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