NSOCM NURSING CARE HANDOUT 12-Feb-18

Nursing care based on the SHEEP VOMIT mnemonic *(page 147 NSOCM field guide)*

- Skin Protection: clean, moisten, protect *(urine, feces, irritants)*, sunscreen, insects)
- Hypo / Hyperthermia
- Elevate Head *(upper body)*
- Exercise *(Active / Passive Range of Motion ROM)*
- Pad Stretcher / Pressure points

- Vital Signs *(and trend your vitals)*
- Oral *(and Nasal)* Hygiene
- Massage *(DVT prophylaxis)*
- Ins & Outs *(Diet & Fluids)*
- Turn/ Cough/ Deep Breath

SHEEP VOMIT covers the Acts of Daily Living (ADL)

- Basic Self-care tasks *("what we normally do in the morning")*
- Bathing, hygiene, grooming, dressing, Toilet hygiene *(getting to the toilet, cleaning oneself, and getting back up)* functional mobility, "transferring" in & out of bed, walk.
- There is a hierarchy to the ADLs: *"the early loss function is hygiene, the mid-loss functions are toilet use and locomotion, and the late loss function is eating".*

Individualized & Holistic Approach (IHA)

- Focused on the specific needs of the patient. Holistic means: not just the absence of illness/injury but physical, psychological & social health.
- *Common sense: Put yourself in the patient's position: what do I want, and what do I need?*
- Focused on maintaining as much as possible of the patients own ADL activities. *(only support that what is impaired to prevent hospitalized behavior)*
- A detailed care plan which is IHA prevents complications and can save time. *(by defining expected outcomes)*

Cyclical care & Continuity of care.

- Nursing is a 24/7 process and you have to sleep too! Your non-medical team members need to be taught and trained on "how to nurse" so you can rest too.
- By writing a detailed care plan describing what to do when, you provide your team members with a step-by-step framework that guarantees continuity of care.
- The care plan is there to maximize patient care, but it's also there to HELP YOU!
- Documentation for handover = continuity of care *(next level of care)*

Translating observations into a Care plan has to be based on the following considerations:

1. Patient focused *(holistic)* **assessment** + medical results and diagnostic reports. This is the first step in order to be able to create a care plan. Information is this area can be subjective and objective.
2. **Differential diagnosis** / Etiology *(what causes the problem?)*
3. **Expected outcomes** are outlined based on pt. 2. These may be long and short term.
4. Nursing **interventions** are documented in the care plan related to a timeline to work towards achieving pt. 3.
5. **Rationale for interventions**; Ask yourself: *"what's the reason you perform interventions"*
6. **Evaluation.** *"Was my intervention effective?"* Document your findings and/or adjust your intervention plan.

Patient comfort:

- Lying on a stretcher/spine board can only be endured for a very short time.
- Ulcers can develop within 1 hour, depending on patient condition.
- Early transferring (ASAP) your patient to a PADDED "bed" or padding the stretcher is essential to improve outcome. *(Even in Spinal injuries>soft immobilization)*
- Consider planning for bringing a large tri-fold lawn chair.
- A talon-2 litter requires a 5 cm mattress/padding *(2 therm-a-rest)* if a bed is not available
- Use towels, pillows, blankets or soft equivalent soft material to pad / support the body.
- Dress your patient when possible (dignity and to support skin integrity)

Patient safety:

- A restless/ combative patient *(low LOC)* can fall. (*hospital beds have side-rails).* They can *(and will)* pull out IV's, NG's, *(inflated)* Foley's, etc. Continuity in monitoring / observation is key.
- Consider using a *(low)* field bed with a mattress to decrease the height.
- A sleeping *(low LOC)* patient can roll on his side. A narrow bed or stretcher on litter stands can cause a fall.
- Always control your immobilized patient when you use positioning techniques to prevent falling.

Tips for SHEEP VOMIT (page 147 NSOCM field guide)

Nursing care is highly developed science based trade and knows a wide range of specializations. Trying to master and understand all those skills is unrealistic.
Your nursing care plan and interventions have to be SMART: Specific, Measurable, Achievable, Realistic and Timely.
The information below does not yet specify which nursing interventions are "Minimum, Better, Best" in accordance with the 10 Core Capabilities of PFC.
Following the SHEEP VOMIT mnemonic and using a selection of achievable- and common sense principles, practical skills- and ergonomic techniques that are used for nursing care from psycho-geriatric care up to IC care, can drastically improve the nursing part of your Prolonged Field Care tasks.

Skin Protection and general hygiene:

- clean, moisten, protect *(urine, feces, irritants)*, use sunscreen or lotion.
  Note; insects: *use a mosquito-net.*
- Perform regular observation/checks on skin condition when performing positioning.
- If any areas of non-blanchable erythema are noted, outline area with a marker and prevent placing the patient on the affected area until it recovers.
- Baby wipes are super, BUT; only good for minimal body hygiene. Face, hands, armpits, groin, genitals, feet. *(you will not have enough for a continuous care process!)*
- Use warm *(to the touch)* water with very little *(or no)* mild soap. If mild soap is used, you need to rinse/wash off the mild soap with water. Mild soap will leave residue and will cause skin problems.

- Use washcloths *(or: clean socks / 4x4" gauzes)* and the patients towels to perform total continuous hygiene measures *(eyes & face: start from the middle and work your way outwards, >hair > neck > anterior chest > anterior legs>ROLL PATIENT >posterior chest> posterior legs> >ROLL PATIENT BACK > armpits > groin > feet. Change the washcloth (or turn over and use the other side) > wash genitals > then anus. (male/female)*
- Genitals: Male: retract foreskin, clean the area. Female: separate labia, clean front to back, from the center> outward.
- Carefully remove and change tape once a day to decrease potential skin breakdown *(IV opsite every 72 hours)* Do not place tape back onto the exact same spot.
- Make sure you dry off creases / where skin touches skin. *(Dab the skin dry if impaired)*

Creases and skin to skin contact areas

- Eyes: In unconscious patients the eyelids can be padded with moist NS gauze as a preventative measure.
- Place a chux-pad under the patients bottom an austere environment to keep your bedsheets clean in case of urine/fecal incontinence.
- Defecation: If the patient has to go, let him pee into a bottle first. Then he needs to roll onto his side with the chux-pad *"strategically placed"* under and behind him. It's Awkward, but for patient safety it is necessary to stay with the patient. Once done defecating, the patient needs to remain on his side while you remove > clean > place a fresh chux-pad under the bottom.
- Clean-up after defecation; use the chux-pad to remove most of the feces. Remove and dispose of the full chux-pad. Wipe their bottom front to back. Inspect the skin surrounding the anus. place a fresh chux-pad in the middle of the bed *(under the bottom)* and have the patient roll back.
  Using a bedpan in the bed is an option if the patient can lift his butt off the bed and is able to sit *(injury/LOC)*. *You will have to clean your bedpan or place a garbage bag into the bedpan. Think it through thoroughly before you choose to use a bedpan in your clinic!*
- Considerations for defecation:

- Always have the patient urinate into a bottle before he defecates for measuring your fluid balance. *Otherwise it's literally going to be a mess…*
- Inspect the feces using the Bristol chart, page 56 NSOCM field guide

Hypothermia / Hyperthermia

- Normal body temperature is about 37 degrees Celsius (°C) or 98.6 degrees Fahrenheit (°F). Your temperature is usually lower in the morning and increases during the day. It reaches its high in the late afternoon or evening.
- You can take a temperature using the mouth *(oral),* anus *(rectal),* armpit *(axillary),* or ear *(tympanic).* A rectal temperature is 0.5°F (0.3°C) to 1°F (0.6°C) higher than an oral temperature. An ear (tympanic) temperature is 0.5°F (0.3°C) to 1°F (0.6°C) higher than an oral temperature.
- *Do not use the same thermometer for both oral and rectal readings. Be sure to label your thermometer either "oral" or "rectal" to know the difference.*
- Rectal techniques *(use a thermometer cover / lubrication can help)*
  - Get *"a visual"* on the anus by lifting 1 leg and separating the butt cheeks.
  - OR: Get *"a visual"* on the anus by rolling the patient *(facing away)* and separating the butt cheeks.
  - Turn ON- and insert thermometer. Hold on to it until it beeps. *(cover patient during procedure)* take it out and document the reading.
- **Hypothermia:** Use heat blankets, regular blankets, improvise with camelback containing warm water *(NOT HOT: careful not to put it directly on the skin!)*
- **Hyperthermia:** Remove blankets / clothing / heat source. Use a ventilator to evaporate. Wipe the patient down with a moist cloth.
- *Check the effectiveness of your interventions (thermometer) to prevent ending up the opposite effect of what you're trying to achieve!*

Elevate Head (upper body) Positioning

- Every 2 hours; reposition the patient and Check Padding
- Positioning the patient in bed by using the lifting technique *("Cat-Claw" your hands under the patient)* with 2 persons, moving up/down-left/right in bed)
  Basically a 2 man carry, supporting the lower back and below the buttocks.

Cat-Claw *(low profile, no Rings / Watches)*

- Perform patient rolling and centralizing *(always placing the patient in the middle)* in bed. *(bring the body "spine in line" as a position for comfort)*
  Common sense: "Does it LOOK comfortable? Then it probably is…"
- Supine patient: Use the logroll technique, place padding behind the body (in line) at a 30-degree angle Lateral Recumbent Position. Pull the shoulder from underneath the body to lower pressure. Separate knees by raising the upper knee *(supporting the knee with a pillow or soft equivalent)*

  - Make sure elbows, knees and ankles are not resting on top of each other.
  - Make sure the arms are not resting on the abdomen *(padding with pillows / or equivalent)*
  - Make sure the head & neck are spine in line.
  - Be aware of external equipment such as Foley-, IV-, ventilator-, tubing etc.
- Fowler/ Reclining position: *(see: Padding)* place as many pillows, blanket rolls or soft equivalent under the knees, ankles, heels and sacrum to support as much of the body as possible. Elevate the arms slightly by placing a pillow or soft equivalent underneath the arm/elbow *(less pull on the shoulder)*. Make sure the sheets are not tucked in too tight at the feet. *(pressure points: toes and ankles)*
- Transfer from the patient lying down to sitting on the edge. Roll patient towards you, dangle the lower legs over the edge of the bed, between your legs, move your upper body towards the head of the bed. Take hold of both shoulders and then bring the torso to a sitting position by *"pushing"* the shoulder up *(never pull on limbs).* Let patient acclimatize *(LOC/BP drop)* while you remain standing in front of him, with his legs between yours.
  Lying down: Reverse Transfer Steps.
  Emergency: hold tight and let yourself "fall" forward on the bed with the patient.
- Assisted Standing up from the bed: Place your hands on the shoulder blades, under the armpits, of the patient. Instruct the patient to place his hands on your shoulders. Lean backwards, bringing the patient with his feet *(between your feet)* to the ground. Lean back, bend your knees and support & follow the patient motion standing up. Once standing; Let patient acclimatize *(LOC/BP drop).*
  If the patient proves unable to stand reverse steps to get back on the bed.
  Emergency: hold tight and let yourself "fall" forward on the bed with the patient.
- Supported stand>turn>sit between the bed and a (toilet) chair. Continues after you assisted the patient with standing up. Once you and the patient stand, you will *"do a little dance"* by slowly turning and swaying on the spot *(shuffling)*. Once in position, have the patient sit down slowly, while you lean back, bend your knees and support & follow the patient motion until he sits.
  Standing up from the chair and getting back into bed > reverse previous steps.
  Emergency: hold tight and let yourself "fall" forward on the bed with the patient.
- Supported walking with patient *(only if LOC / Balance and strength is OK)*
  A 2-man supported walk speaks for itself, allowing you to do anything without difficulty.
  BUT; If you cannot walk alone with your patient, it is probably a bad idea to try to walk!
  Stand next to the patient on their healthy side. Bring your arm under their arm (between their body and their arm) and take hold of their hand/wrist. Pull and lock the patients elbow against your body. Provide support and balance as a counterweight while slowly moving forward.
- Changing the bed sheets on an occupied bed. You will need 2 persons to do this, since you don't have side-rails on the bed *(safety)*.
  - Simple version *(if the bed and the patient are clean)* Roll patient to 1 side and roll and tuck the old bedsheet as far as you can under the patient. Roll the clean bedsheet in such a way that it follows the old bedsheet under the patient. Roll the patient on his other side. Pull the old sheet from under him and put it aside. Pull the clean bedsheet from under the patient. *MAKE SURE THERE ARE NO CREASES AND BUMPS UNDER THE PATIENT*. Tuck the bedsheet under the mattress and reposition your patient.

- Difficult version *(If the old bedsheet is dirty from incontinence/vomiting)* Use a towel or something disposable instead, to place under the patient after rolling. First clean your patient and bed before you put back a clean bedsheet.

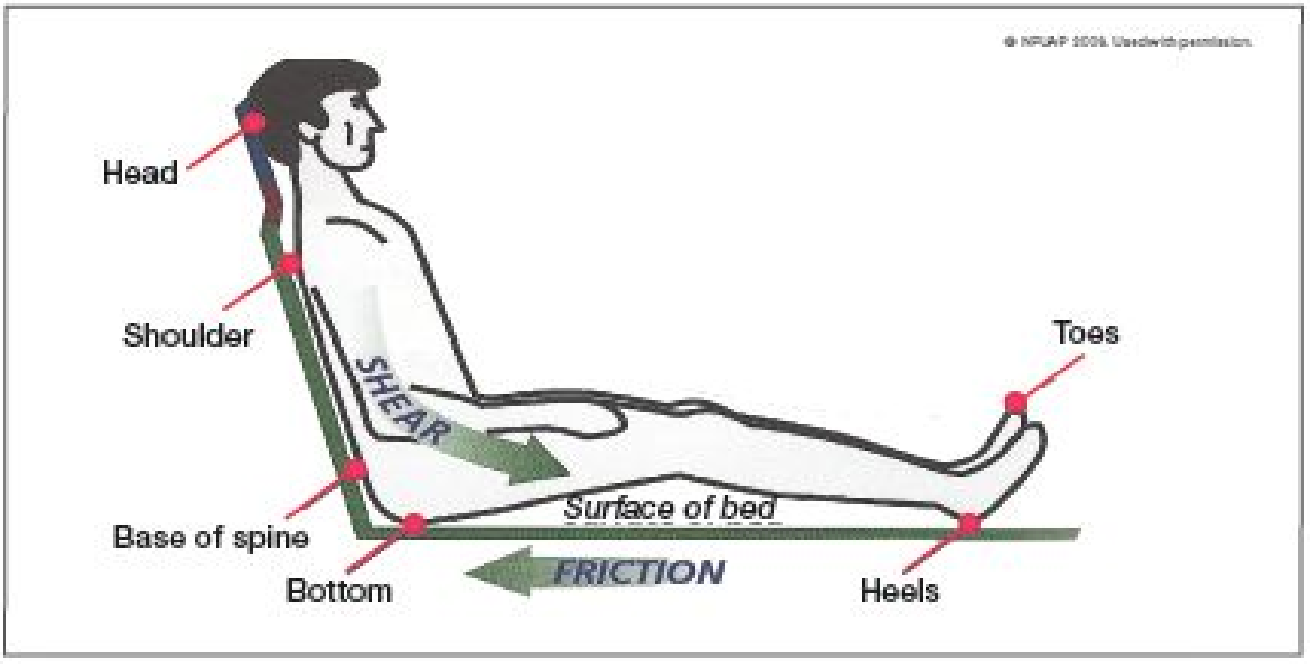
Exercise (active / Passive Range of Motion ROM)

- Stimulate your patient to Stretch, Flex, Curl/Roll, Elevate/Lift and Move their body themselves.
- If they can sit, stand or walk; Let them, but never unsupervised or without support!
- Purpose is to retain muscle tone, to prevent atrophy, stiffness, contractures and spasticity.
- Perform passive ROM measures. (supported by DVT massage) every 4 hours, for up to 20 min at the time *(for a total care patient)*
- Passively Stretch, Flex, Curl, Elevate and Move the affected limbs within the normal movement patterns and range of motion.

Pad Stretcher / Pressure points

- CONTINUOUSLY assess *(especially when repositioning)* the skin for signs of pressure points that WILL lead to bed sores. If any areas of non-blanchable erythema are noted, outline area with a marker and prevent placing the patient on the affected area until it recovers.

- Mitigate the risk of getting pressure points on the skin, joints and bony prominences *(as shown below)* by providing and adjusting proper padding *(Blankets, Bed Sheets, Pillows or soft equivalents)*
  Common Sense: "what are the pressure points when the patient is lying/sitting in this position?"



Fowler position

Vital Signs (and trend your vitals)

- Vital signs are the fundamental objective data collected and gives you an immediate sense of whether your patient is "sick" or "stable. Your objective information validates your subjective observations.
- By "trending" the vitals over a longer period of time onto the PFC trending sheet www.prolongedfieldcare.com you can:
  - Follow through on interventions already in place *(I.E. Pain management)*
  - Start fine-tuning the interventions that are already in place *(I.E. adjusting fluid input or ventilator settings)* and anticipating the next interventions needed by *"connecting the dots"* instead of being surprised by an unnoticed gradual negative change in patient condition. *(I.E. Compartment Syndrome requiring Escharotomy)*

- Clear and uniform documentation *(your handwriting must be understandable for everyone)* is essential for continuity of care internally *(when you are resting)* and when the patient is handed over to the next level of care.

Oral (and nasal) Hygiene

- Oral hygiene reduces oropharyngeal colonization *(associated with ventilator acquired pneumonia).* Conscious patients have to brush their teeth every 12 hours, unconscious patients require oral care every 4 hours. *(avoid aspiration)*
- Use tap water or normal saline to provide oral care; do not use commercial mouthwashes containing irritating substances, like alcohol or hydrogen peroxide.
- Have suction equipment ready when performing oral care.
- To keep the mouth open, make a padded tongue depressor by wrapping gauze around 1 end and secure it with tape.
- Assess oral / nasal *(look & smell)* cavity at least once daily and note any discoloration, lesions, edema, bleeding, exudate, or dryness.
- Observe ability to eat and drink. Take out dentures if necessary.
- *(gently)* Brush without toothpaste if LOC is low or wrap a moistened *(do not oversaturate>risk of aspiration)* gauze around your finger with a little bit of toothpaste and "brush" teeth. Afterward, clean with a gauze, moistened with just water to rinse out *(again: do not oversaturate>risk of aspiration)*.
- use a chap stick or Vaseline to keep the lips moist.

Massage (DVT prophylaxis)

- DVT, or Deep Vein Thrombosis, can be a very serious and life threatening situation in a very inactive patient.
- If available; use compression stockings *(like in geriatric care)*
- Purpose of massage: to stimulate circulation and also; give general relief, to prevent bedsores and to give comfort to the patient.
- Check distal pulses and/or CR, check skin temperature to the touch (back of your hand) Stretch the leg, Flex the feet, Curl the toes, (gently) massage the skin using intermittent compression to increase the venous flow. *Ergo; work upward starting at the feet.*
- Difficult to measure a real positive outcome, but it supports passive ROM exercises.

Ins & Outs (Diet & Fluids)

- If the patient can drink and eat safely (LOC), let them.
- Use a Camelbak / straw / short piece of tubing, so patients in a supine position (I.E. paralysis) can drink.
- Document oral intake of food an (amount) of fluid.
- Measure urinary output *(The numbers on the bag are not a reliable measurement!!!)*
- Document your ins & outs to trend your fluid balance.
- NG tube is mainly for gastric deflation, but fluids *(also: protein shake)* can be given through it as well. IF you choose to feed through NG tube: Check /measure the stomach content by aspirating > return content and add up to 200 ml > wait 1 Hour > aspirate and measure

stomach content to ensure if- or how well- the GI tract is working > adjust the amount of fluid given per hour without exceeding 200 ml.

- Flush the NG tube after aspiration / insertion of fluids/nutrition and document.

Turn/Cough/Deep Breath

Assisted Coughing https://www.youtube.com/watch?v=ZvXvqQyje5o

Costophrenic assisted coughing *(the sharp downwards angle between the diaphragm and the chest wall at the bottom of the lung).*

1. Patient in a Supine position (I.E. paralyses)
2. In supine apply a quick downward force from the costophrenic angles *(Place hands under the ribs, thumbs pointing inward).*
3. Upon inspiration give 2-3 quick downward stretches to maximize inhalation
4. Instruct patient to hold breath at end of inspiration
5. Patient: Turn face away
6. COUGH and apply strong pressure inward and upward near the end of expiration (strong diaphragmatic contraction)

Costophrenic assistance in a lateral position (side lying)

- Similar, but with 1 hand, combined with the other hand supporting the back by the shoulder

Heimlich type

1. Push up and in at the diaphragm as the patient begins to Cough/Exhale
2. Works best in those with low tone or flaccid muscles
3. This may work well on somebody who is bit bigger
4. Easy breath in, blow it out, deep breath in, hold it, then cough as you help them
5. In supine, place 1 hand directly over the diaphragm
6. Deep breath in, hold it
7. Patient: Turn their head and cough.
8. Push down and upward

Heimlich Side lying:

- Similar, combined with the other hand supporting the back by the shoulder

Anterior Chest Compression assist (Supine only)

1. Facilitate inspiration at upper chest by giving 2-3 quick downward stretches to maximize inhalation
2. Place both lower arms on the patient's chest
3. Above and below (diaphragm) the nipple line
4. Inspiration (deep breath) and Hold it
5. Turn head
6. Assist w/ Cough while applying a downward force

References:

- *College of Remote and Offshore Medicine (CoROM): SHEEP VOMIT mnemonic*
- *PFCare.com: Nursing CPG, Feb 2018.*
- *NATO-Special Operations Combat Medical Field Guide, ISTC NSOCM, CoROM 1st Ed. May 2017.*
- *www.nurselabs.com CPG's: oral hygiene, skin care, hyperthermia, hypothermia, positioning, exercise.*
- *MOH nursing clinical practice guidelines: oral hygiene, skin care, hyperthermia, hypothermia, positioning, exercise.*
- *https://healthtimes.com.au/cpd online: oral hygiene, skin care, hyperthermia, hypothermia, positioning, exercise.*
- *Algemeen Militair Verpleegkundige opleiding niveau 2, 3, 4, Defensie Geneeskundig OpleidingsCentrum (DGOTC: NLD military medical school, RN course level 2, 3, 4).*

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