**Definitions of WDL and Focused Assessment**

**Biological Systems** – Patient will attain/maintain optimal physiologic function. Note: Labs should be reviewed, when appropriate, for all biological systems.

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<th>CLASS in HED</th>
<th>WDL “Within Defined Limits” Definitions</th>
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<tbody>
<tr>
<td><strong>Comfort</strong></td>
<td>Basic WDL: Verbalizes/Demonstrates absence of pain and/or ability to sleep/rest. Pediatric patient demonstrates rest within adult arms.</td>
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</table>
| **Neurological** | Basic WDL: Awake, alert; responds/arouses easily to verbal and/or tactile stimuli; oriented to person, place, and time; face symmetrical; gross motor movement coordinated and equal; no seizures, tremors, or posturing; speech clear and appropriate for age; absence of implantable device.  
**Basic WDL – Pediatrics:** Awake, alert; responds/arouses easily to verbal and/or tactile stimuli; loud, lusty cry; facial symmetry; moves all extremities equally; behavior/affection appropriate to situation, developmental stage, and parent’s observation; age appropriate muscle tone; normal facies; anterior fontanelle soft and flat; neck supple (non-trauma); absence of implantable device. |
| **Pupils WDL:** shape is round, reaction is brisk. |
| **Movement/Sensation WDL:** movement is strong and controlled with absence of numbness and tingling. |
| **Cardiac**  | Basic WDL: Heart Rate/BP within Age specific parameters; regular rhythm.  
**Heart sounds WDL:** S1 and S2 present, without murmur, rub, S3 or S4 (adult); S1, S2 and S3 present, without murmur or rub (pediatric). |
| **Invasive Cardiovascular** | Basic WDL: Site soft without evidence of hematoma; dressing clean, dry and intact. |
| **Peripheral/Neurovascular** | Basic WDL: Color, movement, sensation (CMS) intact; no edema.  
**Fistula WDL:** AV fistula/graft thrill present/bruit present. |
| **Respiratory** | Basic WDL: Rate, pattern, appropriate for age specific norms without use of supplemental oxygen or artificial airway; breath sounds clear and equal bilaterally; no involuntary cough, or sputum; absence of cyanosis. |
| **Gastrointestinal** | Basic WDL: Tolerates customary diet without gastric distress, nausea or vomiting; no tubes, fistulas, or ostomies; stool frequency, consistency and color are usual for the patient and passed without interventions/appliance; continence of stool appropriate to developmental age.  
**Abdomen WDL:** Abdomen soft, non-tender, non-distended.  
**Stoma/mucous fistula WDL:** moist, red, patent, protruding. |
| **Nutrition/Hydration** | Basic WDL: Appears oral food/fluid intake meets nutritional needs; no current alteration to nutritional status. |
| **Genitourinary** | Basic WDL: No difficulty voiding; continent of urine age/developmentally appropriate; no tubes/drainage/ostomies.  
**Urine Description WDL:** Urine clear, yellow, absence of sediment or unusual odor.  
**Stoma WDL:** moist, red, protruding, patent.  
**Basic Pregnancy WDL:** Membranes intact; absence of vaginal bleeding.  
**Basic Postpartum WDL:** Fundus firm and centered; Lochia < 2 hours post delivery - minimal to moderate rubra, may have occ. clots < 4 cm & > 2 hours post delivery - scant to minimal rubra to Serosa. |
| **Peritoneal Dialysis** | Exit Site WDL: Cath site without erythema, tenderness, swelling, and drainage. |
| **Musculoskeletal** | Basic WDL: Gross motor movement unrestricted.  
**Cast WDL:** Clean, dry, intact. |
| **Mobility/Activities of Daily Living** | Basic WDL: Independently performs Basic Activities of Daily Living (BADLs). |
| **Integumentary** | Basic WDL: Skin warm dry & intact without generalized or localized discoloration; color normal for person; mucous membranes pink/moist; absence of ostomy/tubes/drainage. Umbilical cord drying, and with no drainage, if present.  
**Incision WDL:** Absence of redness, drainage, edema and warmth with edges approximated.  
**Surrounding Skin WDL:** Dry, intact, color normal for person.  
**Wound VAC WDL:** No leaks, tubes away from skin, dressing compressed.  
**Circumcision WDL:** Minimal swelling, scant drainage, yellow, granulated exudate.  
**Postpartum WDL:** Breasts-soft to filling/firm; nipples intact; labia-none to minimal edema; perineum/rectum: intact, none to minimal bruising or edema, no evidence of hematoma. |
| **Invasive Lines** | Basic WDL: Without erythema, tenderness, drainage, edema. Dressing intact, flushes easily, sutures intact if applicable. If gauze dressing in place-dressing dry and intact, without tenderness, or visible erythema. |
| **Safety** | Basic WDL: Patient verbalizes and/or demonstrates no risk of injury or threat of harm to self. |

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For documentation purposes, the following are defined:

**STANDARDS OF PRACTICE**
provides care supporting these standards but also within their legally defined scope of practice.

**process** encompasses all significant actions taken by clinicians, and forms the foundation for clinical decision-making. Each discipline include the components of assessment, diagnosis, outcomes identification, planning, implementation and evaluation. The critical thinking Interdisciplinary Standards of Practice describe a competent level of patient care as demonstrated by critical thinking processes that

**INTERDISCIPLINARY STANDARDS OF PRACTICE**

| Interdisciplinary Standard of Care Definitions: |
| INTERDISCIPLINARY STANDARDS OF PRACTICE |
Interdisciplinary Standards of Practice describe a competent level of patient care as demonstrated by critical thinking processes that include the components of assessment, diagnosis, outcomes identification, planning, implementation and evaluation. The critical thinking process encompasses all significant actions taken by clinicians, and forms the foundation for clinical decision-making. Each discipline provides care supporting these standards but also within their legally defined scope of practice.

**STANDARDS OF PRACTICE**

I. **Assessment:** The clinician collects comprehensive data pertinent to the patient’s health or the situation.
   a. Patient acute care needs are determined through a comprehensive assessment and screening.
   b. Data is collected in a collaborative manner to avoid duplication.
   c. Data collected is documented and retrievable by all disciplines.
   d. Patient need and condition will determine the frequency of assessment.

For documentation purposes, the following are defined:

**Basic assessment:** minimum assessment performed each time a component is assessed.

**Focused assessment:** more detailed assessment based on information gathered in basic assessment; required whenever Basic assessment is not within defined limits, or whenever further assessment is required based on identified or potential risk.

- **Family** refers to two or more persons who are related in any way – biologically, emotionally or legally.
- Patients and families define their “family” and determine how they will participate in care and decision-making.

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