ICU/PCU Documentation Requirements (EBCD 2018.2)

Core Measure Sheets: Green, Lavender, or Purple (as appropriate)

Admission/Shift Assessment

Full (QShift & change to higher level of care)

Selected Focus Systems

(Cardiovascular: Cardiac Monitor = Q4hrs + paper EKG strip) – Other systems (PRN ANY CHANGE!)

Safety/Risk/Regulatory

Sepsis (QShift)

Skin (QShift)

Fall (QShift)

(suicide risk) **Assess Suicide** (QShift)

(Restraints)

Order present

Assess Restraints

Document alternatives utilized (Initiation)

Document application of restraints (Initiation)

Safety/Rights/Dignity maintained verified (Initiation)

Document restraint status monitor (Q2hr)

Safety/Rights/Dignity maintained verified "THREE TIMES EVERY HOUR" (End of Shift)

Document RN assess/discontinue (Discontinue)

Pain Assessment: (Q4hr) w/ *appropriate* scale (may also be in eMAR)

Non communicative = CPOT Non VERBAL = Wong-Baker (Faces).. must POINT to face Verbal Numeric = Number

(AMS/Neuro/Stroke pt) **Frequent Neuro Checks**: at least GCS & Pupil (Q4hr)

(ETOH) **CIWA Ar**: Before & after any Ativan use (PRN/As ordered)

Vitals/Ht/Wt/Measurements

Vital Signs: ICU (≤ Q1 hr), PCU (≤ Q4hr, cardiac gtt ≤ 2hr, titrating gtts ≤ 1hr)

Temperature (Q4hr)

Weight (Q24hr)

Critical Care Flow Record:

(Vented Patient) Document Ventilator Management

SAT Safety Screen, if "Pass", then also SAT (QShift)

RASS/CAM ICU

(sedated) RASS (Q4hr) (may also be in "IV Drip Titration")

CAM ICU (QShift)

Intake and Output

ICU = Intake (≤Q6hr), Output (Q1hr)

PCU = I&O (Q4hr)

Lines/Drains/Airways:

(central line) Lines:

Start/Monitor/Discontinue (QShift)

Dressing Changed (Q7days)

(Foley) Drains: Urinary Catheter

Indication

Start/Monitor/Discontinue/POA (Qshift)

Routine Daily Care:

Activity (w/ Meals & PRN)

Hygiene Care Provided (QD)

Oral Care (QShift unless Vent/Trach – then Q2hr)

(ICU) CHG used for bath

Teach/Educate: (QShift)

(IV controlled gtt) **Controlled Substance Handoff**: (QShift/transfer)

IV Drip Titration: (Q Start/Titrate/Discontinue/Restart) *If using paper flowsheet - minimum Q6hrs

Manage/Refer/Contact/Notify:

(ICU – ICU status) Multidisciplinary Rounds (QD during rounds)

Critical Values &/or Physician Communication (PRN)

Transport: Pt leaves/returns from unit (PRN)

Incentive Spirometry: (Q2hrs While Awake even if not ordered!!!)

Plan of Care: (QShift) *** MAXIMUM 3-4 TOTAL active plans!!!! ***

Checklists Admit/Transfer/Discharge

EBCD

Admission:

*** Use Admission Folder ***

- Assessments tab – Enter new: Quick Start
- Admission Health History
- Admission/Shift Assessment (FULL)
- ***Medication reconciliation w/ Preferred Pharmacy***
- Safety/Risk/Regulatory
  - Isolation status
  - Assess sepsis
  - Assess vaccines
  - Assess adult skin risk
  - Assess fall risk
  - Assess suicide
  - Assess restraints (if ordered)
- 1st Point of Contact MRSA/TB/RESP
- Pain Assessment
- (AMS/Neuro) Frequent Neuro Checks
- Sleep Apnea Screening
- (ETOH) CIWA-Ar
- Vitals/Ht/ Wt/ Measurements
- Critical Care Flow Record
  - (vent) Document Ventilator Management
  - Document Glasgow coma scale
  - (ICU) Document RASS/CAM ICU
  - (CVC,Foley,Drain) Document lines, drains, and airway
  - (fresh s/p OR) Document PAR (Post Anesthesia Record)
- Routine Daily Care (**ICU = CHG!** + Iodophor!)
- Teach/Educate
- (IV controlled gtt) Controlled Substance Handoff
- (IV gtt titration) IV Drip Titration
- Manage/Refer/Contact/Notify (location)
- (NOT intubated/BiPAP/CPAP) Incentive Spirometry
- Plan of Care (3-4 max problems)

*** Green, Lavender, Purple Sheet
*** Paper Kardex
*** Orderset "ICU Decolonization"

Discharge:

- *Notify Charge Nurse/ Team Lead of discharge orders*
- Paper Chart Check
- *Green, Lavender, Purple Sheet (2nd RN)
- Lines/Drains/Airways (d/c or Inactivate lines!!!!)
- Intake and Output
- Safety/Risk/Regulatory (vaccine if not completed)
- Teach/Educate (Stroke, DM, CHF, Opiate!!!!)
- Plan of Care ("problem has" field to complete + Change Status
- Med Rec
- Discharge Instructions
- *Notify Charge Nurse/ Team Lead when pt has left*
- ***REMOVE PATIENT ARMBAND WHEN THEY LEAVE MCL!***

Transfer:

(receiving)

- *"Receive/Acknowledge" Transfer Order*
- *Acknowledge new orders*
- (if change care area) Assessments tab – Enter new: Quick Start
- Admission/Shift Assessment (FULL)
- Safety/Risk/Regulatory
  - (isolation) Isolation status
  - Assess sepsis
  - Assess adult skin risk
  - Assess fall risk
  - (suicide idiation) Assess suicide
  - (if ordered) Assess restraints
- Pain Assessment
- (AMS/Neuro) Frequent Neuro Checks
- (ETOH) CIWA-Ar
- Vitals/Ht/ Wt/ Measurements
- Critical Care Flow Record
  - (vent) Document Ventilator Management
  - Document Glasgow coma scale
  - (ICU) Document RASS/CAM ICU
  - (CVC,Foley,Drain) Document lines, drains, and airway
  - (fresh s/p OR) Document PAR (Post Anesthesia Record)
- Routine Daily Care (**ICU = CHG** + Iodophor!)
- Teach/Educate
- (IV controlled gtt) Controlled Substance Handoff
- (IV gtt titration) IV Drip Titration
- Manage/Refer/Contact/Notify (location)
- (NOT intubated/BiPAP/CPAP) Incentive Spirometry
- Plan of Care (3-4 max problems)

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(sending)

- *Notify Charge Nurse/ Team Lead of transfer orders*
  - ** Change Status to "C" for completed << - - Physician Orders- ->>
- *Acknowledge the Order to Transfer ("Pop" the transfer bubble)*
- *(Transfer w/ Tele:) Ensure MD order for Tele is place*
  - *Confirm with Tele Tech when Monitor is applied (x. *02090)*
- *Complete SBAR form & call report*
- Vitals/Ht/ Wt/ Measurements
- Lines/Drains/Airways **D/C CVC/FOLEY IF POSSIBLE**
- Pain Assessment
- Intake and Output
- Teach/Educate
- Plan of Care
- Manage/Refer/Contact/Notify

Right Before sending:

- *Acknowledge the Order to Transfer ("Pop" the transfer bubble)*
- *Check Med Room & transfer any pt specific medications*
- *Notify Charge Nurse/ Team Lead when pt has left the room*

Restraints: NON-VIOLENT (MITTENS ARE NOT RESTRAINTS)

INITIATION

- ***Physician order*** *"Restraints" *** RENEW Q24 ****
- **Plan of Care** - *Health behavior problem = 2Violence/Restraint Risk*
- **Primary RN** : Safety/Risk/Regulatory (Assess restraints
  - **Document alternatives Utilized**) & file
- **Charge RN** : Safety/Risk/Regulatory (Assess restraints
  - **Second Tier Review**) & file
- **Primary RN** : Safety/Risk/Regulatory (Assess restraints
  - **Document application of Restraints**
  - + **Safety/Rights/Dignity maintained verified** (DONE NOW) & file

Q2

- **Primary RN** : Safety/Risk/Regulatory (Assess restraints
  - **Document restraint status monitor**) & file

END OF SHIFT

- **Primary RN** : Safety/Risk/Regulatory (Assess restraints
  - Document restraint status monitor
  - **Safety/Rights/Dignity maintained verified" (3 x every hr**) & file

DISCONTINUE

- **Primary RN** : Safety/Risk/Regulatory (Assess restraints
  Document RN assess/discontinue