USC Arcadia Hospital
Keck Medicine of USC

Title: Documentation Standards in Intermediate Care Unit (IMCU)	Page 1 of 4
Policy #: CR1044	
Type: Critical Care	
Standard: N/A	

GUIDELINES: To provide a guide and standard in documenting patient information for all nursing personnel. The Critical Care Electronic Medical Record (EMR) Flow Sheet will be used in the Intermediate Care Unit (IMCU) for charting and documentation of patient information. When the EMR is in downtime the Critical Care Paper Flow Sheet will be used.

PROCEDURE:

1. IMCU Nurses will document patient information in the Electronic Medical Record. During downtime procedures, nurses will document pertinent information on the Critical Care Paper Flow Sheet.

2. Each patient will have a complete physical assessment performed and documented on admission and each shift. Reassessments will be done as changes occur.

3. Vital signs will be documented a minimum every two hours (Blood Pressure, Respiratory Rate, Pulse, and SpO2) for the first 24 hours unless making changes to vasoactive medications, change in patients' condition and/or post procedure vitals will be taken more frequently per physician order. If the patient is stable after 24 hours, vital signs will be documented every 4 hours.

4. Electrocardiogram (EKG) strips will be mounted in the patients chart every 4 hours (08:00, 12:00, 16:00, 20:00, 00:00 and 04:00). Mount strip to "Cardiac Rhythm Documentation Form" verifying patients name, date and time.
Appropriate information will be documented including patients name, date, time, Lead(s), rhythm interpretation, measurements of PR interval, QRS duration and QT interval in the electronic medical record (EMR) every four hours. Notify the critical care Intensivists, physician or critical care provider with any EKG rhythm changes.

5. Post procedural and clinical monitoring should be documented every two to four hours.

6. Vasoactive medications are documented in the drips section of the vital signs flow sheet, noting titration changes in doses. Drips will be documented every 2 hours or more frequently when making changes to the drip.

7. The Richmond Agitation-Sedation Scale (RASS) : The RASS score shall be documented every two hours for all sedated patients and every 4 hours on all patients. If titrating sedation medication, assess patient RASS score every 15 minutes until desired RASS score is achieved per physician's order. RASS score: -5=Unarousable, -4=Deep Sedation, -3=Moderate Sedation, -2+Light sedation, -1=Drowsy, 0=Alert & Calm, 1=Restless 2=Agitated, 3=Very Agitated, 4=Combative. Goal RASS 0 to –2. If RASS is ≥ -3 proceed to CAM-ICU. Once the goal is achieved, monitor the RASS score every 2 hours.
    7.1. The CAM-ICU consists of 4 steps but not all steps are appropriate for every patient. If the patient has a negative CAM-ICU they have no delirium. If a patient has a positive CAM-ICU and a RASS less than 0, delirium is present. Document in EMR and notify physician of findings.

8. All patients will be turned every two hours, if they cannot tolerate being turned, the reason must be documented and re-evaluated every two hours.

9. All fluids given to the patient must be recorded to identify each fluid that is infusing. (Cumulative totals will be recorded for each eight-hour shift).

10. Blood products and derivatives will be recorded and identified as to specific product and amount in colloids section under intake on flow sheet.

11. Intake and output will be documented every 8 hours. NGT output documented every 4 hours. (Do not include other department intake/output). 24-hour balance will be documented at 0600.

12. Output and source will be recorded as ordered or at least every 8 hrs. The amount of nasal gastric NG residuals will be noted every 4 hours. Shift totals are recorded for individual sites and amounts.

13. Intake and Output will be documented every 8 hours. Nasal gastric tube (NGT) output documented every 4 hours. (Do not include other department intake/output). 24-hour Intake and Output balance will be recorded at 6am.

14. Peripheral intravenous (PIV) and Central Line (CL) sites will be documented every 2 hours or more often if needed.

15. The neurological status will be documented every 2 hours. Code stroke or neuro intervention patients will be documented as per physician order.

16. Blood gases will be recorded on flowsheet as well as specific changes in the oxygen and/or ventilator settings.

17. Nursing interventions under the care column indicate hospital policy followed and no further documentation needed. Blank spaces are provided for additional care given per hospital policy.

18. Skin Integrity assessment will be done every 12-hours, using the Braden Scale and more often as indicated by patient condition, and documented on appropriate section of flow sheet. Documentation will reflect a scoring system that evaluates patients' risk for skin breakdown. Photos will be taken and placed in the medical record upon admission and when any skin changes are noted. Dressing sites will be documented in skin assessment. If dressings are soiled, they will be changed unless ordered differently by physician.

19. All patients will be turned every two hours, if they cannot tolerate being turned, the reason must be documented and re-evaluated every two hours.

20. Interdisciplinary Plan of Care will be updated in the Adult Plan of Care Flowsheet daily.

21. Pain assessment will be documented on admission and with vital signs at least every 2 hours and as needed using 0-10 pain scale. Functional pain goal will be documented daily. Pain reassessment documented after medication given.

22. Fall risk assessment will be documented every shift. Fall risk interventions are mandatory for scores of 25 or greater. Fall TIPS education will be given in the patient's native language.

23. Restraints used and circulation assessment will be documented per protocol in restraint area on flow sheet. When restraints are used, document on safety section of flow sheet every two hours. Refer to Restraint Policy MA 1307 for guidelines.

24. Nutritional assessment will be documented on flow sheet every 24 hours or more often as indicated by patient condition. Nutritional consult will be documented on multidisciplinary charting. Document % of meals taken.

25. Psychosocial and safety needs of patients will be evaluated and documented on flow sheet every shift.

26. Assessment on flow sheet will reflect systems approach to include:
    - 26.1. Psychosocial
    - 26.2. Neurological
    - 26.3. Cardiovascular
    - 26.4. Pulmonary
    - 26.5. Gastrointestinal
    - 26.6. Genitourinary
    - 26.7. Skin risk assessment/Braden Scale
    - 26.8. Fall risk assessment.
    - 26.9. Medical/Surgical restraints

26.10. Equipment in use
26.11. Documentation of multidisciplinary team conference and evaluation by ancillary personnel i.e., respiratory therapy, physical and occupational/speech therapy, dietitian, social services, chaplain, and discharge planning will be documented daily as needed.

26. Blood sugar results along with interventions given will be documented in the point-of-care metabolic flow sheet.

System Generated Footer

Attachments:

Approvals:
Board of Directors: 9/24
CNO: 4/24
Critical Care Committee: 4/24
Director Critical Care: 4/24
Governing Policy and Procedure Committee: 9/24
MEC: 4/24
Medicine Department: 7/24
Surgery Committee: 4/24

Effective Date: 12/24

Reviewed Dates: 9/24

Revised Dates: