| Title: | Critical Care Documentation | Page 1 of 9 |
|---|---|---|
| Policy No: | 2 CC 108 | Effective Date: 1/1/04 |

OBJECTIVE
To ensure the consistent recording of patient needs, problems, capabilities, and limitations.

SCOPE
RN, LPN, PCA, and SNA staff with Critical Care skills and education.

POLICY
1. This clinical policy has been accepted as the standard of practice for the Detroit Medical Center to ensure the consistent provision of care for all Critical Care units except Sinai-Grace Hospital.

PROVISIONS

## I. GENERAL CONSIDERATIONS

1. All personnel document on the appropriate forms in a legible and concise manner in black ink.
2. All forms are dated, timed, signed, and labeled. Military time is used.
3. All documentation errors must remain legible. One line is drawn through an error and it is initialed above. Erasures or the use of correction fluid is prohibited.
4. Registered Nurses are not accountable for documenting other health care professionals' actions except medications given by physicians, when the RN knows what medication and dose is given
5. All caregivers are required to document initials, signature, title and indicate time responsible for patient care in space indicated.
6. Registered Nurses verify and co-sign documentation of data collected by Licensed Practical Nurses (LPNs), Patient Care Associates (PCAs), and Student Nurse Associates (SNAs).
7. Late entries to charting are clearly marked by circling the time in the minute column.

## II. CRITICAL CARE FLOWSHEET

1. Nursing care is documented on the Critical Care Flowsheet beginning at 0700 and ending at 0659 on the following day. The Critical Care Cue Sheet is used in conjunction with the flowsheet to define abbreviations, scales, and standard verbiage. See Appendix A. The Cue Sheet is kept on each patient's bedside clipboard.
2. Events are recorded on the flowsheet at the time of occurrence.
3. Findings, assessments, nursing interventions, and resulting patient outcomes related to the intervention are recorded.
4. The five shaded minute columns are used to document the exact time during the hour of the assessment or intervention. Entries on the same line in different sections of the flowsheet may be independently timed. See Figure 1.
5. All data entered into each hour section reflect findings or interventions that transpired during that hour. If additional space for entries is needed, a blank column is used or another column not in use may be relabeled.

6. Unlabeled columns are used for ongoing parameters that are not identified on other areas of the form.

7. A new flowsheet is not routinely initiated when a patient returns from the Operating Room/PACU or is transferred from another Critical Care unit. Ongoing assessment data is compared to the previous *12-Hour Assessment* and information recorded in the *Events and Interventions Section*. If all of the new data cannot be documented in the *Events and Interventions Section*, a new flowsheet may be initiated.

8. Documentation is guided by variances. Documentation is not required for normal assessment findings unless they represent a change from data in the 12-Hour Assessment section. Critical Care Standards of Care are only documented if there is a variance from normal or if the standard of care intervention is not done (Tier II CC 232).

9. A patient label is placed on the *Vital Sign Section* and the *Assessment Section* on the front and back of the form.

| | Min | Medications | Min | 40 60 80 100 120 140 160 | MAP | Temp | RR | Pain VAS/PABS | RSS | $SpO_2$ | PAP | PAWP CVP | $SVO_2$ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 35 | MS 3 mg IVP | 30 | | 75 | 37.8 C | 12 | 7 | 1 | 73 | 42/22 | 18/16 | 75 |
| 07 | 50 | | | | | | | 3 | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

Figure 1

**A. Medications Section**

1. Infusion data (solution/concentration, dose/rate, site and port, insertion date, and intravenous site assessment) are recorded on admission, at 0700, and 1900 in the *Solution Section* at the top of the form.

2. Nonscheduled and STAT medications, initiation dose and/or titration of medicated infusions, fluid boluses, blood products, Albumin, Hespan, or changes in IV rate are recorded in the *Medications Section*.

3. Documentation in the Medications Section does not replace Medication Administration Record (MAR) documentation.

4. Admission and today's weight are recorded daily in area above form title as appropriate.

**ADMISSION Wt.** _88kg__ **TODAY's Wt.** __95kg___

Figure 2

**B. Vital Signs Section**

1. Vital signs that are ordered per "ICU protocol" are documented as the patient's condition warrants based on RN assessment. Frequency may progress as follows:
   a. Q 15 minutes unless there is a significant variance from the previously recorded value.
   b. Q 1 hour.
   c. Q 2 hours.

d. Q 4 hours.

2. In the ICU, pain as the fifth vital sign is documented as follows:
   a. Either VAS or PABS is circled to reflect scale used.
   b. Document patient's pain upon initial assessment and every 4 hours with the focused assessment.
   c. Before and after every PRN analgesic delivery or change in continuous infusion.
   d. At rest and with activity.
   e. VAS documentation in the *Events and Interventions Section* includes location and duration of pain.
   f. Intubated patients assessed using the PABS may have a total score of 8 instead of 10 since vocalization is not measurable. See Appendix A for Cue Sheet.

3. The Modified Ramsay Sedation Scale (MRSS) 0 –5 is used to document a patient's level of agitation before and after medication is administered and as part of the baseline neurological assessment.

4. If invasive arterial pressures are used, label findings "A line." If non-invasive cuff pressures are used, label findings "cuff" or "NBP" (non-invasive BP). Document correlation between invasive and non-invasive pressures with initial assessment. Arterial pressure values are used unless an abnormal Square Wave Test is noted. Documentation of the abnormal Square Wave Test is posted in the chart.

5. Blood pressure and heart rate is graphed using the following symbols
   a. ∨ Systolic
   b. ∧ Diastolic
   c. ▲ Diastolic augmentation pressure
   d. • Heart rate

6. If the systolic is greater than 200 or diastolic is less than 40, the value is written in place of symbols.

7. Mean Arterial Pressure (MAP), Temperature (TEMP), Respiratory Rate (RR), Pain (Visual Analogue Scale, VAS or Patient Assessment Behavioral Scale, (PABS), Modified Ramsay Sedation Scale (MRSS), Pulse Oximetry ($SpO_2$), Pulmonary Artery Pressure (PAP), Pulmonary Artery Wedge Pressure (PAWP), Central Venous Pressure (CVP), and Venous Oxygen Saturation ($SvO_2$) values are recorded in the appropriate columns.

## C. Cardiopulmonary/Events Section

1. Baseline ventilator settings are recorded at 0700 and 1900 on the 12-Hour Assessment page but may be included as a reference in this section by off going shift.

2. All ventilator and oxygen changes, weaning parameters, baseline and ongoing Train of Four (TOF), and hemodynamic studies (e.g., cardiac output, and cardiac index) are documented.

3. Each suction episode is documented as well as the amount and characteristics of secretions if different from assessment. See Figure 3

| | INTRAVENOUS SOLUTIONS/CONCENTRATIONS | DOSE/RATE | SITE/PORT | |
|---|---|---|---|---|
| A. | Dopamine 400/250 ml D5W | @ 5 mcgm/kg/min | Rt SC Cordis | *Patient Label* |
| B. | 0.9 NS | @ 150 ml/hr | PA VIP | |
| C. | $D_5$ 0.45NS + 40 meq KCL | @ 40ml/hr | LSC TLC Prox | |
| B ~~D.~~ | $D_5$ W plain | @ 10ml/hr | PA VIP | |
| D ~~E.~~ | Epidural | @ 10ml/hr | --- | Date 11/30/03 |

| | min | CARDIOPULMONARY | PO/TF | A Dopa | B 0.9NS | C D5.45 | D | | | | NG | URINE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 07 | 45 | CO 4.2 CI 2.1 SVR 1350 PVR 185 | | | | | | IVPB | | | | |
| | 55 | Suction x 4 copious yellow | | 30 | 150 | 40 | 10 | | | | 100 | 100 |
| | | | | | | | | | | | | |
| | | | | 30 | 150 | 40 | 10 | 100 | | | | 100 |
| 08 | 00 | TOF 2/4, mA 40, rt. ulnar | 25% | | | | | | | | | |
| | 15 | ↓FiO2 to .4 | 50% | 30 | 150 | 40 | 10 | | | | 0 | 110 |
| | | | ☑75% | | | | | | | | | |
| | | | 100% | 60 | 300 | 80 | 20 | 100 | | | 100 | 210 |

Figure 3

## D. Intake and Output Section

1. Each critically ill patient has hourly intake and output recorded.

2. Each intake and output column is divided into hourly unshaded and cumulative shaded sections.

3. Intake and output values in the unshaded area reflect fluid volume at the ***end*** of each hour. For example, at 0359, entries are made in the 0300 *Intake and Output Section* reflecting the amount of fluid administered and drained from 0300 through 0359.

4. Oral intake and enteral feeding are recorded in the first column. Total meal intake is estimated as percentage eaten. When the patient is receiving enteral nutrition, label the first column with type of tube feeding and record volume.

5. Intravenous solutions are listed at the top of the page including dose, site, insertion date, site assessment, and tubing change. Intravenous piggyback (IVPB) medications are not listed in this section but on the MAR and on the *Medications Section* if unscheduled or STAT. Volume of IVPB solution is included in the 12 hour total.

   a. Intake columns are labeled with letters that correspond to the *Intravenous Solution Section* and are labeled beginning with the column on the far left.
   b. When solutions are changed during a shift, the next available line is used in the *Intravenous Solution Section.* Either the letter is changed to reflect to which column the new solution corresponds or another column may be used on the *Intake and Output Section.*
   c. Epidural and PCA solutions are added to the *Intravenous Solution Section* and labeled in the intake columns.

6. Blood products, cardiac output volumes, patient controlled analgesia, IVPB, and epidural volumes are included in the total intake.

7. The last column is labeled urine output. Any other measurable output is labeled to the left of the urine output.

8. Document total intake and output values from non-Critical Care units (e.g., Operating Room) on the *Intake and Output Section* and include in Critical Care totals.

9. Total intake and output values are recorded at 12-hour intervals at 1859 and at 0659 in the *24-Hour Intake and Output Section* on the 1900 12-Hour Assessment page. Totals are transcribed by the midnight shift in the *Previous 24 Hour Section* upon initiation of a new day's flowsheet.

| PREVIOUS 24 HOUR TOTAL | |
|---|---|
| *OR - 2500 crystalloids 500 PC* 4,645 | *OR EBL- 1500 u/o 300* 5,015 |
| **TODAY'S TOTAL** | |
| 0700 –1900 1,890 | 0700 –1900 1,850 |
| 1900 – 0700 1,755 | 1900 – 0700 1,800 |
| TOTAL 3,645 | TOTAL 3,650 |

Figure 4

**E. Events and Interventions Section Page 3**

1. Ongoing nursing assessment, interventions, procedures, specimen collection, patient transport, and/or significant occurrences are recorded in this section.

2. Every four hours a focused assessment is completed and changes from the previous 12-Hour Assessment are recorded in the *Events and Interventions Section*. If no change from previously documented assessment, the word "unchanged" is recorded after the assessment cue.
   a. A focus assessment targets areas that require more frequent monitoring based on the 12-Hour Assessment, ongoing data collection, changes in patient condition, abnormal findings, and systems that need to be monitored more frequently due to the potential for injury to the patient.

| | | | Motor (0-5) | | Pupils | | GCS | | | | ICP/CPP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | UPPER R/L | LOWER R/L | R SIZE/ REACT | L SIZE/ REACT | EYES OPEN 1-4 | BEST MOTOR 1-6 | BEST VERBAL 1-5 | TOTAL | |
| 07 | 00 | Bld, sputum, & urine C & S sent | 5/5 | 5/5 | 4/2 | 4/2 | 4 | 6 | 5 | 15 | 12 / 60 |
| | | Tip R radial aline sent | | | | | | | | | |
| | | | | | | | | | | | |

Figure 5

**F. Neurological Section**

1. The following items are recorded in the flow columns, but considered part of every 12-Hour assessment: Motor Strength, Pupil Reaction, Glasgow Coma Scale (GCS), ICP (Intracranial Pressure), CPP (Cerebral Perfusion Pressure), and Modified Ramsay Sedation Scale (MRSS). See Figure 5.

2. Upper and Lower Extremity motor strength is assessed on a 0-5 scale.

3. Right and left pupil size and reaction are recorded.

4. The Glasgow Coma Scale (GCS) total is completed by assessing Eyes Open 1-4, Best Motor 1-6, and Best Verbal 1-5. For intubated patients, the letter "I" may be used for verbal response.

5. Intracranial Pressure (ICP) and Cerebral Perfusion Pressure (CPP) are recorded.

**G. ASSESSMENT SECTION**

1. All patients are assessed within 10 minutes of admission. This assessment and all subsequent assessments must be documented within two hours of assuming responsibility for patient care. A focused assessment is completed every four hours and documented in the *Events and Interventions* Section.

2. Each RN performs a complete assessment when assuming shift responsibility for patient care. Complete patient assessments are documented every 12 hours.

3. Documentation is completed by variance. If a box or space is not checked or completed, this indicates that the sign or symptom is not present or the area is not applicable.

4. An ECG strip is attached and interpreted with every 12-Hour assessment.
   a. Minimally, a 3-second ECG strip is mounted on the flowsheet and must include date, time, and patient's name or medical record number. The remaining space is used for other invasive lines. Both adhesive tabs must be removed and the space filled with either ECG or invasive pressure waveforms.
   b. Document PR and QRS intervals on the ECG strip.
   c. Pulmonary artery pressure, pulmonary artery wedge pressure, intracranial pressure, and intra-aortic balloon pump (IABP) waveforms are attached every 12 hours to the flowsheet or 12-Hour Assessment in unused C*omment* or *Wound Sections*. If space not available, strips are mounted in the Progress Note or Rhythm Strip Form.
   d. All pressure waveforms are attached on admission or insertion.
   e. All pressure waveforms are assessed for dynamic response using the Square Wave Test. If dynamic response is abnormal, a strip is documented in the Progress Note or Critical Care Flowsheet. See CC 201 Arterial Pressure Monitoring or CC 224 Pressure Transducer System.

5. The following items are recorded in the flow columns, but considered part of the 12 Hour assessment: Vital Signs including Pain Scale, Motor Strength, Pupil Reaction, Glasgow Coma Scale (GCS), ICP (Intracranial Pressure) and CPP (Cerebral Perfusion Pressure) if applicable, and Modified Ramsay Sedation Scale (MRSS).

6. Site assessment is documented and the section is completed as follows if site is visible through transparent film.
   - 0 = No pain, erythema, swelling, induration
   - 1+ = Pain at site. Erythema and or edema. No streak. No palpable cord
   - 2+ = Pain at site. Erythema and or edema. Streak formation. No palpable cord
   - 3+ = Erythema and or edema. Streak formation. Palpable cord
   - G = Gauze

7. If the IV site is covered with a non-transparent dressing, the site is assessed and documented when

the dressing is changed/initialed.

8. If intravenous solution and tubing are changed, label the corresponding box, check Tubing Change and document time.

9. After a patient has returned from an area where responsibility for nursing care has been delegated, an assessment is performed and changes from the patient's previously documented assessment are documented in the *Events and Interventions Section* or in the Progress Notes if no room available on the Critical Care Flowsheet.

10. Skin and Wound Section allows for documentation of wounds or incisions any time during the 12 hour shift. Time, type of wound, location, size in centimeters, drainage, presence of drains, condition of peri-wound skin, and type of dressing covering site is described in the section. Integrity of dressings (e.g., clean, dry, and intact) may be documented in any *Comments Section* related to wound location.

11. Operating Room and IV insertion site dressings are assessed and dated upon admission to the unit.

**H. Reproductive Section** (Obstetrical Patients only)

1. For antepartum patients, assess:
   a. Fetal Heart Rate – Normal 120-160, regular rate and rhythm
   b. Positive fetal movement
   c. Fundus relaxed
   d. Fundal height consistent with gestational age
   e. No palpable contractions
   f. Bag of water intact
   g. No vaginal bleeding or discharge

2. For postpartum patients, assess lochia for progression through 3 stages, (ruba, serosa, and alba) with distinctive characteristics that reflect progressive endometrial healing. See Appendix A and B for description.

3. Document clonus, deep tendon reflexes, and fundal height

**I. Name and Professional Designation Section**

1. RNs sign, initial, and record the range of time they are responsible for the patient.
2. Other RNs who assume responsibility for the patient in the middle of a shift record their time span of responsibility.
3. If RN providing patient coverage administers a medication or intervenes, the entry is initialed and this section is signed.

## III. LABORATORY FLOWSHEET

1. The date and time of blood sampling is recorded on the Critical Care Laboratory Flowsheet with the results. See Appendix C.
2. When blood gases are recorded, the ventilator or oxygen settings and respiratory rate are documented.

## IV. PROGRESS NOTES

1. Documentation in the Progress Notes is based on the unmet outcomes of the Patient Outcome Record (POR) or variances that cannot be recorded on the flowsheet. See Tier II PCD 220.

2. A note is documented in the Progress Notes for all patients sent to the Operating Room or other

departments where responsibility is transferred. Documentation on PORs and /or Progress Notes is completed for patients who are not expected to return by shift's end.

3. Invasive monitoring waveforms are documented upon insertion.

**VARIATION:**

| HOSPITAL | DRH | HARPER | HUTZEL | HVSH | SINAI-GRACE | TOSH |
|---|---|---|---|---|---|---|
| Progress Note Documentation | Q 12 hours | Q 12 hours | Q 24 hours | Q 24 hours | Q 12 hours | |
| Intravenous Solution Documentation | The off going shift documents intravenous and epidural/PCA solutions in use for the next shift. | The off going shift documents intravenous and epidural/PCA solutions in use for the next shift. | | | Policy not applicable to Sinai-Grace | |

| HOSPITAL | DRH | HUH | HWH | HVSH | SINAI-GRACE | TOSH |
|---|---|---|---|---|---|---|
| Hemodynamic calculations | Hemodynamic calculations are printed from the monitor and are mounted in the strip flow sheet. Forms are signed if any additional information is added in writing. | Hemodynamic calculations are not printed. | Hemodynamic calculations are printed and added to the Progress Notes. | Hemodynamic calculations are printed from the monitor and placed in the patient's chart. Forms are signed if any additional information is added in writing. | Policy not applicable to Sinai-Grace | |
| Critical Care Lab Flow Sheet | In use | In use | In use | Not in use | Not in use | |

| HOSPITAL | DRH | HUH | HWH | HVSH | SGH | TOSH |
|---|---|---|---|---|---|---|
| PACU Documentation | | The Critical Care Flowsheet is used in PACU for patients who will be transferred to Critical Care. The PACU Assessment Form is used for the initial admission assessment. Subsequent assessments are documented in the Critical Care Flowsheet 12-Hour Assessment | | | | |

APPENDIX
Appendix A: Critical Care Flowsheet Cues
Appendix B: Critical Care Flowsheet OB Information
Appendix C: Critical Care Laboratory Record

ADMINISTRATIVE RESPONSIBILITY:
The Chief Nursing Officer/Senior Vice President of Patient Care has overall responsibility and authority for the administration of policies, procedures and guidelines related to patient care.

Approval Signature:

Iris Taylor, Ph.D., RN, Chief Nursing Officer,
Senior Vice-President, Patient Care Services

Date

REVIEW DATE: January 2007

SUPERSEDES: 8/01