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LSUHSC-Shreveport
Critical Care

Critical Care Flow Sheet/PLAN OF CARE

PURPOSE:

1. Provides the data needed to plan the critically ill patient's care and insure continuity of that care.
2. Provides a method for incorporating the plan of care into the nurses notes, showing evidence that developmental needs of the patient were considered in the assessment, planning, intervention, and evaluation of the provision of care.
3. Provides a mechanism for health-team professionals to communicate with each other.
4. Provides a way to review, study, and evaluate patient care to assure Standards of Care are met through nursing interventions.
5. All areas of the Critical Care Flow Sheet shall be completed as needed. If area not needed or not pertinent at the time of nurse documentation it shall be left blank in case it is needed later in the 24 hour shift.
6. Provides a legal record that documents the care delivered.

POLICY:

- A. **Addressograph**
The Critical Care Flow Sheet shall be stamped with the patient's addressograph card prior to adding to patient's chart.
- B. **Placement of the Critical Care Flow Sheet in the Chart**
The Critical Care Flow Sheet shall follow the Patient History and Discharge Record in the patient's medical record. If the patient's chart is to be thinned, a minimum of 72 hours of Flow Sheet documentation shall stay on the chart.
- C. **Minimum Documentation Requirement**
The patient's progress, response to care, nursing interventions, and effectiveness of nursing interventions based on the developmental needs of the patient, shall be documented in the narrative nurses' notes by a nurse **at least every 2 hours**, more often if necessary. Assessments shall be performed and documented at least every 4 hours.
- D. Initial and Daily Documentation
 1. The Critical Care Flow Sheet is a reflection of a 24-hour clock day (0700 - 0700.)
 2. The Critical Care Flow Sheet shall be initiated within the first 2 hours of the patient's admission or transfer.
 3. ~~Afterwards,~~ The Critical Care Flow Sheet will be initiated at the beginning of each day at 0700 thereafter. The 7p – 7a shift will copy the flow sheet and have ready for the following shift.

Critical Care Flow Sheet Documentation

1. Front Kardex Page:
 - a. All areas shall be completed. Unit/Post Op/Cannulation Day starts at Day 0. The day of admission is 0 and first 0700 is day 1.
 - b. Daily weights shall be performed and documented on all ICU patients. On admit Height and weight is entered into cardiac monitor to obtain BSA
 - c. Fall Precautions is documented for all patients in the ICU. Patients in the ICU are at risk for falls due to invasive lines, impaired mobility. All ICU patients shall have the bed in low position, the call light within reach or a nurse at bedside, assistance with ambulation if ordered and be oriented to their surroundings.
 - d. The I & O summary shall be completed throughout the shift. The 7P shift shall carry over previous cumulative total to the next day's flow sheet.
 - e. The access portion of the Kardex shall be completed as appropriate per patient.

All dressings for invasive access shall be documented in the space provided. Most recent dressing changes and previous access information shall be carried over daily. All central line access dressings are changed per hospital policy using chlorohexidine unless otherwise indicated in the nurses' notes for patients with chlorohexidine allergies. All IV line tubing shall be assessed daily for appropriately tagged "Date Change" labeling. When appropriate a tag is present and a is placed in the box.

- f. All nurses documenting on the Critical Care Flow Sheet shall be identified by full legal signature in the space provided. Entries thereafter may be initialed. A "*" in front of the nurses signature indicates 2nd nurse verification for continuous infusions of insulin and heparin.
 - g. Password: Passwords may be used in the ICU for families of unconscious/pediatric patients to get condition updates over the phone. The initial password must be set up in person. Only persons with the password shall get patient information other than a status report over the phone. If no family is available to receive patient information in person then the nurse will notify the compliance office to insure HIPPA is abided by.
 - h. The infection Prevention section shall be completed daily. Isolation is checked as to which type of isolation the patient is in. Infection Prevention education is presented in the ICU family guide. Once client education is presented the date in which it is done is documented and carried over daily.
2. Graphic/Hemodynamic/Vasoactive/Ventilator Page:
- a. Temperature shall be documented at least every 4 hours. If active cooling or warming is preformed, the temperature of the unit used shall be documented.
 - b. Vital signs including heart rate, blood pressure, MAP (if indicated), respiratory rate, and SaO₂ saturation shall be documented at least every hour. Changes in Vital signs may be documented more frequently based on the nurse's discretion. If patient has IABP or ICP, they shall document data at least hourly. Hemodynamics (if present) shall be documented at least every 4 hours with complete assessments. If continuous hemodynamics is present, data shall be documented at least hourly.
 - c. SVO₂/ScVO₂ calibration shall be done and documented at least once every 24 hours. (Routinely performed with AM ABG). "Recalibrated" is documented at time of occurrence.
 - d. All vasoactive drugs will have the dosages (i.e. mg/hr, units/hr, mcg/kg/min) documented initially and at least every 4 hours. Dosage changes shall be documented at the time of change. Mcg/kg/min is abbreviated as mkm.
 - e. Vascular leg checks includes the assessment of extremity color, presence of baseline pulse as documented on the hourly assessment, dressing at access site is dry and intact with no hematoma. The nurse shall document a if extremity is warm and dry, a baseline pulse is present as documented on the hourly assessment and the dressing at access site is dry and intact with no hematoma. Any variations from the above will be documented using "*" and will also be documented in the narrative.
 - f. Ventilator settings shall be documented at least every 4 hours including setting changes.

At any time in the critical Care Flow sheet a "*" occurs, this means see the narrative.

3. Intake and Output Page:
- a. Strict I & O's shall be calculated on all ICU patients.
 - b. The nurse shall document intake and output hourly.

- c. Patients undergoing CEBT shall have their hourly crystalloid calculated for appropriate calculation of Fluid Removal Rate. The nurse may use the formulas given to aid in the calculations for CEBT rates.
 - d. Total intake and output shall be calculated at 0600 and documented in area provided. This total is then transferred to the front of the flow sheet to calculate Current Cumulative Total. Current Cumulative Total is then transferred to the following day's flow sheet as the Previous Cumulative Total.
 - e. Each drain system shall be documented separately in the output section.
 - f. Ultra filtrate shall be documented at the end of the hour. (0700's Actual Fluid Removed Rate will be obtained and documented @ 0800 but placed in the 0700 place) for all CEBT patients. Hemodialysis ultra filtrate amount is documented at the end of the hemodialysis treatment.
 - g. Presence of stool or lack thereof shall be documented at least every 4 hours.
 - h. Gastric residual and pH shall be obtained and documented as per physician orders.
- 4. Medication Page:**
- a. The nurse shall document all routine and prn medications in the spaces provided.
 - b. All new orders shall be transcribed by the nurse onto the medication page in a timely fashion.
 - c. The medications shall be documented with order date, medication, dosage, route, frequency, and administration time schedule.
 - d. The nurse shall document when medication administered by initialing in the appropriate time box (non MAK units). MAK units shall document administration in MAK but use medication page as reference. If a medication is held it shall be documented on the medication page.
 - e. PRN medication responses shall be documented in the area provided.
 - f. The toxicology level area is provided to assist in the drawing and documentation of peaks, troughs, and random levels.
- 5. Blood Component/STAT & One Time Meds/PCA Epidural Page:**
- a. All blood products shall be documented in the space provided. The nurse may place the Blood Bank sticker off the back of the blood product bag or hand write the unit number in space provided.
 - b. STAT & One – Time Medications shall be documented in the space provided as well as response to medication administered.
 - c. Any patient with a PCA or epidural shall have assessment and documentation performed with each new shift, initiation or change. The cumulative total shall be documented at the end of the 7P shift in the space provided.
- 6. Restraints Tool:**
- a. The restrain tool shall be used as per Hospital Policy 5.15
- 7. Wound Care/Surgical Site/Skin Breakdown Tool:**
- a. This tool shall be used to aid the nurse in documenting any variation in skin integrity. The nurse shall document any dressing change for burns, wounds or surgical sites in the space provided. If other verbiage used other than provided in legend the nurse shall document complete word or place a "*" and refer to narrative.
 - b. Skin Risk Assessment shall be documented at least every shift. If the patient has more than 2 identifiers, skin care prevention begins and a WOCN consult is performed.
- 8. Hourly Assessment/Nursing Physical Assessment:**
- a. The nurse shall perform an assessment and document such assessment at least every 4 hours.
 - b. The nurse shall use the spaces provided and incorporate the legend into the documentation of assessment.
 - c. The Hourly Assessment page is set up to provide space for hourly assessments as

- needed on the ICU patient.
1. The nurse shall document which pain scale using in the line beside Pain Score
- d. The Nursing Physical Assessment is set up for a generalized assessment every 4 hours.
1. The “man” shall be used to documents variations in skin integrity. This allows a more visual picture of skin assessment.
 2. All invasive pressure monitors shall be documented when zeroing and square – tests performed by placing a in the space provided.
9. Plan of Care/Time Out/ Sepsis Screening Page:
- a. The Critical Care Flow Sheet shall reflect the Plan of Care. The Plan of Care is the clinical assessment, prioritized patient problems/needs, the interventions and the expected outcomes.
 - b. Each shift shall document the appropriate plan of care for the patient and identify needed interventions. **Prioritization shall be done daily and documented in the Problem/Need box. All interventions performed shall be documented by each shift.**
 - c.
 - d. “Time Out” shall be done for all bedside procedures. If the patient leaves the area (i.e. Interventional Radiology, Cath Lab, OR), the area performing the procedure is responsible for documenting the “Time Out”
 - e. The Sepsis Screening tool shall be used to assess for early signs of severe sepsis and ICU patients with deteriorating conditions. Each shift shall be responsible for screening the patient for signs of severe sepsis. If a patient screens positive for severe sepsis then the nurse shall notify the physician and document as such.
10. Educational Tool:
- a. Patient education activities are documented in education portion of the Critical Care Flow Sheet.
11. EKG Strips:
- a. The nurse shall document a telemetry strip at least every 12 hours. The nurse shall interpret and document telemetry in the Nursing Physical Assessment area. All other waveforms shall be interpreted in the nurses’ notes. Each nurse has documented competencies on waveform interpretation. The nurse may use this area to place recorded strips of any waveform used.
12. Narrative Notes:
- a. The narrative notes will contain an opening note from the beginning of each shift.
 - b. Complete assessments shall be performed every 4 hours using the Hourly Assessment and Nursing Physical Assessment tools as well as narrative notes. Specific assessments may be documented more often as needed or ordered.
 - c. Patients with invasive pressure monitoring shall have waveform verification and interpretation performed in the nurse’s narrative note.
 - d. In the narrative notes, on all shifts, the following must be documented:
 1. An opening note.
 2. Any deviations or changes from the initial assessment or original plan of care.
 3. Nursing interventions and effectiveness of nursing interventions.
 4. Nursing interventions not listed in the plan of care along with effectiveness of the interventions.
 5. If a patient leaves against medical advice or abandons the hospital.
 6. Other pertinent observations as appropriate.
 7. Assessment when the patient returns from invasive procedures.
 8. Time and initials for each entry in the plan of care (must have legal signature in signature block on front page of flow sheet to use initials).
 9. All transports to special departments, or any departure of the patient from

the unit for any purpose, shall be documented in the narrative. If the nurse stays with the patient he/she shall continue to document on the Critical Care Flow Sheet. If the patient is under the care of another department the Critical Care Flow Sheet shall stay with the patient's nurse. (Additionally, [Transfer/Discharge Summary S/N 1176](#), Plan of Care SN 7565 and/or [Inpatient Transport Summary S/N 7280](#) is completed as appropriate).

13. Scales Legend Page:

- a. This page is to provide legends for nurse documentation of commonly used ICU scales. These are the approved scales for the ICU and shall be used for documentation of pain, coma and sedation.
- b. The Richmond Agitation and Sedation Scale (RASS) shall be used for sedation
- c. The Numeric Pain, Whaley & Wong Faces Pain Scale and Critical Care Pain Observation Tool (CPOT) shall be used for pain. (Numeric with alert and verbal patients, CPOT for unresponsive).
- d. The Bedside Shivering Assessment Scale (BSAS) shall be used to assess for the presence and amount of shivering.
- e. The Glasgow and Four Score shall be used for coma scales.

14. Labs Page:

- a. The nurse shall document all ordered and pertinent lab in the spaces provided when the lab is drawn. Any medication dosage/ lab value changes should be performed based off the time the lab value was drawn.
- b. Critical Lab values are documented per Hospital Policy 5.30

15. Extracorporeal Life Support (ECLS) Page:

- a. The ECLS page shall be used on all ICU patients undergoing any ECLS procedure (CEBT, ECMO, and AVCO2R).
- b. The nurse shall document at least every 4 hours all settings, pressures, and data present for specific procedure. If any changes occur the nurse shall document changes at that time in the space provided.
- c. The ECLS lab area is used for the nurse to document ECLS specific lab. If documented in this space the nurse shall not have to document on the lab page.

16. Back Kardex Page:

- a. The nurse shall document any other scheduled treatments in the area provided. The nurse shall place the times for treatments needed in space provided.
- b. Each physician caring for the patient shall be listed with appropriate beeper numbers.
- c. Any Sliding Scales ordered for the patients shall be documented in space provided.
- d. Notification parameters shall be documented in area provided
- e. Drug titration with parameters shall be documented as per physician's order.