SUBJECT: **ICU DOCUMENTATION GUIDELINES**

Purpose: Provide documentation guidelines for nursing staff in ICU to promote efficient communication of the plan of care between caregivers.

Provider's Order Required: No

Performed By: RN

Policy Guidelines:

I. New Admission

A. Nursing Admission Assessment is completed within two hours of admission and is documented by the end of the shift.

Exception: Patients who are transferred to ICU for a special diagnostic procedure.

B. Nursing staff will complete the following items for all new admissions within 8 hours.

1. Admission History Adult
2. Basic Admission Information
3. Immunization Screening
4. Order Entry Detail
5. Interdisciplinary plans of care (IPOCs)
6. Adult Education
7. Medication History

C. Nursing staff will complete the following items for a patients who transfer into the ICU

1. Physical Assessment
2. Update IPOCs
3. Adult Education

II. Routine Documentation

A. Baseline assessment will be completed within 1 hour from start of shift. RN may utilize the reassessment option with or without changes throughout the remainder of the shift.

B. Adult Quick View

C. Adult lines

D. Intake and Output

E. Adult education

APPROVED BY: ICU Collaborative Council

F. ECG rhythm strip will be obtained at 0800, 1600 and 2400 and interpreted with the following information documented, Rhythm, PR interval, QRS complex, QT interval. The ECG strip will be placed in the progress notes section of the medical record. The RN will notify the Provider of acute changes noted.

G. Vital signs every 2 hours and as needed

H. Evalysis (TID)

I. Review and update IPOC by the end of the shift

J. Patient/family education

III. Discharge Documentation

A. The discharge task will be completed

B. Discharge forms including patient education will be printed and discharge instructions will be given to the patient. Patient signature will be obtained.

C. Resolve IPOCs as appropriate

D. The transport service will be provided a copy of the patient Face Sheet, medical records, and the diagnostic tests.

E. PM Conversation will be completed "discharge encounter"

V. Admission for Diagnostic Procedures

A. Authorization for and informed consent to surgery or special diagnostic or therapeutic procedures is to be obtained by physician.

B. All pre, intra, and post procedure monitoring and care will be documented on the "Moderate-Deep Sedation" section of the health record, including the transfer / discharge note.

C. If hospital / ICU admission is necessary after the procedure, implement admission documentation procedure.

VI. Emergency Discharge to Another Acute Facility

A. A Discharge summary statement is documented following the nursing department guidelines

B. The education summary is to be reviewed and completed as appropriate.

VII. Discharge/Transfer from ICU, refer to Policy C211 – Care Plan Process and In-Patient Documentation for details.

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References:

Rancho Los Amigos National Rehabilitation Center Nursing Clinical Manual:
Inpatient Documentation Guidelines
Rancho Los Amigos National Rehabilitation Center Specialty Nursing Manual
PACU-01 – Care of Patient in PACU
Rancho Los Amigos National Rehabilitation Center Administrative Manual
B815 – Moderate Sedation Guidelines

07/99 – Revised (formerly SCU 05)
08/00 – Revised
07/03 – Revised
04/07 – Revised
01/10 – Revised
06/13 – Revised
08/14 – Revised
01/17 – Revised
05/20 – Revised