Documentation / Care Expectations

Nursing Notes are **REQUIRED**

- At admission / discharge / transfer
- Each Shift / encounter
- At initiation and discontinuation of restraints
- For status changes
- When MD notifications occur

Care Plan Requirements

- Care Plan note is required **EACH SHIFT**
- Individualization for each patient (updates as needed)
- Stroke CPG for all ischemic and hemorrhagic stroke patients
- Intubated patients need Artificial Airway and Medchanical Ventilation CPGs

Patient Family Education

- Required Every 24 hours (see page 10)

Critical Results– All Critical Results called to you by the lab or obtained by Accucheck Require

- Documentation of result, MD notification and treatment on Critical Results Flowsheet
- Blood sugar critical results also require a note

IV drip Rate verification is to be completed and documented on the MAR at each shift change

Documentation / Care Expectations Cont..

Pain Assessment

- Re-assessment within 60—90 minutes of treatment
- Q4 hours

Sedation Holiday / Spontaneous Awakening Trial

- Completed daily for intubated and sedated patients

Admissions Documentation

- CPGs specific to diagnosis
- Admission Assessment INCLUDING A NURSES NOTE
- Height and weight
- Depression and Suicide
- NAST
- Lift Tool

Assessment Requirements

- Fall—Q shift/Q12
- Braden—Q shift/Q12
- Care Plan—Q shift (whenever caregiver changes)
- RASS—Q 4 and prn with sedation adjustments
- CAM-ICU Q 12
- Alcohol Detox (Modified CIWA)if ordered
  - 15 minutes after prn Ativan administration
  - 1 hour after po prn administration
  - Q 2 hours while awake
  - Q 4 hours while asleep