Document Owner:	Reviewed By:	Approved By:
Mgr of Acute Care	MSCC/ICC Manager, MSCC/ICC ANM Manager	Dir, Acute Care

	MSCC PATIENTS		ICC CONSIDERATIONS		OBSERVATION PATIENTS

MSCC PATIENTS	0800 (1000)	1200 (1400)	1600 (1800)	2000 (2200)	2400 (0200)	0400 (0600)	Immediately	During Shift	End of Shift	Comments/Tips:
SYSTEM ASSESSMENT FLOWSHEET										
Admission								x		• Within 12 hours of arrival to the unit (Admission Navigator) • Assessment and vital signs documented within 1 hour of arrival to unit
Neuro	x		x		x					• 12 hour night staff- additional assessment at 2000.
Pupils							x	x		• PRN for any patient with changes in LOC, or suspected head injury.
Swallow Screen							x*			• On admission. *Also if NPO prior to PO medications if c/o swallow impairment.
Psychosocial	x		x		x					
Cardiovascular	x		x		x					
DVT Prophylaxis	x		x		x					
Pulmonary Breath	x		x		x					• WDL includes clear breath sounds. Document exceptions only
Gastrointestinal	x		x		x					• Document GI issue and effect of meds given (nausea, vomiting, diarrhea)
Genitourinary	x		x		x					• Foley catheters are exceptions
Musculoskeletal	x		x		x					• "Unsteady" is an exception
Integumentary	x		x		x					
Head to Toe Skin	x		x		x					• Initial assessment on admission and every 8 hours.

MSCC PATIENTS	(0700) 0800 (1000)	1200 (1400)	(1500) 1600 (1800)	2000 (2200)	(2300) 2400 (0200)	0400 (0600)	Immediately	During Shift /Event	End of Shift	Comments/Tips:
VASCULAR ACCESS FLOWSHEET										
IV Sites	xx	xx	xx	xx	xx	xx				• Monitor anytime you go in the room. Document every 2 hours.
Vascular Access	x	x	x	x	x	x				• Saline Lock is q 4 hours, if there is a continuous infusion (central or peripheral) assess/document q2 hours. Flush every 8 hours minimum. Change PIV per criteria listed in P&P
Central Lines	x	x	x	x	x	x	x	x	x	• Dressing changes: Sterile Chlorhexidine- every 7 days & PRN (damp, loose, soiled). Covered in gauze- every 2 days & PRN • Date/Time/Initials on dressing and documented in EPIC • Transparent semipermeable are preferred, but gauze may be used if site damp.
IV MAR FLOWSHEET										
IV MAR	700			1500			2300			• Add up all IV Fluids/total pumps and documents volumes. Chart "real time" and remember PCA's.
ADULT I/O FLOWSHEET										
I/O	x	x	x	x	x	x		x	x	• Document in "real time" throughout shift (voiding, emesis, stool).
Drains/Foleys	700			1500			2300			• Drains/Foleys emptied at the end of every 8 hour shift.

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CARES AND SAFETY FLOWSHEET										
Hygiene/Activity	x	x	x	x	x	x				• Offer baths (even if refuses), document turns/repositions, mobility and trips (up to chair, bathroom), HOB elevations every 2 hours.
VTE Prophylaxis	x		x		x					• On admission and during each 8 hour shift
Equipment	x	x	x	x	x	x				• All applicable equipment, interventions, specialty beds (fans, ice packs for fever & warm blankets for hypothermia patients only)
Nutrition	x	x	x	x	x	x				
Safety	x	x	x	x	x	x				
Violence Risk Assessment	x		x		x					• On admission and during each 8 hour shift
Suicide Risk Assessment	x		x		x					• On admission, with each shift, and upon change in status. Document UTA (unable to assess) if intubated/sedated. After 2 consecutive scores of 0 assessments can be discontinued.
Braden Scale	x		x		x					• On admission and every 8 hours. Also with condition changes and on transfer. • If <19 or any sub score <3, initiate SAFER and appropriate interventions
Risk for Injury	x		x		x					• If risk for injury score is 1-4, implement/document appropriate Fall Prevention Interventions
Hendrich II- Falls	x		x		x			x		• If Hendrich score is 5 or greater, implement/document appropriate Fall Prevention Interventions beyond Standard • Initial Falls Assessment and Risk for Injury to be done at the time of the initial assessment • Complete re-assessment with changes of status or fall event
Safety Intervention	x		x		x					• Interventions to be documented every 8 hours • Standard interventions for all patients, add appropriate additional interventions for patients with RFI and or Hendrich 5 of greater

Infection Risk	x		x		x					• Document Isolation type/Infection Risk to reflect acuity
VITALS FLOWSHEET										
*Vital Signs	x		x		x		x	*	*	• Unless ordered differently by provider. *Immediately if any change in condition. • If patient is on oxygen, chart "in use" under Respirations/Oxygen Therapy. • For CP chart cuff site, patient position and method (auto, manual).
*Weights									x	• On admission and daily as ordered. Document type of scale used. Height on admission.
*Orthostatic VS									x	• If symptomatic, per provider order, and first time up after spinal anesthesia. Document by clicking "add row" and also in notes.
Pain	x		x		x					• Upon admission, minimum every 8 hrs, change in condition. Reassess within 2 hours after medication intervention • After intervention chart "reassessment", otherwise for routine "shift observations." • If sleeping after intervention, use "reassessment" and "appears sleeping."
Restraint (nonviolent)	xx	xx	xx	xx	xx	xx				• Every 2 hour documentation • Every calendar day a new order is needed (violent restraint requires more frequent assessment/orders)
CIWA Vital Signs	x	x	x	x	x	x				• RN may initiate CIWA Assessment based on patient history and/or presentation. If CIWA score 8 or above, call MD for CIWA order set (Alcohol Detoxification) • CIWA <8 : VS Q 4 hours • CIWA greater than or equal to 8: VS Q 1 hour
CIWA assessment	x	x	x	x	x	x				• CIWA 0-4: RN to assess patient based on CIWA every 4 hours • CIWA 5-7: RN to assess patient based on CIWA every 1 hour • CIWA greater than or equal to 8: RN to assess every 15 minutes and provide a dose based on the regimen ordered until the patient's CIWA is less than 8, then continue to assess based on CIWA score.

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TELEMETRY MONITORING FLOWSHEET										
*Telemetry	x		x		x					• Place strip in chart, document in tele flowsheet. Document EKG alarms high and low on telemetry (not ICU) flowsheet. Document arrhythmias PRN.
CARE PLANS										
*MSCC & ICC	x		x		x			x		• Initiate within 24 hours and includes goals and nursing interventions individualized to the patient, including their diagnosis. • Prioritize and document goals every 12 hours in a care plan progress note. • Goals/interventions need to be resolved or addressed before discharge. • Care plan note once between the hours of 0700 and 1900, and also 1900 and 0700 and with condition changes.
COMMUNICATION FLOWSHEET										
Critical Labs							x			• Chart exact time of call, value & action. • Do not use "Continue to Monitor" unless provider aware.
Echo Results							x			
MD/Provider notify							x			• Must be documented even if MD is on unit: provider, reason, time, action.
Significant Event							x	x		• Chart precise start time of event/procedure
Interpreter							x			• Document time service called & arrived for each interpreter use.

ICC Considerations	0800 (1000)	1200 (1400)	1600 (1800)	2000 (2200)	2400 (0200)	0400 (0600)	Immediately	During Shift /Event	End of Shift	Comments/Tips:
Admission							x	x		• Assessment and full set of Vital Signs within 15 minutes of arrival to the floor • Document within 1 hour of admission in EHR. • Admission completed within 12 hours of arrival to unit (Admission Navigator).
Vital Signs	xx	xx	xx	xx	xx	xx				• Every 2 hours minimally; Every 15 minutes if titrating pressors
Pain Assessment	xx	xx	xx	xx	xx	xx				• Reassess within 2 hours after medication intervention.
Head to Toe	x	x	x	x	x	x				• On admission and every 4 hours
Drains/Foleys	x	x	x	x	x	x				• Foley urine output monitored & documented every 2 hours minimally. I/O on ALL patients
Weight								x		• On admission and daily as ordered. Doc type of scale used. Height on admission.
ADL's	xx	xx	xx	xx	xx	xx				• Every 2 hours w/turns, cares, baths (document reason for refusal)
ICC Vitals / FLOWSHEET										
TIA/ FULL NIHSS							x			• Immediately at Admission using Stroke Navigator. Modified NIHSS frequency per MD Order. Full NIHSS also at discharge
CIWA Vital Signs	x	x	x	x	x	x				• RN may initiate CIWA Assessment based on patient history and/or presentation. If CIWA score 8 or above, call MD for CIWA order set (Alcohol Detoxification) • CIWA <8 : VS Q 4 hours • CIWA greater than or equal to 8: VS Q 1 hour
CIWA Assessment	x	x	x	x	x	x				• CIWA 0-4: RN to assess patient based on CIWA every 4 hours • CIWA 5-7: RN to assess patient based on CIWA every 1 hour • CIWA greater than or equal to 8: RN to assess every 15 minutes and provide a dose based on the regimen ordered until the patient's CIWA is less than 8, then continue to assess based on CIWA score.
RASS and CAM-ICU Scales	xx	xx	xx	xx	xx	xx				• Every 2 hours

OBSERVATION PATIENTS	0800 (1000)	1200 (1400)	1600 (1800)	2000 (2200)	2400 (0200)	0400 (0600)	Immediately	During Shift /Event	End of Shift	Comments/Tips: Follow MSCC Assessment Guidelines and/or ICC Assessment Consideration for Observation Status Patients and include Care Plan End Points listed below.
MSCC/ICC Observation Navigator										
Care Plan End Points	x	x	x	x	x	x				• Alert provider when all care plan end points are met.