

Supplemental material. Sample Intensive Care Unit nursing shift progress note.

The below template should be adapted to local context and reviewed and approved by institutional leadership. This template may be entered into the electronic health record in lieu of other ICU nurse documentation in settings of ICU nursing staff limitation.

ICU Nursing Daily Progress Note CONTINGENCY STATE

The goal of this template is to adapt routine documentation practices to conserve nursing time and energy, while continuing to support effective clinical communication. This template was **approved for use** by the Chief Nursing Officer and Incident Command during CONTINGENCY STATE. Our bioethics team has also reviewed this template and determined that this practice is ethically permissible (reviewed xx/2022).

Events this Shift:

ONLY chart details for events that OCCURRED. Blank cell = no events occurred on this shift	
Clinical Stability:	
Pain:	
Fall:	
Restraints:	
Tubes/Drains:	
Social:	
Other:	

Nursing Assessments:

	No change (mark with 'X')	ONLY CHART CHANGES from the initial assessment. If the below template is not completed, changes from initial assessments are charted in the EHR.						
		Neuro	Cardiac	Pulmonary	GI	GU	Skin	Misc.
1 st Assessment (start of shift)		Initial assessments charted in the EHR (i.e., Neuro, head-to-toe, etc)						
2 nd Assessment								
3 rd Assessment								
4 th Assessment								

Abbreviations: Electronic health record, EHR

Block Charting for IV Infusions with Frequent Titration

Unless RN Name(s) is entered, block charting was NOT used. All IV infusion(s) are charted in the MAR.			
Remember to add 2nd RN name 	Block charting can be used for IV Infusions listed in MAR for up to FOUR hours or when clinical stability is reached, whichever comes first. *Add the maximum infusion dose in a flagged comment in the MAR at END of each block period.		
	<ul style="list-style-type: none"> Start-time of block period is recorded in the MAR with the starting infusion dose and independent verification by two licensed staff. (Enter 2nd RN name below) End-time of block period is recorded in the MAR with the ending infusion dose and noting the maximum infusion dose used during the block period with a flagged comment. (An end-time may also be the start of a new block period.) 		
	Name of 2 nd licensed RN for initiation of block charting:		
	1 st 4-hour block	RN Name:	Remember to note max dose in a flagged comment in MAR entry at the end of each block
	2 nd 4-hour block	RN Name:	
	3 rd 4-hour block	RN Name:	
4 th 4-hour block	RN Name:		
The IV infusion order contains the patient-specific physiologic parameters for each IV infusion. Block charting is a strategy during contingency, which was announced by the Chief Nursing Officer and Incident Command and			

	<p>this template was approved for use. <i>Block charting for IV Infusions requiring frequent titration works to help prevent crisis state by focusing staff time on direct patient care and eliminating all non-essential charting as supported by the American Association for Critical Care Nursing and the Joint Commission.</i>^{1,2}</p> <p>Medications appropriate for Block Charting:</p> <ol style="list-style-type: none"> 1. Sedative and analgesic agents including but not limited to midazolam, lorazepam, dexmedetomidine, propofol, ketamine, fentanyl, morphine, and/or hydromorphone 2. Vasoactive agents including but not limited to norepinephrine, phenylephrine, epinephrine, dopamine, dobutamine, milrinone, isoproterenol, vasopressin, angiotensin II, clevidipine, nicardipine, sodium nitroprusside, nitroglycerin, esmolol, labetalol, and/or diltiazem
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Abbreviations: Medication Administration Record, MAR

End of Charting

Contingency Charting Rationale:

The Washington Department for Public Health and the NW Healthcare Response Network outline strategies and rationale for Scarce Resource Management in Crisis Standards of Care (available online). Plans for disaster preparedness support two main objectives: (1) Use all possible mitigation (contingency) strategies to avoid Crisis and (2) if a Crisis State is not avoidable, allocate scarce resources in a way that maximizes lives-saved and respects equity.³ Crisis can be caused by scarcity of staff, space, or supplies. The Department of Health advocates “reducing documentation requirements” as an effective mitigation strategy.⁴ CMS has also issued a COVID-19 Emergency Declaration Blanket Waiver for Healthcare providers¹ that outlines changes to the standard of practice to ensure all patients receive treatment.⁵

Our ICU is in Contingency state, and we are attempting to identify and implement all possible strategies to provide the best possible care for all patients and to avoid progression to Crisis capacity. In low/moderate contingency state, clinicians may be asked to take higher acuity assignments and/or asked if they can pick up additional shifts. In severe/high contingency state, clinicians may be asked to care for more patients than typical for standard practice as a last resort to avoid overt rationing. A contingency charting practice allows for clinicians to focus more time at the bedside to maintain standard of care for all patients in need by **focusing on essential elements of charting that support clinical communication.**^{4,6} Specifically, block charting for IV Infusions requiring frequent titration works to help prevent crisis state by focusing on direct patient care and eliminating all non-essential charting as supported by the American Association for Critical Care Nursing and the Joint Commission.^{1,2}

References:

1. American Association of Critical Care Nurses (AACN). Expectations for Implementing Medication Titration Orders. June 29, 2020. <https://www.aacn.org/nursing-excellence/nurse-stories/expectations-for-implementing-medication-titration-orders>. Accessed September 7, 2021.
2. The Joint Commission (TJC). Does block charting during the administration of titrated medications take the place of an order? <https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medication-management-mm/000002337/>. Accessed September 7, 2021.
3. National Academy of Medicine, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report*, 2009
4. Washington State Department of Public Health and NW Healthcare Response Network [Scarce Management and Crisis Standards of Care Overview and Materials](#). Updated 04-10, p. 30 “Reduced documentation Requirements.”
5. CMS “COVID-19 Emergency Declaration Blanket Waivers for Healthcare Care Providers” <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>
6. John L. Hick, MD, Sharon Einav, MD, Dan Hanfling, MD, Niranjana Kissoon, MBBS, FRCPC, Jeffrey R. Dichter, MD, Asha V. Devereaux, MD, MPH, FCCP, Michael D. Christian, MD, FRCPC, FCCP (2014) *Surge Capacity Principles*. CHEST: 146;4 e1S-e16S DOI: 10.1378/chest.14-0733