Critical Care Progress Notes

Purpose

Respiratory Care Services staff will utilize the use of the progress notes to convey pertinent information regarding the patients' therapy regime or response to therapy.

Audience

Licensed Respiratory Care Practitioners employed by Respiratory Care Services.

Scope

Initiated on all patients in the Intensive Care Units.

Guidelines

Vent Updates are placed in the Progress notes in all areas, except ISCU where vent updates are written on the physician order form.

All progress notes will be written in the S.O.A.P. format.

Entries will be made in the progress notes by a Respiratory Care Practitioner upon extubation of a patient, if the patient requires further Respiratory therapy (excluding oxygen therapy.

Progress Notes must include:

- Date of entry
- Time of entry
- Signature
- Credentials
- Patient assessment, including subjective and objective patient data and a care plan

Patient Assessment:

- A shift assessment will be written on the RCS flow sheet:
- On every patient receiving ventilatory support
- On patients who require intubation and initiation of ventilatory support
- On those patients extubated during the therapist's shift.

Patient assessment on the RCS Flow sheet is written in the SOAP format. All entries will be made in black ink.

- Notes - enter notes in S.O.A.P. format and sign appropriately.

Document – enter physical assessment information including past medical history

Corresponding Policies

RCS Policy and Procedure Manual, Guidelines For Medical Record Documentation, # 7.1.1