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Multidisciplinary ICU Daily Rounds Goals

Complete all highlighted sections on every ICU patient every day. Complete other checklist items as they apply. Write the multidisciplinary Daily Goals or Plan of Care in the Daily Goals column.

	Patient Care Issue:	Checklist	Daily Goals:
Neuro	Analgesia, Sedation, Delirium	<input type="checkbox"/> Y <input type="checkbox"/> N Pain control adequate? <input type="checkbox"/> Y <input type="checkbox"/> N CAM positive? <input type="checkbox"/> Restraints (orders up-to-date?) <input type="checkbox"/> Y <input type="checkbox"/> N Sedation Vacation?	Sedation/Narcotics → Pre-SV dose _____ Sedation/Narcotics → Post-SV dose _____
Pulm	Ventilator	<input type="checkbox"/> Weaning plan? <input type="checkbox"/> Oral Care? (check if ordered)	RT: <input type="checkbox"/> SBT: Rate _____ VT _____
	O ₂	<input type="checkbox"/> Weaning?	
Invasive Lines	Foley: Y N Need Foley? Y N Date placed _____	<input type="checkbox"/> Y <input type="checkbox"/> N Nurse Driven Protocol? Indications: <input type="checkbox"/> Immobilization for surgery or trauma <input type="checkbox"/> Strict UOP monitoring (hourly UOP to guide volume resuscitation; hemodynamically instability requiring vasopressors; high dose diuretic therapy) <input type="checkbox"/> Open perineal/sacral wounds with incontinence <input type="checkbox"/> Acute ventilator dependent resp failure <input type="checkbox"/> Acute worsening of mental status <input type="checkbox"/> Palliative or end of life care.	
	CVC: Y N Need CVC? Y N	1. Type _____ site _____ 2. Type _____ site _____ 3. Type _____ site _____ Indications: _____ hemodynamic monitoring _____ Administration of high risk medication _____ hemodialysis, plasmapheresis, apheresis _____ Poor peripheral access (have PIVs been attempted?)	
	Aline: Y N	Need Aline? Y N site _____ date placed _____	
CV	Hemodynamics	<input type="checkbox"/> BP Goal _____ <input type="checkbox"/> HR Goal _____ → DVT prophylaxis _____ <input type="checkbox"/> Fluid Balance Goal _____	
GI	Nutrition Bowel Pattern	→ Nutrition: _____ → Last BM _____ <input type="checkbox"/> GI prophylaxis _____ <input type="checkbox"/> Blood Glucose Control/ Type _____	
Skin	Skin	<input type="checkbox"/> Y <input type="checkbox"/> N Braden <18? Appropriate bed? <input type="checkbox"/> Breakdown? Skin care consult? <input type="checkbox"/> Breakdown PTA? <input type="checkbox"/> MD documentation	
Tx	Therapy Note: if Stroke, must have all 3.	→ Activity orders/ PT Consult? <input type="checkbox"/> Speech therapy? (check if ordered) <input type="checkbox"/> Occupational therapy? (check if ordered)	
To Do:	Plans for test/ treatments/ procedures	→ AM CXR/ labs ordered? <input type="checkbox"/> Can labs/BG be discontinued? <input type="checkbox"/> Y <input type="checkbox"/> N Plans for tests/procedures today?	
	Disposition	→ Has the family been updated? → What needs to be done for the patient to be transferred out of the ICU?	
	Other/		

RN Signature _____

Date: _____ Time: _____

RT Signature _____

Date: _____ Time: _____

Physician Signature _____

Date: _____ Time: _____

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BM King



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