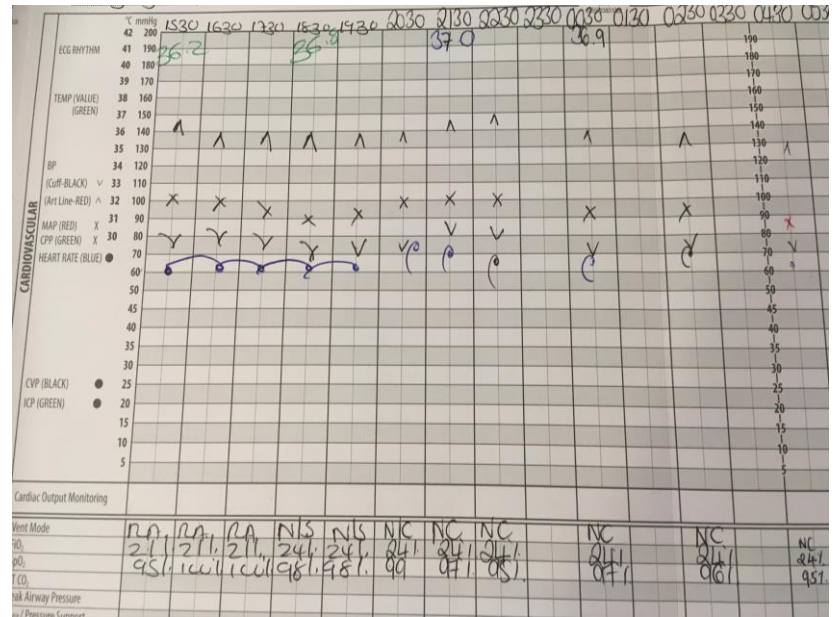


# Collecting the physiological data for the case mix (ICNARC) program

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The nurses start a new pink chart when the patient is admitted to the critical care unit. There are two formats depending on if the patient has had a sub-arachnoid haemorrhage or some diagnosis. After 24 hours they start an new white chart. The pink charts should stay at the end of the bed for a few days unless the patient is discharged, if they are discharged early the charts will be left at the nurses' station. The chart will have all the information you need to complete the EPR document you will see in the next slide. When you have transcribed the information, please write in the instructions box in the top right of the form that you have transcribed the information to the EPR document so the form can then go off for scanning.

The image shows a multi-section medical chart. At the top left is a 'MEDICAL SAFETY CHECK' section. Below it is a 'Vital Signs' section with handwritten data for temperature, heart rate, blood pressure, and oxygen saturation over time. The central part is a 'Neurological assessment' table with columns for 'LOC', 'Pupils', 'CNS', 'Cranial Nerves', 'Motor', 'Sensory', and 'Reflexes', and rows for 'R' and 'L' sides. Below this is a 'Limb Power' section with 'UPPER LIMB POWER' and 'LOWER LIMB POWER' tables. At the bottom is a 'Respiratory Assessment' section with handwritten values for respiratory rate and oxygen saturation.



To find the document type “ICNARC” into the document entry field of the EPR record. It will open up as shown below. It should be intuitive to fill in, if the patient was sedated all the time for the first 24 hours then the GCS can be left blank. The paired diastolic is what the diastolic blood pressure was at the reading of the lowest and highest systolic blood pressure. The total urine output should be found at the bottom right of the chart. The admission date and time can be got from the first entry on the chart. Don’t forget to annotate the chart that you have done this to save your colleagues having to do it again and so that the forms can go to be scanned.

Document Info
Sections

ICNARC Admission Data (first 24 hours)

**Unit admit date and time** \_ \_ / \_ \_ / \_ \_ : \_ : \_ \_

**Sedation**
 Sedated for whole of first 24 hours

Paralysed for whole of first 24 hours

Sedated and / or paralysis for part of the 24 hours

No sedation or paralysis during first 24 hours

**GCS**  
(lowest sedation-free)

**Eyes**

**Motor**

**Verbal**

**Was patient intubated during GCS assessment**  Yes  No

**Observations**

	Lowest	Highest
<b>Heart rate (bpm)</b>	<input type="text"/>	<input type="text"/>
<b>Central temperature (degrees C)</b>	<input type="text"/>	<input type="text"/>
<b>Non ventilation respiratory rate (resp/min)</b>	<input type="text"/>	<input type="text"/>
<b>Ventilation respiratory rate (resp/min)</b>	<input type="text"/>	<input type="text"/>
<b>Systolic (mmHg)</b>	<input type="text"/>	<input type="text"/>
<b>Paired diastolic (mmHg)</b>	<input type="text"/>	<input type="text"/>

**Pupil reaction**

**Pupil reaction - left**  Yes  No

**Pupil reaction - right**  Yes  No

**Urine output**

**Able to measure urine output**  Yes  No

**Total urine output for first 24 hours**  ml