CDI Clinical Designs - Cover Sheet*

Document Type	**Nursing Handover Document**
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Document Owner (e.g. NCP)	**National Clinical Programme for Critical Care**
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National Clinical Guidelines must use NCR cover sheet if being uploaded onto NCR. Otherwise this cover sheet applies

***** Refer to HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs)***

Version	Revision Date	List Section Numbers Changed	Author
V02	February 2025	No change	National Clinical Programme for Critical Care

EMERGENCY DEPARTMENT TO INTENSIVE CARE UNIT / HIGH DEPENDENCY UNIT
NURSING HANDOVER DOCUMENT

CRITICAL CARE

EMERGENCY MEDICINE

Place patient addressograph here

Diagnosis: _____

Past Medical/Surgical Hx:

_____

_____

Adverse Events in ED:

_____

AIRWAY & BREATHING

Self-ventilating ☐

Non rebreather 100% ☐

Venturi Mask ☐

Non Invasive ☐
Cpap ☐
Bpap ☐

Intubated ☐
Time & Date
_____
ET Tube size
_____

Lip level
_____

Airway Grade _____

Ventilated Patient

Ventilator mode
PRVC ☐
PS/CPAP ☐
Volume support ☐
Other _____

TV Max 6mls/kg IBW ☐

Fio2 _____

PEEP _____

ABG ☐ Time

Cuff Pressure _____

Closed Suction ☐

Continuous Waveform
Capnography ☐

CIRCULATION

Weight kg _____

Temp: _____

BP: _____
MAP: _____
RR : _____

HR: _____
Spo2: _____

BSL: _____

Noradrenaline
☐
Dosage

Adrenaline
☐
Dosage
If >5mcg/kg then:

Y connector
☐

2nd Drug syringe
☐

IV Fluids given ☐
Volume & Type
_____
_____

Blood Products
RCC ☐ Platelets ☐
Plasma ☐
Fibrinogen ☐
_____
_____

NEURO

GCS: _____

Pupils: ☐
Time _____
Size
Equal ☐
Reactive ☐

Sedation-please state
_____
_____

Paralysis ☐
Drug & amount

Time _____

Spinal precautions ☐
_____
Last log roll time
_____

C-collar
☐

VAC Mattress
☐
Time commenced

Skin Integrity intact?
☐
If no specify:
_____
_____
_____

Braden Score value
_____

INVESTIGATIONS

Blood Cultures ☐
Urine ☐
Sputum ☐
Wound swab ☐
_____

Chest X-Ray ☐

ECG ☐

Pregnancy Test
☐

Toxicology Screen
☐ Results
_____

CT/MRI
☐ _____

Bloods
FBC ☐ U&E ☐
COAG ☐ LFT ☐
CRP ☐ GROUP & HOLD ☐ OTHER
_____
_____

TIME _____

Additional Info
_____
_____

ACCESS

Central Line:
☐
Date & Site:

Arterial line:
☐
Date & Site:

Peripheral Cannula: ☐
_____
Date & Site:

Chest drain
☐
site
Suction

Drains

Urinary Catheter: ☐

Nasal Gastric Tube ☐
Fine bore ☐
Ryles tube ☐
Insertion date:

Colostomy ☐
Ileostomy ☐
Urostomy ☐

OTHER DRAINS
Please specify
_____

PERSONAL

Next of Kin informed ☐

Next of KIN details in patient chart ☐

Dentures ☐

Glasses ☐

Valuables
_____

Allergies
_____

Isolation ☐
Reason
_____

Transfer Events
_____
_____
_____
_____
_____
_____
_____
_____

Time admission to ICU requested
_____

Actual time of admission to ICU
_____

Date: _____ **Emergency Nurse:** _____ **Intensive Care Nurse:** _____

Form designed by the nursing staff of the Emergency Department & Intensive Care Unit, St James Hospital.
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