Patient acuity tool
Using the patient acuity tool, RNs can assess patients'
risk level to help create equitable, quantifiable assignments.

	1: Stable	2: Moderate-risk	3: Complex	4: High-risk patient
	patient	patient nical patient character	patient	pacienc
Assessment	Q8h VS Alert and oriented x4	• Q4h VS • CIWA-Ar ≤8	Q2h VS Delirium/ altered mental status CIWA-Ar >8	Unstable VS (determined by ordered parameters)
Respiratory	Stable on room air	Oxygen ≤2 L via NC	Oxygen >2 L via NC Tracheostomy	Oxygen via mask Can't maintain secretions independently
Cardiac	VS (determined by ordered parameters)	Low-grade temp: 98.7*F-100.3*F Pacemaker/AICD HR >130	Change in BP Temp > 100.3°F	Unstable rhythm Atrial fibrillation or PE
Medications	PO/IVPB Blood glucose normal	TPN/heparin infusion Blood glucose requiring notifying provider Blood draws from PICC Dialysis	CBI I unit blood transfusion Fluid bolus for BP	>1 blood transfusion Chemotherapy
Drainage devices	 ≤2 drains (Jackson- Pratt, hemovac, percutaneous nephrostomy, etc.) 	Chest tube to water seal Nasogastric/nasoduodenal tube Continuous tube feeding	Chest tube to suction Drain measured q2h Bolus tube feeding	Drain measured q1h Chest tube output >100 ml/ 2h
Pain management	Pain well managed with with PO or I.V. meds every 4 hours	Patient-controlled analgesia/nerve block Nausea/vomiting	Q2h pain management	Uncontrolled pain with multiple pain devices (IV, IM, PO, etc.)
	N	urse workload indicat	ors	
Admit/discharge/ transfer	Stable transfer Routine discharge	Discharge to outside facility	New admission Complex discharge Discharge to hospice	Complicated postop Transfer to higher-level care
Education and/or psychosocial	Calm, cooperative	Anxious/slightly agitated Education needed	New trach/ amputee Translator needed Requires consistent assistance (>q1h)	End-of-life care
Wound, ostomy, continence	QD/BID dressing Wound vac One-person assist to bathroom/ bedpan	Ostomy/rectal tube Enema Bowel prep Incontinent b/b Ostomy/rectal tube	TID/complex dressings by RN High-output ostomy Multiple wound vacs	Active drainage, change > 30 min or >TID Q1h toilet needs
ADLs & isolation	Independent in ADLs Standard precautions	Assist with ADLs Two-person assist for out of bed Isolation (contact, enteric)	Turns q2h Bedrest Respiratory isolation	Paraplegic or quadriplegic Total care (lifts)
Safety	• Falls risk	• Sitter 1:1	Bed alarm without sitter Sensory deficits (blind, deaf, etc.)	Highly agitated 1:1 Restraints
Patient score:	Most = 1	Two or more = 2	Any = 3	Any = 4

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