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PROGNOSTIC CRITERIA IN PATIENT ADMISSION IN THE ADULT INTENSIVE CARE UNIT: SUBSIDIES FOR THE PREVENTION OF COMPLICATIONS FROM THE NURSING PERSPECTIVE

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Abstract: The Intensive care is based on different technological resources, however, the use of prognostic criteria supported by scientific evidence can early identify parameters related to unfavorable outcomes. **Objectives**: To identify the impact of the prognostic criteria used in ICU in the admission of the patient that contribute to the clinical worsening. **Methodology:** Exploratory, descriptive, cross-sectional study with a quantitative approach, conducted in the Intensive Care Unit of the "Hospital Universitário", linked to the "Universidade de São Paulo". The sample consists of patients older than 18 years hospitalized between October 2021 and January 2022, regardless of the diagnosis. **Results:** The prognostic criterion used in the institution is the Simplified Acute Physiology Score III. As for the sociodemographic profile, male sex predominates, mean age of 63 years and mortality rate of 26.7%; in the clinical profile, 79% had comorbidities, with hypertension and diabetes mellitus predominant. In the first 24 hours of hospitalization, 46.8% underwent mechanical ventilation, 70.6% received sedatives and 57.3% needed vasoactive drugs. As for the clinical worsening profile, the highlight parameters were: age, vital signs, Braden scales, RASS and SAPS score 3, in addition to the results of laboratory tests. The study showed that the combination of altered urea values and TTPA increase the mortality rate, with a positive predictive value of 92.3% for death. **Conclusion:** Health professionals must be empathetic and skilled in recognizing and managing protocols for transgender children and adolescents. Public policies must guarantee specific conduct. This topic must be included in undergraduate and graduate courses in Health and Humanities. People must be guaranteed Human Rights, regardless of sexuality.

Keywords: Intensive Care Unit. Critical patient. prognosis. Nursing. Complications.

INTRODUCTION

The Intensive Care Unit (ICU) includes complex health conditions, in which patients are routinely in situations that alter vital parameters, increasing the risk of death (MORTON; FONTAINE, 2014). This way, there is a need for continuous assistance, guided by cutting-edge technology, the ability to provide agile care in emergency situations and specialized and trained professionals who act in an interdisciplinary manner, in order to promote clinical stabilization through humanized patient care. (BOLELA; JERICÓ, 2006).

With the intention of ensuring conduct and conducting care, it is essential to use clinical assessment instruments, based on consolidated scientific evidence, making the language used by the team organized and thus defining priorities in care (GARDONA; BARBOSA, 2018). Within the possibilities of instruments, there are three main prognostic scales used in intensive care: Acute Physiology and Chronic Health Evaluation (APACHE), Mortality Probability Model (MPM) and Simplified Acute Physiology Score (SAPS); This one, used in the third version (SAPS 3) completed in 2002, it is composed of 20 different variables divided into demographic data, reason for hospitalization and physiological variables, measured upon admission (JUNIOR; et al,2010)

This way, the question is: what is the impact of the prognostic criteria used in the ICU in the admission of the patient and its clinical evolution?

In this sense, the present study aims to identify the impact of the prognostic criteria used in the ICU on patient admission and their clinical evolution associated with the health status outcome from the nursing perspective.

Therefore, the importance of this study is emphasized as a means of better understanding the factors that influence the clinical evolution of patients in the ICU from the perspective of admission, highlighting the performance of the multidisciplinary team in care.

CASUISTRY AND METHOD

This is an exploratory, descriptive, cross-sectional study with a quantitative approach, classified as a descriptive/exploratory survey, financed by the Unified Scholarship Program (PUB) of the "Universidade de São Paulo". The research was carried out in the ICU of the "Hospital Universitário" (HU), medium-sized and teaching, linked to the "Universidade de São Paulo", with 12 beds, clinical and surgical care, except for cardiac and neurological surgeries, with two nurses and six nursing on duty. The sample consisted of medical records of patients over 18 years of age admitted to the ICU of the "Hospital Universitário" from October 2021 to January 2022, regardless of the diagnosis. The research project was submitted to the Ethics and Research Committees of the School of Nursing of the "Universidade de São Paulo" and the "Hospital Universitário" of the "Universidade de São Paulo" under opinion Number: 5.11.602 and Number: 5,286,060, respectively. At the time of data collection, all patients had already been discharged or died, and the use of an informed consent form was waived. An evaluation instrument was used, containing two parts: sociodemographic characterization form and clinical evaluation of the patient. Part I - Patient admission - Medical record number, date of hospital admission, reason for hospitalization, date of birth, age (years), sex, religion, personal history: DM, SAH, heart diseases, other diseases, use of continuous medication (which ones), laboratory tests requested on admission, devices implanted, interventions performed. Admission to the ICU: date, reasons for admission, signs and symptoms of shock, interventions performed, results of interventions, vasoactive drugs, cultures, medical prescription, laboratory tests and prognostic criteria applied at admission. Part II - Clinical outcome - SAPS 3, complications, interventions, clinical outcome (death or ICU discharge). Data collection was carried out without contact with patients, only with data from medical records of the internal nursing system (Procenf) and consultation of test results (SADT). The data were analyzed using descriptive statisticswith mean, standard deviation, minimum, maximum, percentile, minimum and maximum confidence intervals, in addition to Student's t-test, Wilcoxon-Mann-Whitney, Welch's t-test and Brunner-Munzel statistical tests. A classification and regression model (CART) was developed to explain the outcome predictor model.

RESULTS

The sample consisted of 165 patients who met the study inclusion criteria, with a mean age of 63.09 years and a predominance of males (60.61%). The ICU includes care for patients classified as semi-intensive and intensive, with an average hospital stay of nine days. Regarding the sociodemographic analysis, most patients did not have schooling, religion and marital status recorded in the medical records (46.06%; 43.64% and 27.88%, respectively); of those who did, 33.71% declared only incomplete primary education, in contrast to 9% who had completed higher education. Regarding religion, 65.59% said they were Catholic, 17.20% Evangelical, 4.30% reported another religion and 12.9% reported having no religion. As for marital status, most were married or in a stable relationship (36.13%), followed by singles

(29.41%), widowers (22.69%) and divorced (11.76%). Regarding the clinical profile of the patients, the majority were surgical patients (47.56%), 38.41% were admitted to the emergency room. Within the first 24 hours of hospitalization, 46.83% were submitted to mechanical ventilation, 70.63% used some sedation, 57.33% needed vasoactive drugs, such as Noradrenaline© and Vasopressin©. As for the clinical outcome, 73.33% were discharged and 26.67% died. In Table 1, we present the clinical variables and the outcome of the patients. 41% were admitted through the emergency room. Within the first 24 hours of hospitalization, 46.83% were submitted to mechanical ventilation, 70.63% used some sedation, 57.33% needed vasoactive drugs, such as Noradrenaline© and Vasopressin©. As for the clinical outcome, 73.33% were discharged and 26.67% died. In Table 1, we present the clinical variables and the outcome of the patients. 41% were admitted through the emergency room. Within the first 24 hours of hospitalization, 46.83% were submitted to mechanical ventilation, 70.63% used some sedation, 57.33% needed vasoactive drugs, such as Noradrenaline© and Vasopressin©. As for the clinical outcome, 73.33% were discharged and 26.67% died. In Table 1, we present the clinical variables and the outcome of the patients.

SAPS 3 is a tool that, when applied, generates a score of 16 to 217 points, from which we have a mortality prediction percentage (JUNIOR; et al., 2010). Table 2 shows the mortality rate obtained compared to the expected mortality rate according to the SAPS 3 scores separated by 10% intervals.

Table 3 presents the variables found in the study that are associated with clinical worsening.

The statistical model of prediction for the death outcome is shown in figure 1.

The Accuracy/Precision Test for the predictive model was estimated at 80.0%, confidence interval (CI) minimum of 73.2% and maximum of 85.4%, where precision portrays the proportion of correctly predicted cases.

DISCUSSION

The bond established between the Nursing team and the critical patient within an Intensive Care Unit is mainly due to the fact that this team remains full-time in patient care, following up from admission and its clinical evolution to its clinical outcome - hospital discharge or death. Despite all the technology and devices that are undeniably important, knowledge of the patient, the use of devices, the complexity of each individual and the organization of the team is the responsibility, mainly, of the unit's nurses (MAURICIO, et al., 2022).

Regarding the physical structure and the team, after experiencing and analyzing the data of the ICU under study, it is clear that, for a unit with 12 beds, a nursing team with at least two nurses and six technicians would be ideal , since at the "Hospital Universitário", intensive and semi-intensive patients remain hospitalized in the same place and, therefore, it is possible to manage the team in order to balance the load and tasks for each one. However, we witnessed days when there was only one nurse in the unit and a smaller number of nursing technicians, and it was necessary to ask the other wards to release one of their employees to assist in intensive care.

In these cases, several were the difficulties presented by those relocated who did not recognize the sector or the profile of the patients who were there, reinforcing that it is essential to have specific training and skills to work in an ICU and provide an adequate service, with quality and with excellence, helping the management of patients,

Variable	clinical outcome	N	average	DP	Median	Min	Max	Lower CI	Upper CI
Age	High	121	59,87	19,52	62	15	98	56,29	63,23
	Death	44	71,95	15,72	73	35	101	66,97	76,20
FC	High	121	91,42	23,80	94	16	137	87,09	95,54
	Death	44	105,70	30,31	106	62	223	97,96	116,00
FR	High	121	20,94	9,14	20	10	97	19,75	23,30
	Death	44	20,75	6,86	20,5	10	44	19,06	23,16
systolic blood pressure	High	120	126,20	30,16	121	53	228	121,00	131,80
	Death	44	115,60	27,05	112,5	55	187	108,50	124,40
diastolic blood pressure	High	120	75,82	19,17	72,5	37	138	72,56	79,40
	Death	44	67,41	16,15	66,5	36	116	62,93	72,39
mean arterial pressure	High	112	91,72	19,78	90	43	142	88,16	95,45
	Death	39	81,97	16,74	81	47	139	77,42	87,95
TºC axillary	High	120	35,64	0,92	35,6	33,2	38,1	35,47	35,81
	Death	43	35,59	1,25	35,5	33	38,7	35,20	35,97
saturation of O2	High	121	95,30	3,09	95	87	100	94,73	95,83
	Death	41	94,93	3,55	95	82	100	93,72	95,89
RASS	High	26	-3,46	1,88	-4	-5	2	-4,05	-2,58
	Death	21	-4,00	1,90	-5	-5	1	-4,60	-2,89
Braden	High	27	9,59	5,97	10	1	22	7,32	11,74
	Death	8	7,75	5,31	8	1	17	4,50	11,40
BH 24H from Admission	High	107	1353	1162	1000	20	5179	1151	1592
	Death	38	1621	1066	1515	34	4809	1315	1988
Hemoglobin	High	113	10,94	2,56	10,9	6,2	16,4	10,46	11,41
	Death	42	10,52	3,09	10,4	4,2	19,7	9,56	11,48
hematocrit	High	113	33,02	7,44	33,6	17	49,9	31,63	34,40
	Death	42	32,40	9,52	31,7	13,1	61	29,43	35,36
leukocytes	High	113	12280	6778	11000	2730	41410	11170	13680
	Death	40	15210	9726	12530	1142	48060	12650	18710
platelets	High	113	240000	116100	223000	194	73000	220600	263600
	Death	40	236700	124400	221000	2000	58900	201300	277800
PCR	High	79	129,10	116,30	74	3	430	105,20	156,40
	Death	32	171,50	110,70	188	2	369	134,20	209,70
Urea	High	110	68,30	46,60	57	12	308	60,65	78,22
	Death	39	118,30	59,26	114	17	228	100,50	137,20
Urea	High	109	1,81	1,51	1,29	0,37	8,29	1,57	2,14
	Death	37	2,96	1,86	2,83	0,47	8,47	2,44	3,63
TGO	High	46	75,15	221,50	35,5	10	1525	39,51	226,00
	Death	16	141,70	135,80	118,5	6,9	506	90,35	225,50
TGP	High	45	91,04	376,90	25	6	2552	30,55	358,50
	Death	16	120,60	195,60	76	6	826	64,53	310,40
TTPA	High	69	27,91	5,94	26,7	20,1	57	26,73	29,58
	Death	30	39,35	19,03	32,2	19,7	94,2	33,72	47,46
TP	High	68	14,18	3,05	13,6	1	22	13,44	14,87
	Death	31	20,10	10,85	15,2	11	54,6	17,14	25,05

Variable	Group							
potassium	High	110	4,23	0,67	4,2	2,2	6,2	4,10	4,35
	Death	41	4,73	1,10	4,6	2,6	7,6	4,43	5,10
Magnesium	High	92	1,93	0,44	1,9	0,6	4,1	1,84	2,02
	Death	33	2,11	0,56	2	1,2	4,6	1,97	2,38
Sodium	High	112	137,90	4,72	137,5	122	152	137,00	138,70
	Death	40	139,60	6,50	139	126	152	137,50	141,70
Ionized Calcium	High	90	1,11	0,13	1,1	0,33	1,44	1,07	1,13
	Death	36	1,09	0,20	1,08	0,6	1,65	1,03	1,16
Albumin	High	32	2,86	0,76	2,75	1,4	4,3	2,58	3,13
	Death	16	2,43	0,55	2,5	1,7	3,6	2,14	2,72
total bilirubin	High	54	0,67	1,17	0,4	0,15	8,8	0,49	1,35
	Death	27	1,65	3,96	0,58	0,15	20,96	0,81	4,93
direct bilirubin	High	54	0,40	0,88	0,21	0,08	6,57	0,26	0,93
	Death	27	1,15	3,00	0,27	0,08	15,73	0,50	3,60
indirect bilirubin	High	54	0,27	0,33	0,18	0,05	2,23	0,21	0,41
	Death	27	0,51	0,97	0,29	0,04	5,23	0,30	1,30
lactate	High	63	20,47	25,72	14,5	5,1	205	16,59	32,88
	Death	36	48,93	72,47	21,8	6,8	414	33,49	89,18
Troponin	High	54	747,90	3615	32,65	6,1	25637	190,50	2848
	Death	29	374,10	1072	68,7	22,4	5680	146,60	1188
CK	High	38	1139	4372	173,5	17	26290	338,70	4155,00
	Death	12	133,8	140,7	68,5	7	416	71,66	229,80
CKMB	High	26	11,96	27,93	2,9	1	143,4	5,73	34,39
	Death	7	7,50	6,74	4,5	2,1	20,7	4,10	14,21
pH	High	96	7,35	0,09	7,36	6,98	7,53	7,33	7,37
	Death	40	7,29	0,14	7,315	6,87	7,53	7,24	7,33
pO2	High	96	70,94	36,09	59	17	186	64,34	78,79
	Death	40	99,33	61,95	87,5	23	286	82,94	121,60
PCO2	High	96	40,18	10,95	39	15	76	38,13	42,50
	Death	40	40,35	13,97	37	14	82	36,54	45,19
CO2 Total	High	95	23,97	7,05	25	8	54	22,62	25,45
	Death	40	20,70	6,06	19,5	9	38	19,02	22,76
HCO3	High	96	22,69	6,75	23,1	7,8	52,1	21,41	24,11
	Death	40	19,40	5,90	18,6	8	36,5	17,77	21,40
B.E	High	95	-2,79	6,80	-2,4	-23,1	24,8	-4,13	-1,41
	Death	40	-6,62	6,62	-6,65	-20,6	10,4	-8,55	-4,49
Sat. 02 Gasometry	High	96	85,86	15,55	90,5	27	100	82,30	88,58
	Death	40	87,45	18,02	96,45	42	100	80,84	92,13
SAPS.3	High	100	0,21	0,20	0,125	0,01	0,78	0,17	0,25
	Death	40	0,53	0,24	0,52	0,06	0,91	0,45	0,60

Caption: Min. = minimum; max. = maximum; HR = heart rate in beats per minute; FR = respiratory rate in movements per minute; Axillary TºC = axillary temperature in degrees Celsius; BH = water balance; Hb = hemoglobin; Ht = hematocrit; CRP = C-reactive protein; TGO =aspartate aminotransferase; TGP =alanine aminotransferase; APTT = activated thromboplastin time; TP = thromboplastin time; K = potassium; Mg = magnesium; Na = sodium; CK = creatine kinase; CK-MB = form of the enzyme creatine kinase in cardiac muscle; pO2 = partial pressure of oxygen; pCO2 = partial pressure of carbon dioxide; HCO3 = bicarbonate; BE = base excess.

Table1. Analysis of clinical variables of patients in relation to their outcomes. São Paulo, 2022.

SAPS-3	% óbito	Lower	Upper	Count	Midpoint
[0,0.0909]	0,00	0,00	52,18	0	4,55
(0.0909,0.182]	0,00	0,00	33,63	0	13,64
(0.182,0.273]	14,29	0,36	57,87	1	22,73
(0.273,0.364]	25,00	0,63	80,59	1	31,82
(0.364,0.455]	75,00	19,41	99,37	3	40,91
(0.455,0.545]	66,67	9,43	99,16	2	50,00
(0.545,0.636]	50,00	6,76	93,24	2	59,09
(0.636,0.727]	0,00	0,00	97,50	0	68,18
(0.727,0.818]	50,00	1,26	98,74	1	77,27
(0.818,0.909]	100,00	2,50	100,00	1	86,36
(0.909,1]	0			0	95,45

Table 2. SAPS-3 predictive score calibration and death outcome. São Paulo, 2022.

Variable	Predictive characteristic for clinical complications
Age	>72
Heart Rate	> 106
Respiratory frequency	> 21
Systolic Blood Pressure	116
Diastolic Blood Pressure	67
Mean Blood Pressure	82
Temperature	36
pulse oximetry	95
Braden scale	8
RASS scale	-4
SAPS 3	>40
Water Balance/24h	+1621
Hemoglobin	10.5

hematocrit	32.4
leukocytes	15,210
platelets	236,700
Urea	118
serum creatinine	2.96
Magnesium	2.1
Albumin	2.43
Potassium	4.7
lactate	49
C-reactive protein	171
liver enzymes	present changes
Myocardial injury biomarkers	present changes

Table 3. Variables associated with clinical worsening, according to predictive statistical model. São Paulo, 2022.
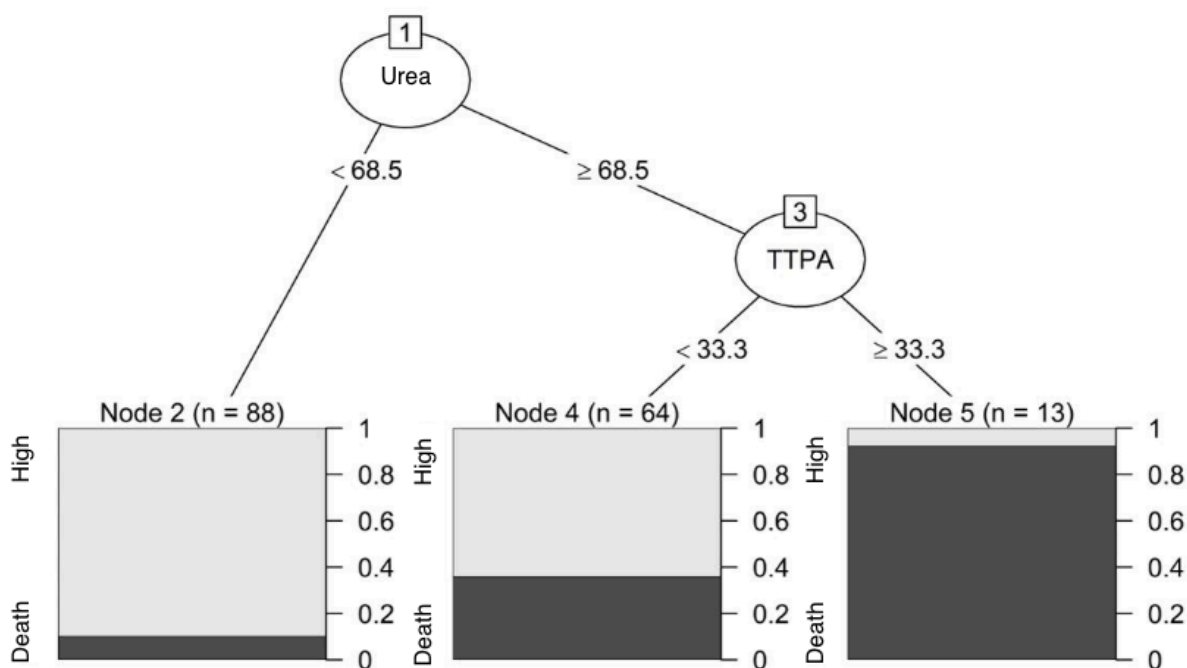

Figure 1. Classification and regression model (CART) for clinical outcome. São Paulo, 2022.

facilitating the dynamics of the team and avoiding the occurrence of iatrogenic events and negative intercurrences.

Despite the above, it is worth highlighting the joint work carried out by the multidisciplinary team in this ICU, bringing together professionals from the areas: Medicine, Nursing, Nutrition, Physiotherapy, Speech Therapy, Pharmacy and Social Assistance. Each professional is fundamental to assist in the recovery process of hospitalized critical patients and all work towards the same goal: to promote clinical improvement as quickly as possible, within the conditions of each patient, respecting their limits and their biological responses, promoting care, and not therapeutic obstinacy, so that, in possible cases, the individual progresses to hospital discharge in adequate health conditions. Multidisciplinary visits take place daily at the bedside and this has been an increasingly common practice in ICUs, aiming to coordinate care, set goals,*et al*, 2021).

A study carried out by Rocha, Neves, Viegas (2016) highlights that the majority of seriously ill patients who are admitted to the ICU may show signs of clinical severity that, if detected early, can show their clinical deterioration, in approximately 80% of cases, signs that can be traced 24 hours before the worsening. According to the Associação de Medicina Intensiva Brasileira (2020), early identification is extremely relevant, since the mortality rate in Brazilian ICUs in 2015 was 12.24%, with a decrease in the following year (11.82%) and 10.76%, in 2019, thanks to the use of evidence-based practices.

The evaluation conducted by the health team, through observation and continuous monitoring of patients, most often defines and anticipates conducts for clinical management. We can infer that the accuracy and objectivity of the assessment based on scientifically proven prognostic scores sustains, standardizes and improves care outcomes (Bekhit, Algameel, & Eldash, 2014).

Predictive scores of clinical severity are increasingly used in hospital environments with the objective of describing prognoses, establishing priorities, characterizing and evolving the severity of the disease. It is noteworthy that other objectives can be achieved with its use, such as assessing the degree of organ dysfunction and results of proposed interventions (Bekhit et al., 2014).

As for the clinical profile of the patients in this study, in Table 1 it is observed that there is a predominance of males, as already demonstrated in other studies, which may refer to the lack of adherence to self-care related to health, of multifactorial causes, such as policies inefficient public policies, increased number of accidents, shame due to the social construction of masculinity, among others (MAURICIO*et al*, 2022; AGUIAR et al, 2022; COSTA et al, 2019).

The average age of the patients was 63 years, with a length of stay of nine days, similar to the rates found in other intensive units in Brazil (MAURICIO*et al*, 2022; AGUIAR et al, 2022); thus needing a team prepared to deal with the health of the elderly and their particularities. However, the study showed that even being considered elderly in Brazil after 60 years of age, according to Law Number: 10,741 of October 1, 2003, the cutoff point for clinical worsening occurs from 72 years of age.

Knowing the profile of the hospitalized patient is, therefore, of extreme importance for the planning of assistance and adequate use of intensive care, in order to intervene in a humanized and patient-centered way, responding to their demands and specificities (AGUIAR*et al*, 2022; COSTA et al., 2019).

According to a study carried out by Alencar et al. (2022) the factors associated with in-

hospital death were: steroid use, cancer, male sex, and immunosuppression. The protective factors were: use of anticoagulants, rheumatological disease, and hematological disease.

Furthermore, the results highlight that the SAPS 3 is an effective tool for predicting complications and death, since half of its predictive power is due to the evaluation of information about the individual before admission to the ICU, justifying its preeminence over other criteria of prognosis (LEÃO; MARQUES; MELLO, 2018); however, it must be noted that it is not a criterion for validating the availability of therapeutic resources and implantation in critically ill patients, especially in scenarios such as Covid-19 (SANTOS; BRITO, 2022), for example.

The profile of patients seen in the ICU point to very similar mortality rates between the expected and the found, as shown in Table 2, realizing that among the 40 deaths, the patients had the SAPS-3 score applied, with values found of at least 0 .06 and at most 0.91. This proves that, although it is quite reliable, this prognostic criterion is subject to errors, since an individual whose chance of mortality was 6%, evolved to death, according to what is predicted by the SAPS 3. Despite this, the other findings prove that the prognostic score criteria have strengthened and sensitive scientific evidence for any type of patient treated in the ICU, even of medium complexity, as in the "Hospital Universitário".

The application and access to this resource, however, is exclusive to the medical team, disregarding the fact that the assistance provided to the client in an individualized way is based on and discussed in the evaluation of the multidisciplinary team. Thus, limiting access to information hinders the process of establishing priorities and more comprehensive knowledge of the patient, highlighting the importance of nurses' involvement in predictive score practices as a foundation for decision-making for care planning.

Although, the effectiveness of the SAPS 3 applied in the ICU of the "Hospital Universitário" of the "Universidade de São Paulo" is proven, this work had several limitations, such as not completely filling out the information in the system when admitting patients, which implies the lack of important data and, in many cases, the individuals were sedated, under mechanical ventilation and, therefore, unable to respond to questions and doubts; patients with hospitalizations prior to the time of this research with outdated sociodemographic and health data; incomplete medical records missing documents; records that were not found; short length of stay in the ICU, so that it was not possible to collect laboratory tests in time for the accounting of deaths. Thus, it is important to point out situations in which patients were hospitalized for a long period in the ICU and, when exclusive palliative care (EPC) is defined, the routine is to request transfer to beds in clinical wards to vacate ICU beds, due to great service demand, however, as long as the patient is clinically stable and not dependent on intensive care. Faced with this administrative situation, all the evolution of the individual and the existing complications occurred within the ICU even though the patient evolved to death in other units. Situations like this imply accounting for the unit's mortality rate and controlling the possible causes that led to the patient's clinical worsening. Furthermore, 28 deaths due to septic shock were found (66,

The detection of patients at high risk of mortality can support the development of specific care by health professionals to minimize the risk of death in the ICU. The use of predictive scores in clinical evaluation can

be a useful tool to prioritize the management of patients at increased risk of complications and mortality, especially in the face of limited therapeutic options (ELHADI et al., 2021).

Still, despite the average length of stay being nine days, there are patients who remain hospitalized for much longer, with one individual being found who stayed for 66 days. In these cases, it is very important to pay attention to the appearance of pressure injuries - which often happens in the unit - to avoid complications and clinical worsening for the individual, in addition to the fact that it is another chance of infection for the individual. In short, the ICU under study, despite presenting its limitations, promotes care centered on the individual and the performance of the multidisciplinary team is essential for achieving the expected objectives, mainly the clinical recovery - but not only - of the patient and the use of the SAPS 3 is reliable as expected according to the clinical profile of patients admitted to this unit.

CONCLUSION

Knowing the profile of patients favors the identification of risk factors that favor complications and an unfavorable outcome, and this assessment is essential to plan care that minimizes these events. Currently, the only prognostic criterion used in this ICU is SAPS 3, which is accessible exclusively to the medical team, which makes the work of the multidisciplinary team difficult. The daily identification of clinical, sociodemographic and laboratory variables by the nurse allows predicting, however, the risks to which the patient is exposed, favoring individualized care planning. However, the study finds that the failure to complete complete social and personal records is still a scenario that interferes with the care and accurate knowledge of the profile of the patient treated

at the institution, limiting care planning and institutional goals. Finally, we innovated with the need to develop an assessment for nurses of admitted patients, regardless of diagnosis, favoring daily monitoring of clinical evolution, including scores in a single care document.

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