STANDARD TITLE: CRITICAL CARE NURSING PRACTICE LEVEL I (BONE MARROW / HEMATOLOGY, CCU, AICU, ICU and SICU)

Section: Critical Care

Keywords: Within Defined Limits, WDL, Charting by Exception, CBE, Assessment, documentation

Policy: # 440.67
Page: 1 of 4

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STANDARD OF CARE:

The critically ill patient can expect systematic and continuous care based on the nursing process to achieve and maintain optimal responses.

NURSING PRACTICE GUIDELINES:

1. Obtain medical history. Refer to Patient Care Services Policy, Admission of Inpatients.

2. Perform a comprehensive systems assessment including blood pressure, pulse, respiration, temperature, pulse oximetry, pain, weight in kilograms (kg), height, and rhythm strip with PR & QRS interval measurements within 15 minutes of admission or per policy, or physician orders.

3. Assess mental status, respiratory, cardiovascular, gastrointestinal, renal / urinary, integumentary, and peripheral vascular every two (2) hours or per policy, or physician order using the pre-established assessment parameters Within Defined Limits (WDL) as a guideline.

4. Assess neurological status as patient condition warrants, according to Patient Care Services Policy, Musculoskeletal, Neurologic, and Peripheral Vascular Assessment using the pre-established assessment parameters Within Defined Limits (WDL) as a guideline. Frequency of Neurological checks will be per Patient Care Services Policy, Musculoskeletal, Neurologic, and Peripheral Vascular Assessment or per physician order.

5. Assess Neurovascular status as patient condition warrants, according to Neurovascular Assessment per Patient Care Services Policy, Musculoskeletal, Neurologic, and Peripheral Vascular Assessment using the pre-established assessment parameters Within Defined Limits (WDL) as a guideline. Frequency of Neurovascular checks will be per Patient Care Services
Policy, **Musculoskeletal, Neurologic, and Peripheral Vascular Assessment** or per physician order.

6. When acute changes in any above system occur, frequency of assessment should be increased as patient condition warrants until point of stabilization.

7. Monitor ECG rhythm continuously. Document rhythm interpretation every two (2) hours.

8. Document and interpret ECG rhythm strip every 12 hours with PR and QRS interval measurements, and PRN with rhythm variance.

9. Monitor intake and output every eight (8) hours or per policy or physician order, and provide cumulative total after 24 hours.

10. Maintain intravenous access while in a critical care area unless otherwise ordered. Assess peripheral IV sites with vasoactive drips infusing every two (2) hours. Assess other IV sites every four (4) hours and according to medication guidelines. Refer to Patient Care Services Policies, Adult & Pediatric: Care of the Patient with a Peripheral Intravenous (IV) Access & Adult & Pediatric: Care of the Patient with a Central Intravenous (IV) Access.

11. Obtain daily AM patient weight in kilograms (kg).

12. Provide appropriate hygiene daily, oral care at least twice daily and as condition warrants. Perform oral care every two (2) hours on ventilated patients.

13. Provide needed assistance with nourishments, oral intake, elimination, activity, and functional status.

14. Maintain skin integrity including a visual head to toe skin inspection per Patient Care Services Policy, **Skin Assessment and Management / Specialty Beds**.

15. Notify and collaborate with physicians and appropriate clinical disciplines for interventions based on holistic patient care assessments.

16. Coordinate care delivered to patients and serve as support and advocate to patient and family.

17. Provide appropriate teaching.

18. Implement and maintain patient safety.
14. ACLS certified RN to accompany patient with continuous ECG monitoring when transporting to ancillary departments unless otherwise ordered.

Definitions for Within Defined Limits (WDL)

<table>
<thead>
<tr>
<th>Assessment Parameters</th>
<th>Critical Care Level I &amp; Level II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological</td>
<td>Alert and oriented X 3 (person, place, and time). Pupils equal, round, reactive to light and accommodation. Eyes able to move in all directions, able to track. Speech clear and appropriate. Face symmetrical. Moves all extremities to command. Grips equal and strong. No tremors or seizure activity.</td>
</tr>
<tr>
<td>HEENT</td>
<td>Eyes clear, moist, and free of edema or discharge. Hearing and vision intact. Oral mucosa moist, pink, and intact. Teeth intact and appropriate for age. Absence of hoarseness. Absence of swallowing or chewing problems. Absence of pain, bleeding, deformity, redness, swelling, drainage, or foreign body.</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Apical pulse regular. Normal sinus rhythm. S1, S2 heart sounds present. No complaints of chest pain.</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>No complaints of nausea or vomiting. Bowel sounds present, normal, and active X 4 quads. Abdomen soft and non-tender. Continent of stool.</td>
</tr>
<tr>
<td>Anus/Rectum</td>
<td>Skin clean, no lesions or fissures. No hemorrhoids, trauma / injury, or masses.</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>No complaints of pain with movement. Moves all extremities. Muscle tone, strength, and ROM appropriate for patient.</td>
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<tr>
<td>Integumentary</td>
<td>Skin color within patient’s norm, warm, dry, and intact (excludes surgical incisions). Turgor within patient’s norm.</td>
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<tr>
<td>Peripheral Vascular</td>
<td>Capillary refill less than 3 seconds. Color within patient’s norm. Warm. Denies numbness or tingling. Pulses are palpable and 3+. No edema.</td>
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<tr>
<td>Psychosocial</td>
<td>Characteristics of behavior and communication appropriate to situation. Affect appropriate.</td>
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</tbody>
</table>
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REFERENCES:

St. Francis Hospital and Health Centers, Patient Care Services Policy, Admission of In-patients.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Adult & Pediatric: Care of the Patient with a Central Intravenous (IV) Access.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Adult & Pediatric: Care of the Patient with a Peripheral Intravenous (IV) Access.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Musculoskeletal, Neurologic, and Peripheral Vascular Assessment.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Skin Assessment and Management / Specialty Beds.

Opp, Adrianne, ASN, RN, Nurse Champions for OneChart Clinical Documentation, - 12/10.

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NURSING & MEDICAL STAFF COMMITTEE APPROVALS:
Clinical Practice Council: - 01/11/11.
Nursing Executive Committee: - 01/11.

Approved by:______________________________ (Signed, original policy on Susan McRoberts, Vice President and Chief Nursing Officer file in Nursing Office)

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