

SUBJECT: INTRAVENOUS CONSCIOUS SEDATION	REFERENCE #1234
DEPARTMENT: INTENSIVE CARE UNIT	PAGE: 2 OF: 4
APPROVED BY:	EFFECTIVE: REVISED:

- The medical director of ICU will be responsible for ensuring that policies and procedures exist in that department and are applicable to ICU practice.
- All IV conscious sedation will be ordered and supervised by the physician credentialed for the specific procedure and administration of anesthetics.
- The licensed professional nurse (RN) responsible for managing the care of the patients receiving IV conscious sedation will complete and maintain competency in the skill.
- All patients requiring IV conscious sedation will have a preprocedure assessment, a minimal preanesthetic assessment including, but not limited to:
  - History and physical performed by a physician (this should include age, review of systems specific to cardiopulmonary disease) and current medications and a history of any adverse or allergic drug reactions with anesthesia or sedation;
    - Vital signs: heart rate, blood pressure, respiratory rate and oxygen saturation;
    - Level of consciousness;
    - NPO status;
    - Proper consents signed; and
    - Pregnancy.
- Emergency equipment must be immediately accessible to every location where IV conscious sedation is administered, and includes at least the following:
  - Defibrillator
  - Suction device
  - Oxygen
  - Airways
  - Emergency drugs, (Narcan, Romazicon)
  - Intubation equipment

SUBJECT: RESTRAINT POLICY	REFERENCE #1228
DEPARTMENT: INTENSIVE CARE UNIT	PAGE: 1 OF: 3
APPROVED BY:	EFFECTIVE: REVISED:

PURPOSE:

To ensure patient safety by defining the Interdisciplinary Team responsibilities in the restraint of patients.

POLICY:

The Administration, the Medical Staff and the Interdisciplinary Patient Care Team of this Hospital believe that patients have the right to be free from both physical and chemical restraint. Restraints are never used as a punishment to the patient or for the convenience of staff, but are used to assist in the care of the patient and to provide for the physical safety of the patient and others.

Restraint Category:

The reason a restraint device is needed determines the restraint category. The restraint categories are; Medical Immobilization, Postural/Adaptive Support and Behavioral. The restraint category dictates the standards that will be required.

RESPONSIBILITY OF PHYSICIAN:

The physician's responsibilities include an assessment of the patient's clinical condition. Medical Immobilization and Postural/Adaptive Supports do not require an order and may be used PRN according to established protocols which have been approved by the medical staff. Behavioral restraint requires a written or signed telephone order be present on the medical record within 24 hours in the Acute Units. The order and documentation must include the following:

- The behavior requiring the restraint
- Less restrictive measures were attempted and not successful
- Use of restraints are clinically indicated
- Type of restraint, *limbs to be restrained and duration*

## SKILLS LIST - REGISTERED NURSE

EMPLOYEE NAME: \_\_\_\_\_ FISCAL YEAR: \_\_\_\_\_

DATE: \_\_\_\_\_

This is to be completed by the employee annually to assess their level of proficiency. Update throughout the year as new skills are acquired.

Skill	Unable to Perform	Needs Assistance	Proficient	Initials	Date
• Medications, blood, blood products					
• Administration of					
■ Emergency IV drugs					
■ Routine IV antibiotics					
• Compatibilities with other ongoing drugs					
• Constant infusion of Vaso-Active drugs					
• Policy and procedure for Hyperalimentation and Intralipid infusions					
• Administration of blood and blood products					
■ Policy and procedure					
■ Transfusion reaction policy and procedure					
• Airway management					
• Suctioning					
■ Endotracheal tubes					
■ Tracheostomy					
■ Nasal/tracheal					
• Care of					
■ Endotracheal tubes					
■ Tracheotomies					
• Endotracheal and trach tubes					
■ Types					
■ Sizes					
• Cuff pressure measurement					
• Use of Ambu bag					
• Set up oxygen					

SUBJECT: NURSE PRACTICE GUIDELINES - MONITORING	REFERENCE #1212
DEPARTMENT: INTENSIVE CARE UNIT	PAGE: 1 OF: 2
APPROVED BY:	EFFECTIVE: REVISED:

**GUIDELINES:**

- Intake and output (I and O)
  - I and O is to be recorded hourly and totaled q shift. A 24 hour total will be done at 0600.
  - Twenty-four (24) hour totals include any pre-admission I and O. (i.e. OR, ED, PACU) except for cardio-thoracic patients.
  - Cardiac output flushes will be recorded as intake.
  - All patients will have admission weights done. Weights will be documented on the admission assessment.
  
- Vital signs
  - HR, RR and BP will be recorded every hour. Temperatures which are within normal limits may be recorded q 2 hours.
  - Stable patients; HR, RR and BP may be recorded q 2 hours, temperature q 4.
  - Vital signs and temperature of patients on research studies will be done according to protocols.
  - Vital signs will be recorded every 30 - 60 minutes when infusing vasoactive medications. HR, BP or the appropriate parameter will be recorded every 15 - 30 minutes when titrating vasoactive medications.
  - When administering blood products vital signs will be done every 15 min. x 4, every 30 min. x 2 then every hour until the infusion is complete. This vital signs protocol will be followed for all admissions to the ICU from the OR. Other admissions to ICU will follow physician's orders.

SUBJECT: DOCUMENTATION	REFERENCE #2402
DEPARTMENT: INTENSIVE CARE UNIT	PAGE: 1 OF: 2
APPROVED BY:	EFFECTIVE: REVISED:

- All components of the patient care process, plan of care, evaluation and outcomes will be documented in the patient's medical record. The documentation will address patients' biopsychosocial needs, capabilities and limitations.
- The nursing process is used in the delivery of patient care and is evidenced in the following documentation:
  - Initial assessment and evaluation, performed by an RN or other qualified staff member and appropriate reassessments
  - An established plan of care
  - Documented nursing interventions which are related to the patient problems identified in the plan of care
  - Documented aspects of nursing care provided to the patient or significant other(s)
  - The effectiveness or outcomes of nursing interventions and the patient's response
  - Discharge planning and preparation activities
  - Data collected within the defined scope of responsibilities/duties of each caregiver may be documented by that individual. The evaluation of the data for identifying patient care needs/problems and planning of care must be documented by the RN.
- All components of nursing care related to the patient are permanently integrated into the medical record or clinical information system and can be identified and retrieved.
- All patients admitted to the ICU will have an initial assessment data documented on the ICU flowsheet. Patients not requiring IV medication infusion, PA line or ICP monitor may have initial and ongoing documentation via the bedside computers.
  - Nurses in the ICU will document patient information on the ICU flow sheet, maintaining current data in the electronic medical record.