ACUTE CARE (Medical) Guideline of Care

General (Medical Unit) Guidelines of Care

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I. Safety:

A. The following emergency equipment will be in the emergency box at each bedside, presence of an intact lock assumes contents are in place:
   1. Infant, school age, adolescent mask.
   2. Resuscitation bag.
   3. Yankauer Suction catheter.

B. The following equipment will be at the bedside of each patient:
   1. Oxygen flow-meter.
   2. Suction bucket in place and ready for use.

C. The following equipment will be at the bedside, open, and ready for emergency use for respiratory pts, pts with seizure disorder, or as clinical condition indicates:
   1. Size appropriate mask, oxygen flowmeter and resuscitation bag.
   2. Suction equipment.
   3. Spare trach tube of appropriate size taped to HOB on all patients with tracheostomy.

D. Emergency medication sheet specific for the patient’s weight will be posted above patient’s bed, in the sleeve provided. Any changes to patient’s dose calculation weight in CIS require an update to the emergency medication sheet.

E. Patients on the Medical Unit are to be on cardiorespiratory, and pulse oximetry monitors as ordered and as concerns with a patient’s condition indicates (See Clinical P&Ps, Cardiac and Respiratory Monitor Use and Pulse Oximetry Use & Care.)

F. Alarm limits are patient specific and will be on At All Times.

G. Each patient will wear an ID band (See Clinical P&P, Patient Identification).

H. Patient name and attending physician/medical team are posted on the bed/crib tag for each patient to allow proper identification.

I. Document allergies on bed tag and patient allergy band. Place the standard Latex Precaution Sign at the bedside of patients requiring latex precautions.

J. Keep at least one side-rail in up position. Side-rail may be down if caregiver is in constant attendance at bedside.

K. Medical Restraints (See Clinical P&P, Restraint and Seclusion).
   1. Restraint is only ordered after first approaches of least intrusive measures are considered. For example, the use of sitters for continuous observation.
   2. Criteria for Use:
      a. Patient has invasive lines or devices such as central line, IV, chest tube, surgical drains; and
      b. Patient is developmentally unable to cooperate with devices left in place (e.g., infants and toddlers or older children with impaired cognitive ability); or
      c. Patient is unable to cooperate with devices left in place because of altered mental status from disease or treatment; or
      d. Patient has demonstrated that s/he is unable to cooperate with devices left in place.

   3. If criteria are met, extremity restraints can be utilized for medical immobilization with the following requirements:
a. Provider order is written and renewed q24 hours, including reason for use of restraint and length of time. PRN orders are not allowed. Restraints are loosened or removed every 2 hours to assess skin and perfusion, with documentation of this on nursing flow-sheet.

4. Each nurse caring for the patient will assess the continuing need for restraints. For Assessment, monitoring, and terminating restraints (See Clinical P&P, Restraint and Seclusion).

II. Comfort/Mobility:

A. Pain is multidimensional; assessment includes physiologic and behavioral signs, with intervention utilizing pharmacologic and behaviorally supportive strategies to manage pain with documentation of response to intervention.

B. Assess and document comfort with vital signs, and before/after pain intervention utilizing an age appropriate pain scale assessment tool (See Clinical P&P, General Pain Management.)

C. Turn and reposition immobilized patients with individualized ROM per patient’s condition every 2-4 hours, otherwise mobilize patient out of bed as ordered, then document on nursing flowsheet.

D. Perform linen change and assist patient with personal hygiene daily. Perform weight check as ordered. Each Sunday night perform complete growth and measurement assessment on all patients <1 year of age, including weight, length, and OFC.

E. Provide mouth care every 4 hours while awake on all NPO patients.

F. Use sheepskin, egg-crate or airflow bed as necessary on patients at risk for skin breakdown (See Housewide GOC, Wound and Skin Care).

III. Family-Centered Care:

A. Orient family to Medical Unit on admission, including a review of the Medical Unit handout, rights and responsibilities handout, and hospital handbook as given by the Unit Coordinator in each admit pack. Check the appropriate box on the admission assessment when this is complete.

B. Assess family for psychosocial and spiritual support needs upon admission and continuously thereafter. Initiate social service and pastoral care referrals as indicated.

C. Encourage family involvement in care decisions and care delivery.

D. Maintain patient confidentiality. Provide patient information and condition reports only to parents and those they designate.

E. Provide information on Advance Directives to all patients over 18 years of age and document this on admission assessment.

F. Families/caregivers will be involved in discharge plan and aware of needs upon discharge.
IV. Neurological:

A. Assess level of consciousness (LOC) and pupil reaction upon patient admission. Continue to assess LOC with baseline assessment every shift or more frequent neurological assessment as patient condition indicates.

B. Position pts with potential for increased ICP with HOB elevated 30°.

C. Follow seizure precautions for patients with known seizure disorder.

V. Respiratory:

A. Assess respiratory status upon admission and every 4-8 hours or more frequently as patient’s condition indicates. Document respiratory rate, quality of breath sounds, and work of breathing on nursing flowsheet.

B. Respiratory score is utilized on all patients admitted with a respiratory condition with focus on RAD and Bronchiolitis. Scoring is performed before and after all respiratory treatments.

C. Document FiO2 level and mode of delivery every 4-8 hours and for all changes.

D. If oxygen administered in response to bradycardia or cyanosis, document patient response, and obtain order from physician/provider for ongoing oxygen administration. If patient has an increasing O2 requirement inform MD.

E. Tracheostomy Suctioning and Tracheostomy site care
   2. Place RT generated diagram illustrating proper suction depth at head of bed (Tube Length Tool) in clear view of staff at bedside.

F. Change SaO2 probe site every 4 hours for all patients and document change on the nursing flowsheet.

G. Document SaO2 reading in column on nursing flowsheet with routine vital signs if pulse oximetry ordered, whenever making FiO2 changes, when obtaining blood gas, during apnea or bradycardia episode, or whenever a clinically significant change occurs.

H. Assess for symptoms of URI (upper respiratory infection) upon admission and each shift. Report any findings/concerns to shift charge nurse for appropriate patient placement and isolation.

VI. Cardiovascular:

A. Patients with dextrocardia and systemic-to-pulmonary artery shunts will have a sign placed at the HOB stating this.

B. Perform perfusion/cardiovascular assessment upon admission and every 4-8 hours or more frequently as patient’s condition indicates. Document heart rate, BP, peripheral pulses, capillary refill, skin temperature and skin color on nursing flowsheet.

VII. GI:

A. Assess gastrointestinal status every 4-8 hours and more frequently as patient’s condition indicates. Document bowel sounds, presence of flatus, abdominal distention/discomfort, nausea/vomiting, and frequency of stools on nursing flowsheet.
B. Measure abdominal girth and record in cm as ordered, and as patient’s condition indicates.

VIII. GU:

A. Perform daily care of an indwelling urinary catheter (See Clinical P&P, Indwelling Urinary Catheter).
   1. Clean catheter and perineum at least once each day and with each bowel movement.
   2. Cleanse catheter from point of entry to port of the foley with alcohol swab.
B. Date Foley drainage bag when initiated and changed every 7 days.

IX. General Care:

A. Vital Signs:
   1. Assessment of vital signs includes temperature, pulse, respirations, blood pressure and pain scale score.
   2. Vital signs are assessed every 4 hours or as patient’s condition indicates unless otherwise ordered.
   3. Vital signs that are ordered every shift will be assessed every 8 hours.
   4. Nurse will assess baseline assessment parameters for patient by reviewing prior documentation and ordered parameters. Nurse will notify provider of assessments outside these baseline parameters, and document reassessments accordingly.
B. Growth Measurements:
   2. Perform daily weights by 0600 as ordered by the physician and/or per the following nursing standards:
      a. Patients with diarrhea.
      b. Patients on diuretics and/or albumin.
      c. Patients considered to medically fragile.
   3. Weights are to be recorded on the nursing flow-sheet under today’s weight meaning the flow-sheet that starts at 0700. For example: if a RN is working a 12 hour shift, shift starts at 1900 on 3/21 and ends at 0730 on 3/22. If the RN weighs the infant at 0200 this weight is recorded at today’s weight on the flow-sheet that starts 0700 3/22.
   4. If the child’s weight has increased or decreased by a clinically significant number (e.g.: infant loss/gain of 10% would be significant) the nurse reweighs the patient immediately, if the weight is accurate then the nurse must notify the physician immediately.
   5. Perform weekly assessment of weight, length/height and OFC recorded on nursing flowsheet and growth graph for all patients <2 years of age each Sunday night on the night shift.
6. Weight measurements are consistently obtained without clothing or diapers for infants, and the scale type used is identified and documented on the nursing flowsheet. The same scale should be used daily. All infants (child < 1yo) will be weighed daily and weight recorded by 0600, regardless of the diagnosis.

7. Perform twice a day weights at 0600 and 1800 as ordered by the physician and/or per nursing standard as listed:
   a. Patients on replacement fluids.
   b. Medically fragile patients with change in stooling or urine or output pattern.

C. Intake and Output / Electrolytes / Nutrition:

1. Assess hydration status every shift and more frequently as patient’s condition indicates, this initial and ongoing assessment of hydration includes:
   a. Total maintenance intake.
   b. Total output (cc/kg).
   c. Patient weight.
   d. Baseline nutritional status.
   e. Serum electrolytes as ordered.
   f. Appearance of eyes, mucous membranes, color, cap refill, pulse quality, presence of edema, fontanelles.
   g. Level of activity, level of consciousness, response to care.
   h. Vital signs: HR, BP, RR and quality of breath sounds.

2. Each patient is on strict I/O unless otherwise ordered.

3. Calculate 24-hour totals, including calculation of cc/kg/day intake, and urine output in cc/kg/hr. If the patient has more output then intake the physician must be notified. If the pediatric patient has < 1ml/kg/hr urine output or <30ml/hr in the adolescent the physician is to be notified.

4. Vital signs and weight will be included with any call to the MD to report volume status concerns. Along with the weight and vital signs include what you are concerned about and what you would like to do.

5. Reminder: in the pediatric patient tachycardia is noted first with a normal blood pressure. As the child decompensates and moves into hypovolemic shock the blood pressure may drop followed quickly by bradycardia and arrest.

6. Fluid totals on post-op patients include OR/PACU intake and output.

7. Intake:
   a. Record IV intake at least every 2 hours, and maintain a running total beginning at 0600 daily.
   b. Record PO intake and NG/GT/JT boluses at the time it is taken, and maintain a running total beginning at 0600.
   c. Check and record continuous drip feedings every 2 hours.
   d. All intake is recorded using running totals where the top number is the current measurement and the bottom number is the cumulative total.

8. Output:
   a. Urine:
i. Weigh all diapers, measure all output, and record on nursing flowsheet in cc.

b. Stool:
i. Record all stool output on nursing flowsheet, describing size, color, and consistency, using key provided on flowsheet.

c. Mixed:
i. Urine/stool output in a diaper is recorded in the mixed column of the nursing flow-sheet and is described using stool key.

ii. Mixed diapers are not quantified separately in cc of strictly urine or stool or calculated in cc/kg total output documentation.

iii. Documentation would be total stool = 300 total urine = 200 mixed = 400. Then in cc/kg/hr urine you would calculate the 200 of urine and add a note that says + mixed diapers, unable to quantify urine amount.

d. All output is recorded using running totals where the top number is the current measurement and the bottom number is the cumulative total.

e. Chest tube output is recorded every 4 hours, with assessments every 2-4 hours as pts condition indicates.

f. NG/GT and other drain output are recorded and emptied every 8 hours unless patient’s condition indicates more frequently. Record color of NG output, i.e. yellow, green, clear, coffee grounds, bloody.

9. Medication and fluid administration are based on admission weight (dose calculated weight).

a. For patients with prolonged stay, this reference weight should be assessed weekly and adjusted at least monthly and per clinical indication.

10. The following criteria will alert nursing to record all weights and 24 hour totals on a graphic sheet which will be kept in the patients chart in front of the nursing flow-sheets:

a. Patients who have diarrhea whether viral, bacterial, or related to short gut or similar diagnosis.

b. Patients on diuretics and/or albumin.

c. Patients with persistent vomiting.

d. Patients on replacement fluids.

e. Patient with diabetes insipidus or other clinical reasons for potential to have greater output then input.

See Also: APPENDIX I: Weight Daily Intake/Output Graph

X. Infection Control:

A. Handwashing is to be adhered to by all personnel and visitors. Perform hand scrubs (10 seconds) or use Purell at the beginning of each shift and between each
patient contact, Purell in and Purell out, (See also Infection Control P&P, Hand Hygiene).

B. Clean multi-use equipment with antiseptic solution after each patient use.
C. Change suction buckets and connecting tubing daily on night shift by 0600 when in use.
D. Dispose of suction buckets and tubing in biohazardous materials garbage cans.
E. Feeding bags, tubing and syringes are rinsed as needed and changed every 24 hours. Date and time all tubing/bags/syringes (See also Clinical P&P, Feeding Tubes: Insertion of and Feeding Via Nasogastric, Orogastric or Nasoduodenal Tube).

XI. IVs:

A. Check IV solutions and rate against e-MAR at beginning of each shift. Obtain clarification order to adjust IV rate as patient’s condition indicates (i.e. IV + PO).
B. Assess the IV and armboard site for signs of irritation and infiltration every 2 hours and before giving meds. Document changes in condition on flowsheet.
C. Change solutions and tubings per Clinical P&P, Intravenous Lines. Write the date and time of change on metriset.
D. Administer medication infusions with an infusion pump.
E. Program the pump with 3 hours' worth of fluid to be infused. Reset the pump every 2 hours on the even hours with the 3-hour amount.
F. See also Clinical P&P, Intravenous Lines.

XII. Medications:

A. All medications are checked against the e-MAR and signed off when administered.
B. The following medications are double-checked and co-signed at each administration: digoxin, insulin, heparin and any other drugs per RN judgment.
C. All medications are adjusted to match standard drug times as appropriate.
D. Chart prn, stat, or one-time medications, on flowsheet as well as eMAR if they have a direct effect on status, i.e. VS, urine output, etc.
E. The RN will calculate the ordered dose of IV medication drips and verify that the dose is consistent with standard medication drips (See Clinical P&P, Medication Drips and its associated Drip Table - Guidelines for Dosing of IV Drugs for Infusion) and document the current infusion rate (ml/hr) in the IV e-MAR at the beginning of each shift and with each titration rate change.
F. Narcotics are to be signed out when taken from the locked narcotics storage. Narcotic wastage must be co-signed by RN/LPN in Omnicell.
G. Filter needles are to be used for glass ampules.
H. Date and time multi-dose containers of NS. These are to be discarded 8 hours after being opened.
XIII. Lab Work & X-Rays:

A. Perform a State Newborn Screening test (PKU) on ALL infants at 3 days of age, and then repeat at 10 days of age per provider order considering patient’s NPO status.
   1. Another repeat is by physician orders only.
   2. Record when done in nursing flowsheets, Kardex and in chart progress notes.

B. Whole blood glucose monitoring is done per provider order according to Clinical P&P, Whole Blood Glucose with Roche Accu-Chek Inform Meter.

C. Test urine (blood, protein, glucose, pH) as ordered. Test stool or gastric secretions for occult blood as ordered.

XIV. Documentation:

A. Documentation will include:
   1. A complete assessment by systems to be done at the beginning of shift (8 or 12 hr) on nursing flowsheet, and prn change in patient status.
   2. Changes in patient status in progress note section of patient chart.
   3. Comfort, with vital signs or at least every 8 hours.
   5. Pertinent communication with other health team members on flowsheet.
   6. Routine teaching with families.
   7. Safety checks on flowsheet every shift.

B. Document all teaching and discharge planning on Guideline of Care Patient/Family education section and as needed to highlight in progress notes. Document care conferences in progress notes.

C. Review and make communication order additions to online Kardex and guidelines of care within 24 hours of admission. On line Kardex reviewed and updated every shift.

D. At change of nursing shift, all orders from previous shift are checked for accurate documentation. The nursing team then reviews upcoming shift orders.

E. Complete acuity tool on nursing flowsheet every 8-hour period.

See Also: APPENDIX I: Weight Daily Intake/Output Graph

XV. References:


APPENDIX I: Weight Daily Intake/Output Graph