PHYSIOLOGIC MONITORING/HYGIENE/COMFORT – ICU/PROGRESSIVE CARE UNIT

PURPOSE: To outline the management of patients in relation to physiologic monitoring/hygiene/comfort measures in the ICU and Progressive Care Unit (PCU) (except Neonatal ICU).

ASSESSMENT:

1. Assess all body systems:
   - Upon admission
   - Within one hour of assuming care and record findings within 2 hours of performing assessment
   - Reassess every 4 hours and more often as patient condition/care plan /Nursing Clinical Standards/Unit Structure Standards indicate
   - Include Richmond Agitation Sedation Scale (RASS) score
2. Complete the following within one hour of assuming care of the patient:
   - Check for orders and tasks that are due on electronic health record (EHR):
     - Care Compass
     - Orders tab
     - Task List
     - Medication Administration Record (MAR)
   - Trace all lines from the bag to the patient and identify invasive lines including:
     - Solutions
     - Rate of infusion
     - Location of catheter
     - Type of catheter
     - All fluids are entered into Guardrails
   - Trace all tubes and drains and assess the following
     - Insertion site
     - External end of tube/drain (e.g. drainage bag, irrigation solution)
     - Characteristics and amount of drainage (as indicated)
   - Confirm correct dose/settings on infusion pumps for continuous medications/fluids
   - Confirm ventilator settings with orders
3. Weigh patient upon admission and daily (Peds: unless contraindicated, with physician's order)
4. Ensure patients are monitored throughout ICU/PCU admission.
   - Electrocardiogram (ECG) and oxygen saturation are minimum monitoring requirements
5. Monitor and record the following a minimum of every 2 hours:
   - Vital signs(VS) (BP, HR, RR)
   - Pain score
   - Oxygen saturation
   - Hemodynamic values (e.g. PAP, RA/CVP) as available
6. Obtain temperature a minimum of every 4 hours, every 2 hours Peds:
   - Every 2 hours if elevated/decreased (greater than 37.8°C/100°F, less than 36.1°C/ 97°F)
7. Assess skin condition (including around and under medical devices) a minimum of every 4 hours including:
   - Rash, petechiae
   - Redness, pressure injuries, skin breakdown
   - Sensory perception
   - Skin moisture
   - Activity, mobility
8. Post and interpret ECG and pressure waveform strips (e.g. Arterial line, CVP, ICP, PAP) within 2 hours of assuming care and whenever a change is noted. Measure ECG strip for (Except Peds):
   - PRI
   - QRS

- QTI

9. Assess I&O balance a minimum of every 8 hours
   - Assess, measure, and record NG aspirate a minimum of every 4 hours (except peds)
   - Determine and document drain output a minimum of every 8 hours
   - Measure and record urine output as follows:
     - Indwelling catheter: a minimum of every 2 hours (Peds: every 1 hour)
     - Condom/urinal/bedpan: every void
     - Weigh diapers with each diaper change (Peds)
10. Obtain lab studies as ordered.
    - Evaluate results when available
    - Notify physician of abnormal values (and document that physician was notified)

HYGIENE/ COMFORT:

11. Assess for pain at onset and for the effect of analgesic medications as given.
12. Provide mouth care (including suctioning) for patients who are intubated or who have decreased level of consciousness a minimum of every 4 hours.
    - Use suction toothbrush kit to brush teeth and tongue every 12 hours or suction swab if brushing causes discomfort / bleeding. Brush teeth for a minimum of 1 minute
    - Use suction swab every 4 hours in between toothbrush kit use
    - Use foam sponge dipped in chlorhexidine to cleanse mouth every 12 hours

    (patients greater than 2 years of age only) for intubated patients as ordered
13. Assist with/provide mouth care for all other patients every 8 hours /after meals.
14. Provide eye care to non-responsive patients a minimum of every 4 hours.
    - Cleanse eyelids
    - Ensure presence of physician's order for lubricant
    - Do not tape gauze/eye patch over eyes
15. Provide Foley/foreskin/peri-care a minimum of every 12 hours.
16. Consider using external devices for patients who are incontinent of urine:
    - External male catheter (condom) for adults and per provider order for adolescents:
      - Change catheter and perform pericare a minimum of daily
    - External female catheter (e.g. Purewick® refer to attachment) for adults:
      - Assess every 2 hours for proper placement, skin integrity and for need to replace
      - Top of gauze aligned with pubic bone, device tucked between labia and gluteus, urethra aligned approximately 1/3 down the length of the device
      - Replace and perform pericare a minimum of every 8-12 hours and when soiled with feces or blood
      - Ensure it is attached to continuous suction minimum of 40 mmHg
      - Remove before turning/rolling patient,when patient is on bedpan or out of bed to a commode, and then reapply
      - Remove when suction cannot be applied (e.g. when patient goes for a procedure or test), then apply a new Purewick® upon return.
17. Bathe patient and change linen a minimum of every 24 hours.
18. Replace routine bathing with 2% chlorhexidine (CHG) cloths (Adults in ICU only):
    - Within 24 hours of admission
    - Daily on night shift
    - Use cloths per Chlorhexidine Bath Nursing Procedure
19. Turn patient every 2 hours if patient unable to turn self.
20. Elevate head of bed greater than or equal to 30 degrees for patients on mechanical ventilation (unless contraindicated.)
21. Check all equipment and set parameters/alarms within 1 hour of assuming care and adjust as indicated by patient's condition.
    - Alarms must be audible at all times and are never to be set on continuous mute or turned off

SAFETY:

    - All monitors with non-functioning alarms must be reported immediately to Biomedical/Clinical Engineering
    - Set bed alarms on patients at risk for falls.
22. Remove monitor with non-functioning alarms from service immediately and place patient on a

monitor with functioning alarms.

23. Keep side rails up and call light within patient's reach at all times except while care is being provided.

COLLABORATION:

24. Participant in primary team rounds, if at all possible.
25. Be prepared to discuss patient's condition for additional rounds and handoff report including:
    - Patient's current diagnosis
    - Reason patient still needs to be in the ICU
    - Plan for the patient
    - Current status of discharge planning

REPORTABLE CONDITIONS:

26. Report significant changes in patient condition to provider including:
    - Significant changes in vital sign and assessment findings
    - Changes in assessments that may require higher level of care (PCU only)
    - Development of pressure injuries

PATIENT/ FAMILY TEACHING:

27. Instruct on the following:
    - Bed controls, call light, ID band
    - Hand hygiene/infection control
    - Fall precautions
    - Visiting and no-smoking policy
    - Meal times, nutritional support
    - Equipment/ alarms / procedures
    - Scheduled diagnostic tests and procedures
    - Discharge instructions including wound and pressure injury care

ADDITIONAL STANDARDS:

28. Refer to the following as indicated:
    - Arterial Line-ICU
    - Artificial Airway - ICU
    - Enteral Feeding and Medication Administration
    - Falls/Injury Prevention
    - Immobility
    - Indwelling Bladder Catheter
    - Intravenous Therapy
    - Mechanical Ventilation
    - Nasogastric Intubation for Decompression
    - Oxygen Therapy
    - Pain Management
    - Pressure Ulcer Prevention and Management
    - Pulmonary Artery Catheter- ICU
    - Restraints
    - Total Parenteral Nutrition (TPN)

DOCUMENTATION:

29. Document in accordance with documentation standards.
30. Document baseline assessment at the beginning of every shift, that reassessment was done a minimum of every 4 hours, and changes noted during reassessment.
    Exception:
    - Document that intravenous lines were "assessed" and "site condition" every 2 hours (Peds every hour)
    - Document assessment for pressure injuries and description of pressure ulcers every 4 hours, whether or not there is a change
    - Document neurological assessment when neurological assessment is required more often than every 4 hours (e.g. patient has intracranial pressure monitoring) whether or not there is change
    - Document additional data per unit protocol
31. Document on applicable areas of the Activities of Daily Living and Patient Safety Measures sections in iView) at the beginning of each shift. In addition, document:
    - When there are any changes (e.g. bed type change)
    - Care at the time it is provided (e.g. mouth care, bath, chlorhexidine bath, linen change, positioning, getting patient out of bed, indwelling bladder catheter care)

- Sequential compression devices when applied and when discontinued
- Orthotic boot /orthotic splints status when applied and when removed (per provider order)

32. Document data on iView and I&O sections (e.g. VS, drip titration, I&O)
33. Record the following on the ECG strip:
    - Patient name
    - MRN
    - Lead
    - PRI, QRS, QTI (except Peds)
    - Rate
    - Rhythm
34. Record the following on hemodynamic strips when available:
    - PAP systolic and diastolic
    - RA/CVP
    - ICP
    - PAWP
    - Arterial blood pressure systolic and diastolic

Initial date approved: 08/03	Reviewed and approved by: Critical Care Committee Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	Revision Date: 94, 95, 97, 99, 00, 08/03, 05/05, 05/08, 7/10, 8/13, 3/15, 05/16, 10/18, 03/19,07/19

Richmond Agitation Sedation Scale (RASS) *

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* (≥10 seconds)	Verbal Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* (<10 seconds)	Verbal Stimulation
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**	Verbal Stimulation
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice or physical* stimulation	Physical Stimulation

Procedure for RASS Assessment

1. Observe patient
   a. Patient is alert, restless, or agitated. **(score 0 to +4)**
2. If not alert, state patient's name and *say* to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. **(score –1)**
   c. Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   d. Patient has any movement in response to voice but no eye contact. **(score –3)**
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
   e. Patient has any movement to physical stimulation. **(score –4)**
   f. Patient has no response to any stimulation. **(score –5)**

* Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002; 166:1338-1344.

* Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation status over time in ICU patients: the reliability and validity of the Richmond Agitation Sedation Scale (RASS). JAMA 2003; 289:2983-2991.

Instructions for Use

PUREWICK
FEMALE EXTERNAL CATHETER

Setup:

1. Connect the canister to wall suction and set to recommended 40mmHg continuous suction. If using the DRYDOC™ Vacuum Station, connect the canister to the unit and turn the unit on. Please consult the DRYDOC™ Vacuum Station User Guide for further information.
2. Using standard suction tubing, connect the PUREWICK® Female External Catheter to the collection canister.

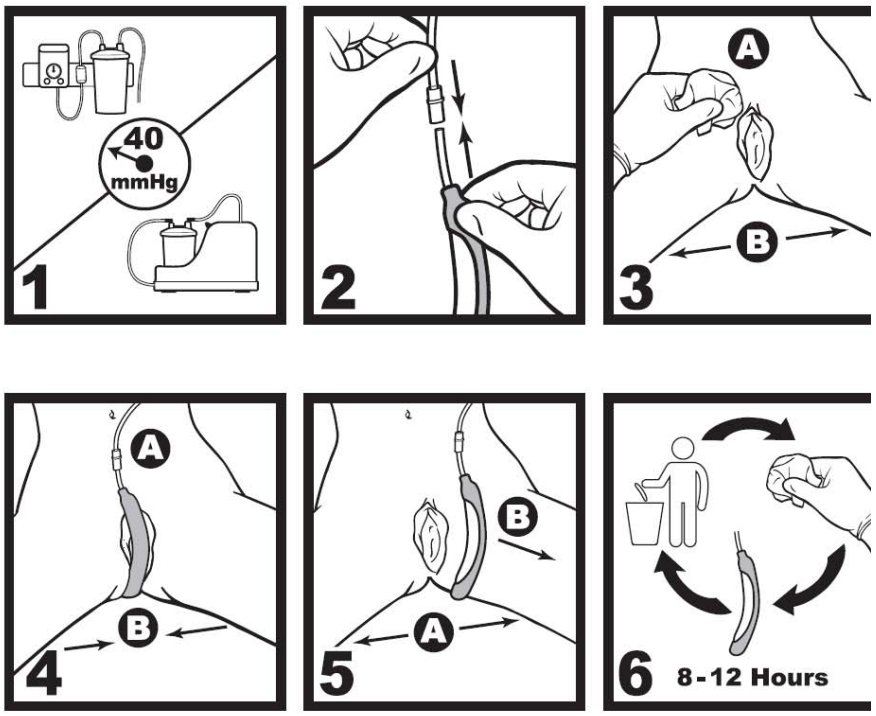
Peri-care and Placement:

3. Perform perineal care and assess skin integrity (document per hospital protocol). Separate legs, gluteus muscles, and labia. Palpate pubic bone as anatomical marker.
4. With soft gauze side facing patient, align distal end of the PUREWICK® Female External Catheter at gluteal cleft. Gently tuck soft gauze side between separated gluteus and labia. Ensure that the top of the gauze is aligned with the pubic bone. Slowly place legs back together once the PUREWICK® Female External Catheter is positioned.

Note: Patient can be positioned on back, side lying, frog legged, or lying on back with knees bent and thighs apart (lithotomy position) prior to device placement.

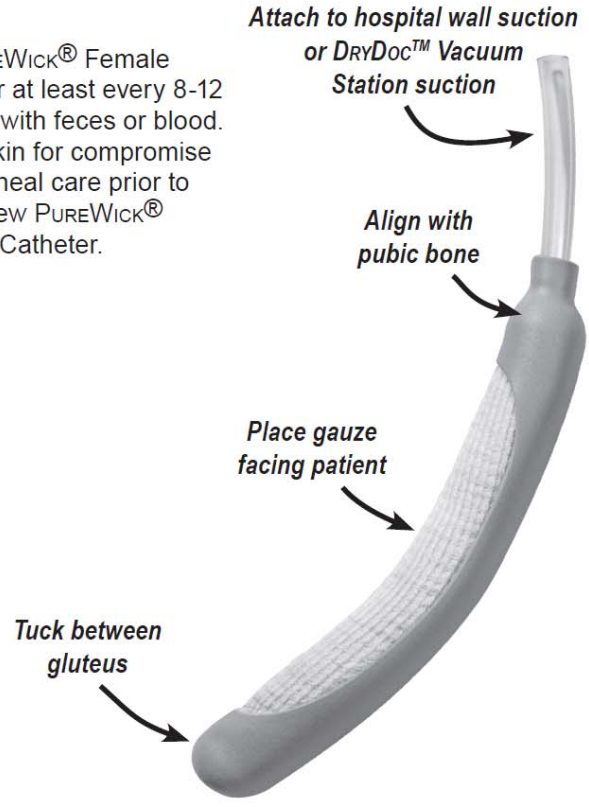
Removal:

5. To remove the PUREWICK® Female External Catheter, fully separate the legs, gluteus, and labia. To avoid potential skin injury upon removal, gently pull the PUREWICK® Female External Catheter directly outward. Ensure suction is maintained while removing the PUREWICK® Female External Catheter. After use, this product may be a potential biohazard. Dispose of in accordance with applicable local, state and federal laws and regulations.



Maintenance:

6. Replace the PUREWICK® Female External Catheter at least every 8-12 hours or if soiled with feces or blood. Always assess skin for compromise and perform perineal care prior to placement of a new PUREWICK® Female External Catheter.



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PUREWICK®

FEMALE EXTERNAL CATHETER

Indication for use:

EXTERNAL USE ONLY

The PUREWICK® Female External Catheter is intended for non-invasive urine output management in female patients.

Caution: This Product Contains Dry Natural Rubber

Contraindications:

- Patients with urinary retention

Warnings:

- Do not use the PUREWICK® Female External Catheter with bedpan or any material that does not allow for sufficient airflow.
- To avoid potential skin injury, never push or pull the PUREWICK® Female External Catheter against the skin during placement or removal.
- Never insert the PUREWICK® Female External Catheter into vagina, anal canal, or other body cavities.
- Discontinue use if an allergic reaction occurs.
- After use, this product may be a potential biohazard. Dispose of in accordance with applicable local, state and federal laws and regulations.

Precautions:

- Not recommended for patients who are:
  - Agitated, combative, or uncooperative and might remove the PUREWICK® Female External Catheter
  - Having frequent episodes of bowel incontinence without a fecal management system in place
  - Experiencing skin irritation or breakdown at the site
  - Experiencing moderate/heavy menstruation and cannot use a tampon
- Do not use barrier cream on the perineum when using the PUREWICK® Female External Catheter. Barrier cream may impede suction.
- Not recommended for use on patients with a known latex allergy.
- Proceed with caution in patients who have undergone recent surgery of the external urogenital tract.
- Always assess skin for compromise and perform perineal care prior to placement of a new PUREWICK® Female External Catheter.
- Maintain suction until the PUREWICK® Female External Catheter is fully removed from the patient to avoid urine backflow.

Recommendations:

- Perform each step with clean technique. In the home setting, wash hands thoroughly before device placement.
- Prior to connecting the PUREWICK® Female External Catheter to hospital wall suction tubing, verify suction function by covering the open end of the suction tubing with one hand and observing the pressure dial. If the pressure does not increase when the line is covered, verify that the tubing is secured, connected, and not kinked.
- Ensure the PUREWICK® Female External Catheter remains in the correct position after turning the patient. Remove the PUREWICK® Female External Catheter prior to ambulation.
- Properly placing the PUREWICK® Female External Catheter snugly between the labia and gluteus holds the PUREWICK® Female External Catheter in place for most patients. Mesh underwear may be useful for securing the PUREWICK® Female External Catheter for some patients.
- Assess device placement and patient's skin at least every 2 hours.
- Replace the PUREWICK® Female External Catheter every 8-12 hours or when soiled with feces or blood.
- Change suction tubing per hospital protocol or at least every thirty (30) days.

Units	**This Product Contains Dry Natural Rubber**
2 Single Use	NON STERILE Non-sterile
REF Catalog number	Do not use if package is damaged
LOT Lot number	Use by date

Manufacturer:
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2030 Gillespie Way, Suite 109
El Cajon, CA 92020
Toll Free: (844) 584-0734
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