PROTOCOL FOR: **Admission: Care of the Patient Admitted to the Adult Intensive Care Unit**

DESIRED PATIENT OUTCOME:

1. Admission assessment, reassessments and documentation will occur within an appropriate time frame.

2. Patient and family will verbalize knowledge and understanding of ICU stay and needs.

CLINICAL ASSESSMENT AND CARE:

1. Patient Care:

   a. An initial head to toe assessment will be performed on each patient within 30 minutes of admission and at the beginning of each shift. System reassessment may then be performed every 2 to 4 hours, or more frequently according to RN's discretion and patient condition.

   b. A Care Plan and Patient and Family Teaching Record will be formulated for each patient upon admission.

   c. If the patient is a new admission, complete the Inpatient Database.

2. Noninvasive Monitoring:

   a. All patients will be attached to a bedside monitor at all times, unless otherwise ordered. Lead II is the usual standard monitoring lead. An alternate lead may be selected per RN discretion and patient condition.

   b. An EKG strip will be placed on the ICU flowsheet every shift, with analysis of PR, QRS and QT intervals recorded on the strip. If there is a change in rhythm during shift – a strip of the change will be documented on the flowsheet or in the progress notes.

   c. Monitor alarms will be "ON" at all times, unless the nurse is in attendance at the patient's bedside when the alarms are suspended.

3. Vital Signs:

   a. Vital signs including HR, RR and BP will be taken every 2 hours, or at RN's discretion and as per patient status.

   b. See Hemodynamic Monitoring Protocol for frequency of readings.

   c. Temperature will be taken every 4 hours or more frequently at RN's discretion.

   d. Intake and output will be recorded every 2 hours unless otherwise ordered or at the nurse's discretion depending on patient status.

   e. Daily weights will be obtained on each patient unless there is an MD/LIP order <u>NOT</u> to do so.

4. IV Access:

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a. All patients admitted will have IV access. An MD/LIP order must be written for IV fluids or if there is a specific reason for not inserting an IV access.

b. If pressor drips or continuous medications are infusing IV, it is preferred the patient have an additional IV access in the event emergency medications are needed.

5. Activity:

    a. Patient will be on bedrest, unless otherwise ordered.

6. Diet:

    a. A diet will be ordered by MD/LIP.

7. Patient Teaching:

    a. All patients, family or significant others will be given an orientation to the ICU. Explanation of visiting hours, specific policies will be provided at that time.

    b. Patients will be informed re: the need for frequent assessments. Need for patient communication of his/her needs should also be emphasized at that time.

DOCUMENTATION:

1. Document assessments and interventions on the ICU unit flowsheet, database, MARs and Patient and Family Teaching Records.

2. Document patient response in progress notes as per unit/department standards.

APPROVALS: ICU Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 2/88

REVISION DATES: 2/90, 9/90, 1/92, 1/93, 1/95, 5/97, 3/00, 6/00, 4/09