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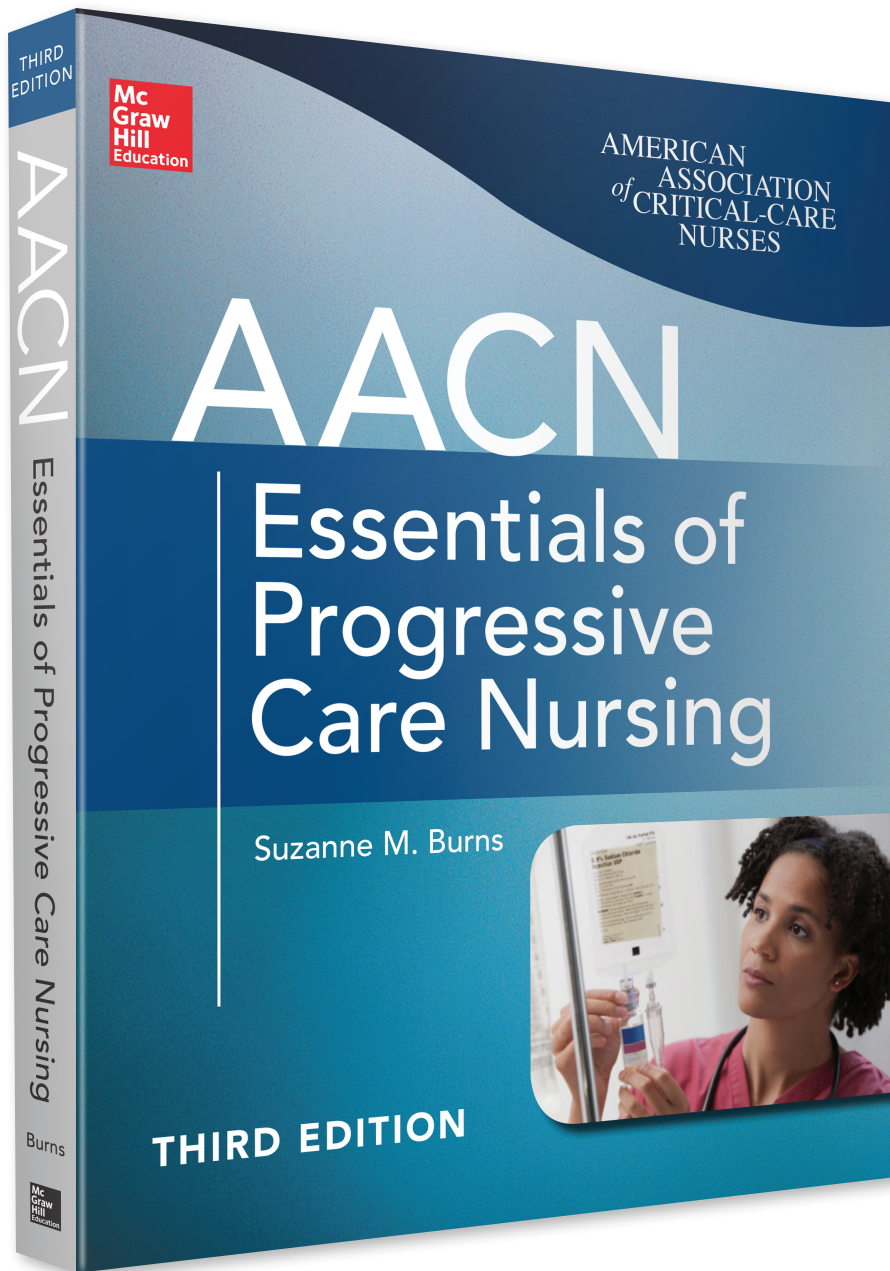
Essentials of Progressive Care Nursing

Suzanne M. Burns

THIRD EDITION



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AACN Essentials of Progressive Care Nursing

Third Edition

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Preface

Progressive care nursing is a complex, challenging area of nursing practice, where clinical expertise is developed over time by integrating progressive care knowledge, clinical skills, and caring practices. This textbook, the first to specifically address the educational needs of the new progressive care practitioner, succinctly presents essential information about how best to safely and competently care for acutely ill patients and their families.

As it has since the first edition, the American Association of Critical-Care Nurses reaffirms this book's value to the AACN community and especially to clinicians at the point of care. The title continues to carry AACN's name, as it has since the first edition.

AACN Essentials of Progressive Care Nursing provides essential information on the care of adult acutely ill patients and families. The book recognizes the learner's need to assimilate foundational knowledge before attempting to master more complex progressive care nursing concepts. Written by nationally acknowledged clinical experts in critical and acute care nursing, this textbook sets the standard for progressive care nursing education.

AACN Essentials of Progressive Care Nursing:

- Succinctly presents essential information for the safe and competent care of progressive care patients and their families, building on the clinician's significant medical-surgical nursing knowledge base, avoiding repetition of previously acquired information
- Stages the introduction of advanced concepts in progressive care nursing after essential concepts have been mastered
- Provides clinicians with clinically relevant tools and guides to use as they care for progressive care patients and families

The AACN Essentials of Progressive Care Nursing is divided into four parts:

- *Part I: The Essentials* presents essential information that clinicians must understand to provide safe, competent nursing care to the majority of progressive

care patients, regardless of their underlying medical diagnoses. This part includes content on essential concepts of assessment, diagnosis, planning, and interventions common to progressive care patients and families; interpretation and management of cardiac rhythms; hemodynamic monitoring; airway and ventilatory management; pain and sedation management; pharmacology; and ethical and legal considerations. Chapters in Part I present content in enough depth to ensure that essential information is available for the new progressive care clinician to develop competence, while sequencing pathological conditions in Part II and advanced content in a later part of the book (Part III).

- *Part II: Pathologic Conditions* covers pathologic conditions and management strategies commonly encountered in progressive care, closely paralleling the blueprint for the PCCN certification examination. Chapters in this part are organized by body systems and selected progressive care conditions (cardiovascular, respiratory, multisystem, neurologic, hematologic and immune, gastrointestinal, renal, endocrine, and trauma).
- *Part III: Advanced Concepts in Caring for the Progressive Care Patient* presents advanced progressive care concepts or pathologic conditions that are more complex and represent expert level information. Specific advanced chapter content includes ECG concepts, cardiovascular concepts, and neurologic concepts.
- *Part IV: Key Reference Information* contains reference information that clinicians will find helpful in the clinical area (normal laboratory and diagnostic values; algorithms for advanced cardiac life support; and summary tables of progressive care drugs and cardiac rhythms). Content is presented primarily in table format for quick reference.

Each chapter in Part I, II, and III, begins with "Knowledge Competencies" that can be used to guide informal or formal teaching and to gauge the learner's progress. In addition,

each of the chapters provide “Essential Content Case” studies that focus on key information presented in the chapters in order to assist clinicians in understanding the chapter content and how to best assess and manage conditions and problems encountered in progressive care. The case studies also are designed to enhance the learners understanding of the magnitude of the pathologic problems/conditions and their impact on patients and families. Questions and answers are provided for each case so the learner may test his/her knowledge of the essential content.

I believe that there is no greater way to protect our patients than to ensure that an educated clinician cares for them. Safe passage in progressive care is ensured by competent, skilled, knowledgeable, and caring clinicians. I sincerely believe that this textbook will help you make it so!

Suzi Burns

THE ESSENTIALS



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ASSESSMENT OF PROGRESSIVE CARE PATIENTS AND THEIR FAMILIES

1

Mary Fran Tracy

KNOWLEDGE COMPETENCIES

1. Discuss the importance of a consistent and systematic approach to assessment of progressive care patients and their families.
 - Comprehensive initial assessment
 - Ongoing assessment
2. Identify the assessment priorities for different stages of an acute illness:
 - Prearrival assessment
 - Arrival quick check
3. Describe how the assessment is altered based on the patient's clinical status.

The assessment of acutely ill patients and their families is an essential competency for progressive care practitioners. Information obtained from an assessment identifies the immediate and future needs of the patient and family so a plan of care can be initiated to address or resolve these needs.

Traditional approaches to patient assessment include a complete evaluation of the patient's history and a comprehensive physical examination of all body systems. This approach is ideal, though progressive care clinicians must balance the need to gather data while simultaneously prioritizing and providing care to acutely ill patients who may either be improving or decompensating. Traditional approaches and techniques for assessment must be modified in progressive care to balance the need for information, while considering the acute nature of the patient and family's situation.

This chapter outlines an assessment approach that recognizes the dynamic nature of an acute illness. This approach emphasizes the collection of assessment data in a phased or staged manner consistent with patient care priorities. The components of the assessment can be used as a generic template for assessing most progressive care patients and families. The assessment can then be individualized by adding more specific assessment requirements depending on the

specific patient diagnosis. These specific components of the assessment are identified in subsequent chapters.

Crucial to developing competence in assessing progressive care patients and their families is a consistent and systematic approach to assessments. Without this approach, it would be easy to miss subtle signs or details that may identify an actual or potential problem and also indicate a patient's changing status. Assessments should focus first on the patient, then on the technology. The patient needs to be the focal point of the progressive care practitioner's attention, with technology augmenting the information obtained from the direct assessment.

There are two standard approaches to assessing patients—the head-to-toe approach and the body systems approach. Most progressive care nurses use a combination—a systems approach applied in a top-to-bottom manner. The admission and ongoing assessment sections of this chapter are presented with this combined approach in mind.

ASSESSMENT FRAMEWORK

Assessing the progressive care patient and family begins from the moment the nurse is made aware of the pending admission or transfer of the patient and continues until transitioning to

the next phase of care. The assessment process can be viewed as four distinct stages: (1) prearrival, (2) arrival quick check (“just the basics”), (3) comprehensive initial assessment, and (4) ongoing assessment.

Prearrival Assessment

Patients admitted to a progressive care unit may be transitioning from a more intensive level of care, as they become more stable and improve in condition. Conversely, they may be transferred from a lower level of care, as their physiologic status may be deteriorating. In either case, the progressive care patient has the potential to have a rapid change in status. A prearrival assessment begins the moment the information is received about the upcoming admission of the patient to the progressive care unit. This notification comes from the initial healthcare team contact. The contact may be a transfer from another facility or a transfer from other areas within the hospital such as the emergency room, operating room, the intensive care unit (ICU), or medical/surgical nursing unit. The prearrival assessment paints the initial picture of the patient and allows the progressive care nurse to begin anticipating the patient’s physiologic and psychological needs. This assessment also allows the progressive care nurse to determine the appropriate resources that are needed to care for the patient. The information received in the prearrival phase is crucial because it allows the progressive care nurse to adequately prepare the environment to meet the specialized needs of the patient and family.

Arrival Quick Check

An arrival quick check assessment is obtained immediately upon arrival and is based on assessing the parameters represented by the ABCDE acronym (Table 1-1). The arrival quick check assessment is a quick overview of the adequacy of ventilation and perfusion to ensure early intervention for any life-threatening situations. The arrival quick check is a high-level view of the patient, but is essential because it validates that basic cardiac and respiratory function is sufficient, and can be used as a baseline for potential future changes in a condition.

Comprehensive Initial Assessment

A comprehensive assessment is performed as soon as possible, with the timing dictated by the degree of physiologic stability and emergent treatment needs of the patient. If the patient is being admitted directly to the progressive care unit from outside the hospital, the comprehensive assessment is

an in-depth assessment of the past medical and social history and a complete physical examination of each body system. If the patient is being transferred to the progressive care unit from another area in the hospital, the comprehensive assessment includes a review of the admission assessment data and comparison to the current assessment of the patient. The comprehensive assessment is vital to successful outcomes because it provides the nurse invaluable insight into proactive interventions that may be needed.

Ongoing Assessment

After the baseline comprehensive assessment is completed, ongoing assessments—an abbreviated version of the comprehensive assessment—are performed at varying intervals. The assessment parameters outlined in this section are usually completed for all patients, in addition to other ongoing assessment requirements related to the patient’s specific condition, treatments, and response to therapy.

Patient Safety Considerations in Admission Assessments

Admission of an acutely ill patient can be a chaotic event with multiple disciplines involved in many activities. It is at this time, however, that health-care providers must be particularly cognizant of accurate assessments and data gathering to ensure the patient is cared for safely with appropriate interventions. Obtaining inaccurate information on admission can lead to ongoing errors that may not be easily rectified or discovered and lead to poor patient outcomes.

Obtaining information from an acutely ill patient may be difficult, if possible at all. If the patient is unable to supply information, other sources must be utilized such as family members, electronic health records (EHRs), past medical records, transport records, or information from the patient’s belongings. Of particular importance at admission is obtaining accurate patient identification, as well as past medical history including any known allergies. Current medication regimens are extremely helpful if feasible, as they can provide clues to the patient’s medical condition and perhaps contributing factors to the current condition.

With the increasing use of EHRs, there are improving opportunities for timely access to past and current medical history information of patients. Healthcare providers may have access to both inpatient and outpatient records within the same healthcare system, assisting them to quickly identify the patient’s most recent medication regimen and laboratory and diagnostic results. In addition, many healthcare systems within the same geographic locations are working together to make available intersystem access to medical records of patients being treated at multiple healthcare institutions. This is particularly beneficial when patients are unable to articulate imperative medical information including advance directives, allergies, and next of kin.

Careful physical assessment on admission to the progressive care unit is pivotal for providing prevention and/or early treatment for complications associated with the illness.

TABLE 1-1. ABCDE ACRONYM

| |
|--|
| Airway |
| Breathing |
| Circulation, Cerebral perfusion, and Chief complaint |
| Drugs and Diagnostic tests |
| Equipment |

Of particular importance is the assessment of risk for pressure ulcer formation, alteration in mental status, and/or falls. Risks associated with accurate patient identification never lessen, particularly as these relate to interventions such as performing invasive procedures, medication administration, blood administration, and obtaining laboratory tests. Nurses need to be cognizant of safety issues as treatment begins as well; for example, accurate programming of pumps infusing high-risk medications is essential. It is imperative that nurses use all safety equipment available to them such as pre-programmed drug libraries in infusion pumps and bar coding technology. Healthcare providers must also ensure the safety of invasive procedures that may be performed emergently.

PREARRIVAL ASSESSMENT: BEFORE THE ACTION BEGINS

A prearrival assessment begins when information is received about the pending arrival of the patient. The prearrival report, although abbreviated, provides key information about the chief complaint, diagnosis, or reason for admission, pertinent history details, and physiologic stability of the patient (Table 1-2). It also contains the gender and age of the patient and information on the presence of invasive tubes and lines, medications being administered, other

TABLE 1-2. SUMMARY OF PREARRIVAL AND ARRIVAL QUICK CHECK ASSESSMENTS

| |
|---|
| <p>Prearrival Assessment</p> <ul style="list-style-type: none"> Abbreviated report on patient (age, gender, chief complaint, diagnosis, allergies pertinent history, physiologic status, invasive devices, equipment, and status of laboratory/diagnostic tests) Complete room setup, including verification of proper equipment functioning <p>Admission Quick Check Assessment</p> <ul style="list-style-type: none"> General appearance (consciousness) Airway: <ul style="list-style-type: none"> Patency Position of artificial airway (if present) such as tracheostomy Breathing: <ul style="list-style-type: none"> Quantity and quality of respirations (rate, depth, pattern, symmetry, effort, use of accessory muscles) Breath sounds Presence of spontaneous breathing Circulation and Cerebral Perfusion: <ul style="list-style-type: none"> ECG (rate, rhythm, and presence of ectopy) Blood pressure Peripheral pulses and capillary refill Skin color, temperature, moisture Presence of bleeding Level of consciousness, responsiveness Chief Complaint: <ul style="list-style-type: none"> Primary body system Associated symptoms Drugs and Diagnostic Tests: <ul style="list-style-type: none"> Drugs prior to admission (prescribed, over-the-counter, illicit) Current medications Review diagnostic test results Equipment: <ul style="list-style-type: none"> Patency of vascular and drainage systems Appropriate functioning and labeling of all equipment connected to patient |
|---|

TABLE 1-3. EQUIPMENT FOR STANDARD ROOM SETUP

| |
|--|
| <ul style="list-style-type: none"> Bedside ECG or telemetry monitoring and invasive pressure monitor with appropriate cables ECG electrodes Blood pressure cuff Pulse oximetry Suction gauges and canister setup Suction catheters Bag valve mask device Oxygen flow meter, appropriate tubing, and appropriate oxygen delivery device IV poles and infusion pumps Bedside supply cart that contains such things as alcohol swabs, nonsterile gloves, syringes, chux, and dressing supplies Admission kit that usually contains bath basin and general hygiene supplies (if direct admission) Admission and progressive care paper and/or electronic documentation forms |
|--|

ongoing treatments, and pending or completed laboratory or diagnostic tests. It is also important to consider the potential isolation requirements for the patient (eg, neutropenic precautions or special respiratory isolation). Being prepared for isolation needs prevents potentially serious exposures to the patient, roommates, or the healthcare providers. This information assists the clinician in anticipating the patient's physiologic and emotional needs prior to admission or transfer and in ensuring that the bedside environment is set up to provide all monitoring, supply, and equipment needs prior to the patient's arrival.

Many progressive care units have a standard room setup, guided by the major diagnosis-related groups of patients each unit receives. The standard monitoring and equipment list for each unit varies; however, there are certain common requirements (Table 1-3). The standard room setup is modified for each admission to accommodate patient-specific needs (eg, additional equipment, intravenous [IV] fluids, medications). Proper functioning of all bedside equipment should be verified prior to the patient's arrival.

It is also important to prepare the medical records forms, which usually consist of paper flow sheets or computerized data entry system to record vital signs, intake and output, medication administration, patient care activities, and patient assessment. The prearrival report may suggest pending procedures, necessitating the organization of appropriate supplies at the bedside. Having the room prepared and all equipment available facilitates a rapid, smooth, and safe admission of the patient.

ARRIVAL QUICK CHECK ASSESSMENT

From the moment the patient arrives in the progressive care unit setting, his or her general appearance is immediately observed and assessment of ABCDEs is quickly performed (see Table 1-1). The seriousness of the problem(s) is determined so any urgent needs can be addressed first. The patient is connected to the appropriate monitoring and support equipment, medications being administered are verified,

ESSENTIAL CONTENT CASE

Prearrival Assessment

The charge nurse notifies Sue that she will be receiving a 26-year-old man from the ICU who was involved in a serious car accident 14 days ago. The ICU nurse caring for the patient has called to give Sue a report following the hospital's standardized report format.

Case Question 1: What basic information will Sue want to know from the pre-arrival communication with the ICU nurse?

Case Question 2: What patient issues are likely to need immediate assessment and/or intervention on arrival to the progressive care unit in order to ensure the appropriate equipment is set up in the room?

Case Question 3: What information should be included in the more formal handoff between the ICU nurse and Sue after the patient is settled in his room in the Progressive Care Unit?

Answers

1. Patient name/age, type and date of accident, extent of accident injuries, pertinent medical history, allergies, vital signs and significant assessment information, placement of lines and tubes, medications being administered, significant laboratory results, anticipated plan for care and discharge plan, presence of family, and any other special instructions.

The patient suffered a closed head injury and chest trauma with collapsed left lung. The patient had been intubated and placed on a mechanical ventilator. The patient had developed pneumonia when in the ICU and though he now exhibited stable oxygenation, a tracheostomy was required to manage copious secretions. He had now been weaned off the ventilator and was requiring 30% FiO₂. A central line with a central venous pressure (CVP) setup and a left chest tube to water seal were in place. Sue questions the critical care nurse regarding whether the patient has been agitated, his level of consciousness (LOC) and neuro deficits, if a Foley catheter or nasogastric tube is present, and whether the family has been notified of the transfer to the progressive care unit.

2. Vital signs, neurologic status, the tracheostomy and oxygen requirements of the patient, medications are appropriately infusing and whether the patient is agitated or experiencing extensive pain.

Sue goes to check the patient's room prior to admission and begins to do a mental check of what will be needed. "The patient has a tracheostomy so I'll connect the AMBU bag to the oxygen source, check for suction catheters, and make sure the suction systems are working. The pulse oximetry is ready to use. I'll also ensure the telemetry pack has fully charged batteries and have the ECG electrodes ready to apply. The CVP line flush system and transducer are also ready to be connected. The IV infusion devices are set up. This patient has an altered LOC, which means frequent neuro checks. I have my pen light handy. The computer in the room is on and ready for me to begin documentation. I think I'm ready."

3. Using an SBAR format, the ICU nurse can give more detailed information about the injuries from the car accident, the patient's complete medical history as

known, reiteration of known allergies, a system by system assessment review, significant diagnostic test results, confirmation of all invasive lines and equipment settings, the anticipated plan for ongoing assessments, interventions, and discharge planning, and any pertinent family information. Sue should also have an opportunity to ask any clarifying questions she might have.

and essential laboratory and diagnostic tests are ordered. Simultaneously with the ABCDE assessment, the patient's nurse must validate that the patient is appropriately identified through a hospital wristband, personal identification, or family identification. In addition, the patient's allergy status is verified, including the type of reaction that occurs and what, if any, treatment is used to alleviate the allergic response.

There may be other healthcare professionals present to receive the patient and assist with arrival tasks. The progressive care nurse, however, is the leader of the receiving team. While assuming the primary responsibility for assessing the ABCDEs, the progressive care nurse directs the team in completing delegated tasks, such as changing over to the unit equipment or attaching monitoring cables. Without a leader of the receiving team, care can be fragmented and vital assessment clues overlooked.

The progressive care nurse rapidly assesses the ABCDEs in the sequence outlined in this section. If any aspect of this preliminary assessment deviates from normal, interventions are immediately initiated to address the problem before continuing with the arrival quick check assessment. Additionally, regardless of whether the patient appears to be conscious or not, it is important to talk to him or her throughout this admission process regarding what is occurring with each interaction and intervention.

Airway and Breathing

Patency of the patient's airway is verified by having the patient speak, watching the patient's chest rise or fall, or both. If the airway is compromised, verify that the head has been positioned properly to prevent the tongue from occluding the airway. Inspect the upper airway for the presence of blood, vomitus, and foreign objects before inserting an oral airway if one is needed. If the patient already has an artificial airway, such as a cricothyrotomy or tracheostomy, ensure that the airway is secured properly. Note the position of the tracheostomy and size marking to assist future comparisons for proper placement. Suctioning of the upper airway, either through the oral cavity or artificial airway, may be required to ensure that the airway is free from secretions. Note the amount, color, and consistency of secretions removed.

Note the rate, depth, pattern, and symmetry of breathing; the effort it is taking to breathe; the use of accessory muscles; and, if mechanically ventilated, whether breathing

is in synchrony with the ventilator. Observe for nonverbal signs of respiratory distress such as restlessness, anxiety, or change in mental status. Auscultate the chest for presence of bilateral breath sounds, quality of breath sounds, and bilateral chest expansion. Optimally, both anterior and posterior breath sounds are auscultated, but during this arrival quick check assessment, time generally dictates that just the anterior chest is assessed. If noninvasive oxygen saturation monitoring is available, observe and quickly analyze the values.

If chest tubes are present, note whether they are pleural or mediastinal chest tubes. Ensure that they are connected to suction, if appropriate, and are not clamped or kinked. Assess whether they are functioning properly (eg, airleak, fluid fluctuation with respirations) and the amount and character of the drainage.

Circulation and Cerebral Perfusion

Assess circulation by quickly palpating a pulse and viewing the electrocardiogram (ECG) and monitor for the heart rate, rhythm, and presence of ectopy if ECG monitoring is ordered. Obtain blood pressure and temperature. Assess peripheral perfusion by evaluating the color, temperature, and moisture of the skin along with capillary refill. Based on the prearrival report and reason for admission, there may be a need to inspect the body for any signs of blood loss and determine if active bleeding is occurring.

Evaluating cerebral perfusion in the arrival quick check assessment is focused on determining the functional integrity of the brain as a whole, which is done by rapidly evaluating the gross LOC. Evaluate whether the patient is alert and aware of his or her surroundings, whether it takes a verbal or painful stimulus to obtain a response, or whether the patient is unresponsive. Observing the response of the patient during movement from the stretcher to the progressive care unit bed can supply additional information about the LOC. Note whether the patient's eyes are open and watching the events around him or her; for example, does the patient follow simple commands such as "Place your hands on your chest" or "Slide your hips over"? If the patient is unable to talk because of trauma or the presence of an artificial airway, note whether his or her head nods appropriately to questions.

Chief Complaint

Optimally, the description of the chief complaint is obtained from the patient, but this may not be realistic. The patient may be unable to respond or may not speak English. Data may need to be gathered from family, friends, or bystanders, or from the completed admission database if the patient has been transferred from another area in the hospital. If the patient or family cannot speak English, an approved hospital translator should be contacted to help with the interview and subsequent evaluations and communication. It is not advised to use family or friends to translate for a non-English speaking patient for reasons such as protection of the

patient's privacy, the likelihood that family will not understand appropriate medical terminology for translation, and to avoid well-intentioned but potential bias in translating back and forth for the patient.

In the absence of a history source, practitioners must depend exclusively on the physical findings (eg, presence of medication patches, permanent pacemaker, or old surgery scars), knowledge of pathophysiology, and access to prior paper or electronic medical records to identify the potential causes of the admission.

Assessment of the chief complaint focuses on determining the body systems involved and the extent of associated symptoms. Additional questions explore the time of onset, precipitating factors, and severity. Although the arrival quick check phase is focused on obtaining a quick overview of the key life-sustaining systems, a more in-depth assessment of a particular system may need to be done at this time; for example, in the prearrival case study scenario presented, completion of the ABCDEs is followed quickly by more extensive assessment of both the nervous and respiratory systems.

Drugs and Diagnostic Tests

Information about infusing medications and diagnostic tests is integrated into the priority of the arrival quick check. If IV access is not already present, it should be immediately obtained and intake and output records started. If IV medications are presently being infused, check the drug(s) and verify the correct infusion of the desired dosage and rate.

Determine the latest results of any diagnostic tests already performed. Augment basic screening tests (Table 1-4) with additional tests appropriate to the underlying diagnosis, chief complaint, transfer status, and recent procedures. Review any available laboratory or diagnostic data for abnormalities or indications of potential problems that may develop. The abnormal laboratory and diagnostic data for specific pathologic conditions will be covered in subsequent chapters.

Equipment

Quickly evaluate all vascular and drainage tubes for location and patency, and connect them to appropriate monitoring or suction devices. Note the amount, color, consistency, and odor of drainage secretions. Verify the appropriate functioning of all equipment attached to the patient and label as required. While connecting the monitoring and care equipment, it is important for the nurse to continue assessing the patient's respiratory and cardiovascular status until it is clear

TABLE 1-4. COMMON DIAGNOSTIC TESTS OBTAINED DURING ARRIVAL QUICK CHECK ASSESSMENT

| |
|-------------------------------------|
| Serum electrolytes |
| Glucose |
| Complete blood count with platelets |
| Coagulation studies |
| Chest x-ray |
| ECG |

that all equipment are functioning appropriately and can be relied on to transmit accurate patient data.

The arrival quick check assessment is accomplished in a matter of a few minutes. After completion of the ABCDEs assessment, the comprehensive assessment begins. If at any phase during the arrival quick check a component of the ABCDEs has not been stabilized and controlled, energy is focused first on resolving the abnormality before proceeding to the comprehensive admission assessment.

After the arrival, quick check assessment is complete, and if the patient requires no urgent intervention, there may now be time for a more thorough report from the healthcare providers transferring the patient to the progressive care unit. It is important to note that handoffs with transitions of care are possible intervals when safety gaps may occur. Omission of pertinent information or miscommunication at this critical juncture can result in patient care errors. Use of a standardized handoff format—such as the “SBAR” format which includes communication of the **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendations—can minimize the potential for miscommunication. Use the handoff as an opportunity to confirm your observations such as dosage of infusing medications, abnormalities found on the quick check assessment, and any potential inconsistencies noted between your assessment and the prearrival report. It is easier to clarify questions while the transporters are still present, if possible.

This may also be an opportunity for introductory interactions with family members or friends, if present. Introduce yourself, offer reassurance, and confirm the intention to give the patient the best care possible (Table 1-5). If feasible, allow them to stay with the patient in the room during the arrival process. If this is not possible, give them an approximate time frame when they can expect to receive an update from you on the patient’s condition. Have another member of the healthcare team escort them to the appropriate waiting area.

COMPREHENSIVE INITIAL ASSESSMENT

Comprehensive assessments determine the physiologic and psychosocial baseline so that future changes can be compared to determine whether the status is improving or deteriorating.

TABLE 1-5. EVIDENCE-BASED PRACTICE: FAMILY NEEDS ASSESSMENT

| |
|---|
| <p>Quick Assessment</p> <ul style="list-style-type: none"> • Offer realistic hope • Give honest answers and information • Give reassurance <p>Comprehensive Assessment</p> <ul style="list-style-type: none"> • Use open-ended communication and assess their communication style • Assess family members’ level of anxiety • Assess perceptions of the situation (knowledge, comprehension, expectations of staff, expected outcome) • Assess family roles and dynamics (cultural and religious practices, values, spokesperson) • Assess coping mechanisms and resources (what do they use, social network and support) |
|---|

The comprehensive assessment also defines the patient’s prevent health status, determining problems or limitations that may impact patient status during this admission as well as potential issues for future transitioning of care. The content presented in this section is a template to screen for abnormalities or determine the extent of injury or disease. Any abnormal findings or changes from baseline warrant a more in-depth evaluation of the pertinent system.

The comprehensive assessment includes the patient’s medical and brief social history, and physical examination of each body system. The comprehensive assessment of the progressive care patient is similar to admission assessments for medical-surgical patients. This section describes only those aspects of the assessment that are unique to progressive care patients or require more extensive information than is obtained from a medical-surgical patient. The entire assessment process is summarized in Tables 1-6 and 1-7.

Changing demographics of progressive care units indicate that an increasing proportion of patients are elderly,

TABLE 1-6. SUMMARY OF COMPREHENSIVE INITIAL ASSESSMENT REQUIREMENTS

| |
|---|
| <p>Past Medical History</p> <ul style="list-style-type: none"> • Medical conditions, surgical procedures • Psychiatric/emotional problems • Hospitalizations • Medications (prescription, over-the-counter, illicit drugs) and time of last medication dose • Allergies • Review of body systems (see Table 1-7) <p>Social History</p> <ul style="list-style-type: none"> • Age, gender • Ethnic origin • Height, weight • Highest educational level completed • Occupation • Marital status • Primary family members/significant others/decision makers • Religious affiliation • Advance Directive and Durable Power of Attorney for Health Care • Substance use (alcohol, drugs, caffeine, tobacco) • Domestic Abuse or Vulnerable Adult Screen <p>Psychosocial Assessment</p> <ul style="list-style-type: none"> • General communication • Coping styles • Anxiety and stress • Expectations of progressive care unit • Current stresses • Family needs <p>Spirituality</p> <ul style="list-style-type: none"> • Faith/spiritual preference • Healing practices <p>Physical Assessment</p> <ul style="list-style-type: none"> • Nervous system • Cardiovascular system • Respiratory system • Renal system • Gastrointestinal system • Endocrine, hematologic, and immune systems • Integumentary system |
|---|

TABLE 1-7. SUGGESTED QUESTIONS FOR REVIEW OF PAST HISTORY CATEGORIZED BY BODY SYSTEM

| Body System | History Questions |
|------------------|---|
| Nervous | <ul style="list-style-type: none"> • Have you ever had a seizure? • Have you ever fainted, blacked out, or had delirium tremens (DTs)? • Do you ever have numbness, tingling, or weakness in any part of your body? • Do you have any difficulty with your hearing, vision, or speech? • Has your daily activity level changed due to your present condition? • Do you require any assistive devices such as canes? |
| Cardiovascular | <ul style="list-style-type: none"> • Have you experienced any heart problems or disease such as heart attacks or strokes? • Do you have any problems with extreme fatigue? • Do you have an irregular heart rhythm? • Do you have high blood pressure? • Do you have a pacemaker or an implanted defibrillator? |
| Respiratory | <ul style="list-style-type: none"> • Do you ever experience shortness of breath? • Do you have any pain associated with breathing? • Do you have a persistent cough? Is it productive? • Have you had any exposure to environmental agents that might affect the lungs? • Do you have sleep apnea? |
| Renal | <ul style="list-style-type: none"> • Have you had any change in frequency of urination? • Do you have any burning, pain, discharge, or difficulty when you urinate? • Have you had blood in your urine? |
| Gastrointestinal | <ul style="list-style-type: none"> • Has there been any recent weight loss or gain? • Have you had any change in appetite? • Do you have any problems with nausea or vomiting? • How often do you have a bowel movement and has there been a change in the normal pattern? Do you have blood in your stools? • Do you have dentures? • Do you have any food allergies? |
| Integumentary | <ul style="list-style-type: none"> • Do you have any problems with your skin? |
| Endocrine | <ul style="list-style-type: none"> • Do you have any problems with bleeding? |
| Hematologic | <ul style="list-style-type: none"> • Do you have problems with chronic infections? |
| Immunologic | <ul style="list-style-type: none"> • Have you recently been exposed to a contagious illness? |
| Psychosocial | <ul style="list-style-type: none"> • Do you have any physical conditions, which make communication difficult (hearing loss, visual disturbances, language barriers, etc)? • How do you best learn? Do you need information repeated several times and/or require information in advance of teaching sessions? • What are the ways you cope with stress, crises, or pain? • Who are the important people in your family or network? • Who do you want to make decisions with you, or for you? • Have you had any previous experiences with acute illness? • Have you ever been abused? • Have you ever experienced trouble with anxiety, irritability, being confused, mood swings, or suicidal attempts? • What are the cultural practices, religious influences, and values that are important to you or your family? • What are family members' perceptions and expectations of the progressive care staff and the setting? |
| Spiritual | <ul style="list-style-type: none"> • What is your faith or spiritual preference? • What practices help you heal or deal with stress? • Would you like to see a chaplain, priest, or other spiritual guide? |

requiring assessments to incorporate the effects of aging. Although assessment of the aging adult does not differ significantly from the younger adult, understanding how aging alters the physiologic and psychological status of the patient is important. Key physiologic changes pertinent to the progressive care elderly adult are summarized in Table 1-8. Additional emphasis must also be placed on the past medical history because the aging adult frequently has multiple coexisting illnesses and is taking several prescriptive and over-the-counter medications. Social history must address issues related to home environment, support systems, and self-care abilities. The interpretation of clinical findings in the elderly must also take into consideration the fact that the coexistence of several disease processes and the diminished reserves of most body systems often result in more rapid physiologic deterioration than in younger adults.

Past Medical History

If the patient is being directly admitted to the progressive care unit, it is important to determine prior medical and surgical conditions, hospitalization, medications, and symptoms besides the primary event that brought the patient to the hospital (see Table 1-7). In reviewing medication use, ensure assessment of over-the-counter medication use as well as any herbal or alternative supplements. For every positive symptom response, additional questions should be asked to explore the characteristics of that symptom (Table 1-9). If the patient is a transfer from another area in the hospital, review the admission assessment information, and clarify as needed with the patient and family. Be aware of opportunities for health teaching and transition planning needs for discharge to home or to a rehabilitation facility.

Social History

Inquire about the use and abuse of caffeine, alcohol, tobacco, and other substances. Because the use of these agents can have major implications for the progressive care patient, questions are aimed at determining the frequency, amount, and duration of use. Honest information regarding alcohol and substance abuse, however, may not be always forthcoming. Alcohol use is common in all age groups. Phrasing questions about alcohol use by acknowledging this fact may be helpful in obtaining an accurate answer (eg, “How much alcohol do you drink?” vs “Do you drink alcohol and how much?”). Family or friends might provide additional information that might assist in assessing these parameters. The information revealed during the social history can often be verified during the physical assessment through the presence of signs such as needle track marks, nicotine stains on teeth and fingers, or the smell of alcohol on the breath.

Patients should also be asked about physical and emotional safety in their home environment in order to uncover potential domestic or elder abuse. It is best if patients can be assessed for vulnerability when they are alone to prevent placing them in a position of answering in front of family