INTENSIVE CARE UNIT
STANDARD OPERATING PROCEDURE

POLICY NO: NSO-

DIVISION: NURSING SERVICE DIVISION

SECTION: INTENSIVE CARE UNIT

POLICY REVIEW DATE:

Reviewed by:		
ICU – Head Nurse	ICU- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. Provide multidisciplinary patient care on a concentrated and continuous basis.
II. Provide a multidisciplinary approach / plan to patient care which includes input from all relevant healthcare professionals.
III. Provide quality nursing care based upon the nursing process of assessment that includes biophysical, environmental, educational and psychological needs of the patient and family, planning, intervention and evaluation.
IV. Assign, orient and maintain a highly qualified professional staff, competent to provide individualized, concentrated care and to provide for the continuity of care.
V. Ensure that standards for professional nursing practice are implemented, evaluated and monitored.
VI. Provide for and participate in relevant studies that investigate problems and provide opportunities to improve patient care.

COVERAGE:

The Intensive Care is open for all health professionals involved in intensive care medicine.

RESPONSIBILITIES:

1. It shall be the responsibility of the **Head Nurse** to manage overall operations in the unit including administrative responsibilities, setting and maintaining patient care standards, and facilitating staff development and quality monitoring.
2. All ICU staff must have a variety of professional experience as well as specialized training in the field of critical care nursing.
   - All Critical Care Nurses should have a certificate in ACLS training
3. There should be at least 2 ICU nurses in every shift. A 1:3 bed at anytime is applied. Staffing ratio is adjusted according to patient acuity.
4. It shall be the responsibility of all **Staff** of this section to observe and follow set standard operating procedures as written in this policy.
5. Facilitate and monitor the workflow, ensuring patient care standards are maintained.
6. Assessing a patient's condition and planning and implementing patient care plans.
7. Ensuring that ventilator, monitors and other types of medical equipment function properly.
8. Assisting physicians in performing procedures.
9. Administering intravenous fluids and medications.
10. Observing and recording patient vital signs.
11. Collaborating with fellow members of the critical care team
12. Responding to life-saving situations, using nursing standards and protocols for treatment
13. Providing education and support to patient families.

POLICY:

I. ADMISSIONS:

All admissions should be discussed as soon as possible with the Attending Physician. The decision whether to admit the patient at the ICU rests on the Attending Physician after having been cleared from PTB as evidenced by chest x-ray readings and AFB results. The ICU nurse should be consulted by the ER Nurse regarding the availability of beds. The Attending Physician and other referring physicians shall be notified of all admissions by the ER resident on duty prior to transfer of patient to the ICU.

II. TRANSFER OUT OF ICU:

Patients should be assessed by the Attending Physician prior to transfer to other areas. Confirmation and reservation for the availability of bed for the patient to be trans out should be done to facilitate process of transfer. There should be a clear written doctor's order indicating for such transfer, detailing updated patient's status and ongoing care plan. For transfer of patients to other hospital, the patient must be coordinated or endorsed to the receiving institution prior to leaving the ICU.

III. ORDERS:

All orders in the ICU must be written in the chart, including date and time of the order. The physician writing the order should also verbally notify the ICU nurse of the order and discuss its implications. In very urgent situations such as cardiac arrest or impending respiratory or cardiac arrest, verbal orders may be given. These should later be transcribed to the chart and signed by the physician.

IV. NOTES:

1. Admission:

   An admission history, physical examination, assessment and plan of management and problem list must be written for each patient. The resident on duty is responsible for this. The ICU nurse should make use of the prescribed nurses' notes in FDAR format.

2. Procedures:

   All procedures must be documented in the progress notes. The note should include all pertinent data such as date, time, anesthesia, compliance with practice guidelines (see below), difficulties in procedure.

   - All arterial lines
   - All central lines, including Swan-Ganz catheters, triple lumens, TPN catheters
   - All intubations
   - All chest tubes
   - All pacemakers
   - All cardioversions
   - All sampling of body fluids (e.g thoracenthesis, paracenthesis, lumbar puncture, etc.)

3. All patients in the ICU must have at least one progress note written daily.

4. Discharges out of the Hospital and Deaths

   A summary must be written as soon as possible by the resident on duty for all patients who expired in the ICU, who are transferred to another hospital, or who are to be discharged home.

   For patients who expired in the ICU, a note describing the circumstances and management at the time of death must also be written.

   The resident on duty at the time of death must notify the next of kin, attending physician, and referring physician (if any).

POLICY ON HIGH RISK PREGNANCY UNIT (HRPU)

I. All patients needing Obstetrical and Gynecological care seen at the ER and OPD clinic shall be referred to the Consultant on duty who will manage/ decide on the patient's condition and referral to other specialty when the need arises.

II. CRITERIA FOR ADMISSION ON HIGH RISK UNIT

The following patients are to be admitted at the HRPU:

1. Pregnant women with medical complications such as uncontrolled hypertension, asthma in exacerbation, heart disease, maternal metabolic disease (uncontrolled diabetes mellitus, thyroid diseases), psychiatric patients.
2. Infectious disease (HIV, toxoplasmosis, fever of unknown origin, etc.)
3. Poor obstetrical History
   a. Preterm – 35 weeks and below by early ultrasound
      -cervical dilatation of less than/ eaual to 4 cms
      -incompetent cervix
   b. Preterm Premature Rupture of Membrane
4. Obstetrical complications- placenta previa, oligohydramnios, fetal growth restriction, multiple gestation, trauma or surgical complications

III. Perinatology is a subspecialty of OB/Gyne that focuses on the specialized and advance care of high risk pregnant women. It aims to provide the highest quality care and improve the outcome for both mother and fetus.

IV. POSTPARTUM GUIDELINES

1. All postpartum patients will be monitored at the recovery room and transferred to the ward once stable.
2. All postpartum mothers with hypertension and/or placed on Nicardipine drip shall be monitored at the ICU for 24 hours unless cleared by the Attending Physician or Internist to be sent to ward.
3. Postpartum patients with co-morbids (hypertensive emergencies, thyroid storm, cardiac problems, postpartum hemorrhage) shall be brought to the ICU for close monitoring if need arises.

DATE OF IMPLEMENTATION:

This policy has been implemented since June 25, 2015

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary