

FIFTH EDITION

AMERICAN  
ASSOCIATION  
*of* CRITICAL-CARE  
NURSES

# AACN

## Essentials of Progressive Care Nursing

Sarah A. Delgado



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# AACN Essentials of Progressive Care Nursing

## Fifth Edition

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Clinical Practice Specialist

American Association of Critical-Care Nurses

Aliso Viejo, California



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# Preface

This text provides the reader with evidence-informed content about the care of acutely ill patients and their families. Written by nursing experts, this book sets a standard for progressive care nursing education, supports preparation for national certifications, and can be a resource to address uncertainty in patient care delivery. The organization of the text recognizes the learner's need to assimilate foundational knowledge before attempting to master more complex progressive care nursing concepts. In addition, the American Association of Critical-Care Nurses affirms this book's value to the AACN community and especially to clinicians at the point of care. As the editor, I am grateful for the time and effort that AACN's team put forth in providing this validation. The title continues to carry AACN's name, as it has since the first edition.

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

- Part I: The Essentials presents core information that clinicians must understand to provide safe, competent nursing care to acutely ill patients who require progressive care. This part includes content on assessment, diagnosis, planning, and interventions common to patients and their families in progressive care units, including interpretation and management of cardiac rhythms; hemodynamic monitoring; airway and ventilatory management; pain, sedation, and neuromuscular blockade management; pharmacology; and ethical and legal considerations. Chapters in Part I provide the progressive care clinician with information to develop foundational competence.
- Part II: Pathologic Conditions covers pathologic conditions and management strategies commonly encountered in progressive care units, closely paralleling the blueprint for the PCCN certification examination. Chapters in this part are organized by body systems and selected conditions, such as cardiovascular, respiratory, multisystem, neurologic, hematologic and immune, gastrointestinal, renal, endocrine, and trauma.

- Part III: Advanced Concepts 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 selected reference information including laboratory and diagnostic values that apply to the content cases in the text; and cardiac rhythms, ECG characteristics and treatment guide. New in this edition is a table that demonstrates how conventional, contingency and crisis standards of care are implemented. Content in part IV is presented primarily in table format for quick reference.

Each chapter in Parts 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 cases” 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 critical care. The case studies are also 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 that learners may test their knowledge of the essential content.

The design of this text demonstrates the expertise of the first edition editors, Marianne Chuley and Suzanne M. Burns. Both are outstanding leaders with boundless nursing expertise, and I am honored and humbled to contribute to their tradition. The world of progressive care nursing has shifted dramatically since they published the first edition. The prevalence of e-learning programs, including AACN's Essentials of Critical Care Orientation, as well as webinars, podcasts and other platforms offers nurses many ways to advance or confirm the knowledge that informs patient care. Technology has also changed our interventions and the way

we document them. New evidence has altered old practices and changed our interpretation of clinical data. The COVID-19 pandemic has profoundly altered the delivery of progressive care, and the lives of those who provide it. While the complexity of progressive care requires collaboration among team members who each bring unique expertise, it is nurses who provide a continual and compassionate presence for patients.

As progressive care continues to evolve, the skills and knowledge that nurses leverage will also change. The constant element will be nurses' profound commitment to

learning and translating that learning to optimal patient outcomes. This 5th edition, like its predecessors, meets nurses in their journey to learn, supports their pursuit of validation through certification, and offers a resource for direct patient care. As the book's editor, I hope it also serves to honor the profound contributions that nurses make every moment of every day and every night in the lives of patients, families, and their communities.

In gratitude for the profession of nursing,

**Sarah A. Delgado, MSN, RN, ACNP**

THE ESSENTIALS



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# ASSESSMENT OF PROGRESSIVE CARE PATIENTS AND THEIR FAMILIES

# 1

*Lynn Orser*

## KNOWLEDGE COMPETENCIES

1. Discuss the importance of a consistent and systematic approach to assessment of progressive care patients and their families.
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.
  - Comprehensive initial assessment
  - Ongoing assessment

The assessment of acutely ill patients and their families is an essential competency for progressive care nurses. 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. Traditional approaches and techniques for assessment are 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 based on the patient's 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. 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 focus first on the patient, then on the technology. The patient is 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 aware of the pending admission or transfer 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 critical care unit, as they become more stable and improve in condition. Conversely, they may be transferred from a less acute level of care because 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 department, 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 pre-arrival 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. This assessment is a high-level view of the patient but is essential because it validates that basic cardiac and respiratory function is sufficient, and it 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 includes 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 with comparison to the patient’s current status. The comprehensive assessment is vital to successful outcomes because it provides insight into which proactive interventions are 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 healthcare providers are 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 challenging due to cognitive impairment or symptoms that affect communication. If the patient is unable to supply information, other sources are 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 and any known allergies. Obtaining current medication regimens as soon as possible is essential to provide clues to the patient’s medical conditions, identify any potential contributing factors to the current condition, and ensure medication reconciliation to continue appropriate medications and avoid medication interactions.

With the use of EHRs, there are 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 to trend laboratory and diagnostic results. In addition, healthcare systems within the same geographic locations may offer intersystem access to the medical records of patients treated at multiple healthcare institutions. This is particularly beneficial when patients are unable to articulate essential medical information including advance directives, allergies, and next of kin.

Careful physical assessment on admission to the progressive care unit is pivotal for the 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 injury, alteration in mental status, infection, 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, identifying patients at risk for falls and implementing mitigation strategies. It is imperative that nurses use all safety equipment available to them such as bar-coding technology to prevent medication errors. Healthcare providers 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

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

<b>Prearrival Assessment</b>
<ul style="list-style-type: none"> <li>Abbreviated report on patient (age, gender, chief complaint, diagnosis, allergies pertinent history, physiologic status, invasive devices, equipment, and status of laboratory/diagnostic tests)</li> <li>Complete room setup, including verification of proper equipment functioning</li> <li>Do Not Resuscitate (DNR) status</li> <li>Isolation status</li> </ul>
<b>Admission Quick Check Assessment</b>
<ul style="list-style-type: none"> <li>General appearance (consciousness)</li> <li>Airway:               <ul style="list-style-type: none"> <li>Patency</li> <li>Position of artificial airway (if present) such as tracheostomy</li> </ul> </li> <li>Breathing:               <ul style="list-style-type: none"> <li>Quantity and quality of respirations (rate, depth, pattern, symmetry, effort—use of accessory muscles)</li> <li>Breath sounds</li> <li>Presence of spontaneous breathing</li> </ul> </li> <li>Circulation and Cerebral Perfusion:               <ul style="list-style-type: none"> <li>Electrocardiogram (ECG) (rate, rhythm, and presence of ectopy)</li> <li>Blood pressure</li> <li>Peripheral pulses</li> <li>Capillary refill</li> <li>Skin color, temperature, moisture</li> <li>Presence of bleeding</li> <li>Level of consciousness, responsiveness</li> </ul> </li> <li>Chief Complaint:               <ul style="list-style-type: none"> <li>Primary body system</li> <li>Associated symptoms</li> </ul> </li> <li>Drugs and Diagnostic Tests:               <ul style="list-style-type: none"> <li>Drugs prior to admission (prescribed, over-the-counter, illicit)</li> <li>Current medications</li> <li>Review diagnostic test results</li> </ul> </li> <li>Equipment:               <ul style="list-style-type: none"> <li>Patency of vascular and drainage systems</li> <li>Appropriate functioning and labeling of all equipment connected to patient</li> </ul> </li> </ul>

of the patient and information on the presence of invasive tubes and lines, medications being administered, other ongoing treatments, and pending or completed laboratory or diagnostic tests. This basic information may indicate a need to consider whether the patient will need a specialty bed such as a bariatric bed or a bed to optimize skin integrity. Determining this in advance is helpful as it may take time to acquire a specialty bed.

It is also important to consider the potential isolation requirements for the patient, including neutropenic precautions, contact precautions, or special respiratory isolation. Being prepared for isolation needs prevents potentially serious exposures to the patient, roommates, or the healthcare providers. The prearrival 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, and medications). Proper functioning of all bedside equipment is verified prior to the patient's arrival. If using a bed scale, zeroing to ensure accurate weight on admission is an important step.

It is also important to prepare the medical record forms, which usually consist of a computerized data entry system or paper flow sheets 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.

**TABLE 1-3. EQUIPMENT FOR STANDARD ROOM SETUP**

<ul style="list-style-type: none"> <li>Bedside ECG or telemetry monitoring and invasive pressure monitor with appropriate cables</li> <li>ECG electrodes</li> <li>Blood pressure cuff</li> <li>Pulse oximetry</li> <li>End-tidal CO<sub>2</sub></li> <li>Thermometer</li> <li>Suction gauges and canister setup</li> <li>Suction catheters</li> <li>Bag valve mask device</li> <li>Oxygen flow meter, appropriate tubing, and appropriate oxygen delivery device</li> <li>IV poles and infusion pumps</li> <li>Bedside supplies to include alcohol swabs, non-sterile gloves, syringes, bed pads, and dressing supplies</li> <li>Admission kit that usually contains bath basin and general hygiene supplies (if direct admission)</li> <li>Bedside computer and/or paper admission documentation forms</li> </ul>
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## ADMISSION 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 condition of the patient 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, and essential laboratory and diagnostic tests are

ordered. Simultaneously with the ABCDE assessment, the patient's nurse validates that the patient is appropriately identified through a hospital wristband, personal identification documents, or family identification. Additional wristbands, per institution policy, may include allergy band, fall risk band, or limb restriction band. 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.

### ESSENTIAL CONTENT CASE

#### *Prearrival Assessment*

The charge nurse notifies Terry that they 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 Terry a report following the hospital's standardized report format.

**Case Question 1: What basic information will Terry want to know from the prearrival 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 and determine 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 Terry after the patient is settled in his room in the progressive care unit?**

#### Answers

1. Patient name/age, date of birth, pain level, pain location, last pain medication dose and response to pain medication or intervention, type and date of accident, extent of accident injuries, pertinent medical history, allergies, vital signs, placement of lines and tubes, other medications being administered, significant laboratory results, anticipated plan for care and discharge plan, presence of family, and any other special instructions such as concerns about fall risk and patient ability to transfer.

The patient suffered a closed head injury and chest trauma with collapsed left lung. The patient was initially intubated and placed on a mechanical ventilator. During his ICU stay, the patient had pneumonia and had a tracheostomy placed due to the duration of mechanical ventilation and the need to manage copious secretions. He is now off the ventilator and requires 30% FiO<sub>2</sub>. A central line with a

central venous pressure (CVP) setup and a left chest tube to water seal are in place. Terry questions the critical care nurse regarding the patient's mental status including his level of consciousness (LOC), neuro deficits, and any agitation. They also ask if a Foley catheter or nasogastric (NG) 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.

Terry goes to check the patient's room prior to admission and begins to do a 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 there are two suction systems available and working. The pulse oximeter 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. Safety equipment to have on hand for the chest tube includes sterile water, sterile dressings including Vaseline gauze and waterproof tape. This patient has an altered LOC, which means frequent neuro checks. I have my penlight handy. The computer in the room is on and ready for me to begin documentation. I think I'm ready."

3. Using an SBAR (Situation, Background, Assessment, and Recommendations) 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. Terry can also clarify any remaining questions.

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 may delegate other tasks, such as changing over to the unit equipment or

attaching monitoring cables. Without a leader, 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 provide verbal reassurance throughout the admission process so the patient knows what to expect 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 indicated. 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 of the airway. 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 that are removed.

Assessment of the patient's breathing also includes observation of the rate, depth, pattern, and symmetry of breathing; the work of breathing; the use of accessory muscles; and, if mechanically ventilated, whether breathing is in synchrony with the ventilator. Do not overlook nonverbal signs of respiratory distress including 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. In addition, assess whether the chest tubes are functioning properly (eg, air leak, fluid fluctuation with respirations) and the amount and character of the drainage.

### Circulation and Cerebral Perfusion

The arrival quick check assessment of circulation includes quickly palpating a pulse and viewing the ECG 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. Assess whether the patient is alert and

oriented, aware of their surroundings, or whether a verbal or painful stimulus is required to obtain a response, or if 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 observant, and what the response is to 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 they nod 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 face a language barrier. 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. For patients who face a language barrier, an approved hospital translator or phone translating service can assist with the interview and subsequent evaluations and communication. Avoid asking family and friends to translate for the patient to protect the patient's privacy, to prevent errors in translating medical terminology, and to eliminate well-intentioned but potential bias in translating for the patient. In the absence of a history source, practitioners need to depend on the physical findings (eg, presence of medication patches, permanent pacemaker, or old surgery scars), knowledge of pathophysiology, access to electronic medical records, and transport records.

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 is immediately obtained and intake and output records started. If IV medications are infusing, check the medication and verify the concentration and 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 available laboratory or diagnostic data for abnormalities or indications of potential problems that

**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

may develop. The abnormal laboratory and diagnostic data for specific pathologic conditions will be covered in subsequent chapters.

### Equipment

The last phase of the arrival quick check is an assessment of the equipment in use. Quickly evaluate all vascular, feeding, 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 patient to monitoring equipment, it is important for the nurse to continue assessing the patient's respiratory and cardiovascular status until all equipment is 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 ABCDE assessment, the comprehensive assessment begins. If at any phase during the arrival quick check, a component of the ABCDEs has not been stabilized or is in question, the priority is to resolve that concern 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. Handoffs with transitions of care are 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 observations such as dosage of infusing medications, abnormalities found on the quick check assessment, and any potential inconsistencies noted between the arrival quick check assessment and the prarrival 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 the patient's family members or friends, if present. The relationship between the family and the healthcare team begins with a professional introduction, reassurance,

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

<b>Quick Assessment</b>
• Offer realistic hope
• Give honest answers and information
• Give reassurance
<b>Comprehensive Assessment</b>
• 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)
• Assess knowledge and capacity for providing support after discharge

review of the plan of care, and confirmation of the intent to give the patient the best care possible (Table 1-5). If feasible, allow the family 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 on the patient's condition. Another member of the healthcare team can assist by escorting them to the appropriate waiting area.

### COMPREHENSIVE INITIAL ASSESSMENT

Comprehensive assessments determine the physiologic and psychosocial baseline to which future changes are compared to determine whether the patient's status is improving or deteriorating. The comprehensive assessment also defines the patient's pre-event 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 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.

An increasing proportion of patients in progressive care units are older adults, requiring assessments that incorporate the effects of aging. Although the 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 older adult are summarized in Table 1-8.

**TABLE 1-6. SUMMARY OF COMPREHENSIVE INITIAL ASSESSMENT REQUIREMENTS**

<b>Past Medical History</b>
<ul style="list-style-type: none"> <li>• Medical conditions, surgical procedures</li> <li>• Psychiatric/emotional problems</li> <li>• Hospitalizations</li> <li>• Medications (prescription, over-the-counter, illicit drugs) and time of last medication dose</li> <li>• Allergies</li> <li>• Review of body systems (see Table 1-7)</li> </ul>
<b>Social History</b>
<ul style="list-style-type: none"> <li>• Age, gender, self-identified gender</li> <li>• Ethnic origin</li> <li>• Height, weight</li> <li>• Highest educational level completed</li> <li>• Preferred language</li> <li>• Occupation</li> <li>• Marital status</li> <li>• Primary family members/significant others/decision-makers</li> <li>• Religious affiliation</li> <li>• Advance Directive and Durable Power of Attorney for Health Care, Medical Orders for Life-Sustaining Treatment (MOLST)</li> <li>• Substance use/abuse (alcohol, illicit drugs or prescription medications, caffeine, tobacco)</li> <li>• Domestic abuse or vulnerable adult screen</li> <li>• Dependence on others—family members or paid caregivers—for assistance with activities of daily living</li> </ul>
<b>Psychosocial Assessment</b>
<ul style="list-style-type: none"> <li>• General communication</li> <li>• Coping styles</li> <li>• Anxiety and stress<sup>a</sup></li> <li>• Expectations of progressive care unit</li> <li>• Current stresses</li> <li>• Family needs</li> </ul>
<b>Spirituality</b>
<ul style="list-style-type: none"> <li>• Faith/spiritual preference</li> <li>• Healing practices</li> </ul>
<b>Physical Assessment</b>
<ul style="list-style-type: none"> <li>• Nervous system</li> <li>• Cardiovascular system</li> <li>• Respiratory system</li> <li>• Renal system</li> <li>• Gastrointestinal system</li> <li>• Endocrine, hematologic, and immune systems</li> <li>• Integumentary system</li> </ul>

<sup>a</sup>Pain may need to be assessed in each body system rather than as a stand-alone assessment—see Table 1-9.

Additional emphasis is also placed on the past medical history because the older adult frequently has multiple coexisting chronic illnesses and is taking several prescriptive and over-the-counter medications. Social history addresses issues related to home environment, support systems, and self-care abilities including the use of assistive devices such as wheelchairs, walkers, or bedside commodes. The interpretation of clinical findings in the older adult also takes into consideration the coexistence of several disease processes and the diminished reserves that can 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, hospitalizations, medications, and symptoms besides the primary event that brought the patient to the hospital (see Table 1-7). A thorough review of medications includes the use of over-the-counter medication 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 transferred from another area in the hospital, review the admission assessment information gathered in prior assessments and clarify as needed with the patient and family. Be aware of opportunities for health teaching and identify transition planning needs for discharge to home or to a rehabilitation facility.

### Social History

The social history includes asking about the use of caffeine, alcohol, tobacco, and other substances such as illicit drugs or prescription medications. 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 use, 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 could 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 are also asked about physical and emotional safety in their home environment in order to uncover potential abuse or exploitation. 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 members or friends who may be abusive. Questions such as “Is anyone hurting you?” or “Do you feel safe at home?” are included in a non-threatening manner. Any suspicion of abuse or vulnerability warrants a consultation with social work to determine additional assessments.

### Physical Assessment by Body System

The physical assessment section is presented in the sequence in which the combined system, head-to-toe approach, is followed. Although content is presented as separate components, generally the history questions are integrated into the physical assessment. The physical assessment section uses the techniques of inspection, auscultation, and palpation. Although percussion is a common technique in physical examinations, it is less frequently used.

Pain assessment is generally linked to each body system rather than considered as a separate system category; for example, if the patient has chest pain, assessment and