

Document Reviewed: 04.20.2021 1332

In preparation for admitting adult patients to HDVCH, please review the resources and references below. Adult nursing staff will be available for questions during each shift – more information will be coming when this process is finalized. An “apricot” colored adult report tool with adult parameters has been developed for use in HDVCH.

Things to remember

- 💡 Follow current pediatric assessment standards for adult patients
- 💡 Documentation will be done on pediatric flow sheets using the pediatric scales and screens
- 💡 Use CPGs to guide patient care for adults – be sure to utilize the Adult CPGs
- 💡 Be aware that medication dosing will be different (not weight based)
- 💡 Always choose the appropriate drug library in the IV pump:
 - Acute care floors – Adult Med/Surg
 - PCCU – Adult Critical Care
 - Some situations in which a pediatric order set is used may necessitate using a pediatric drug library, such as an insulin drip or chemotherapy
- 💡 DVT prophylaxis is important – follow provider orders for SCDs or Ted hose and early mobility (may need to use a gait belt)
- 💡 Use of incentive spirometry as ordered
- 💡 Ask the patient if they would like report to be done at the bedside
- 💡 Echocardiograms will be done by the adult echo techs, but ECGs will be done using our current process
 - ECG tech will do for 5, 6, 9, 10 and SPRU
 - NT will do for 7
 - RN will do for PCCU and PCICU
 - Adults do a 12 lead ECG instead of a 15 lead ECG. Leave off leads V7, V3R and V4R

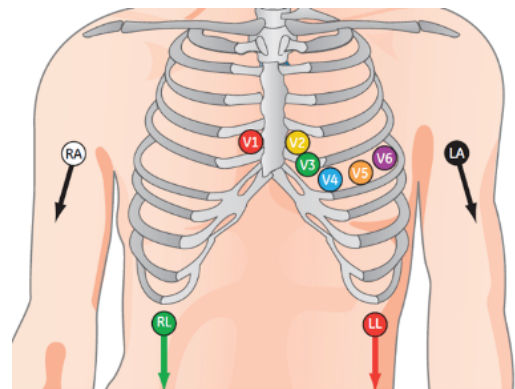


Figure 8.1 Lead Placement for 12 lead ECG

The online resource eLippincott is the primary reference source for basic nursing procedures for adult patients. Occasionally a basic nursing procedure will be written specifically for Spectrum Health and are also included in this guideline. All Spectrum Health procedures supersede eLippincott procedures.

Common Policies

Listed below are common adult nursing policies that can help with the care of this patient population. These references have many hyperlinks that can be great resources for adult care.

Adult nursing procedure reference list

Reference #15005

Highlights hyperlinks for adult care and use of eLippincott resource.

Assessment standards Adult

Reference #19576

Listed within the policy are various hyperlinks to help with bedside care, for example wound and pressure injury prevention, skin care, fall risk factors and post fall follow up.

Tracheostomy tube care- Adults

Reference #8182

Highlights inner cannula care q shift unless on mechanical ventilation then q week. Site care q shift with .9NS

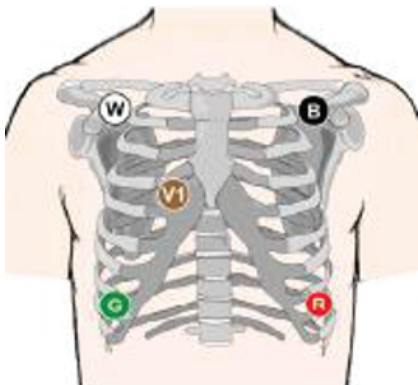
Oral care of the adult

Reference #9647

Continuous cardiac monitoring - Adults

Reference #6948

We will use 5 lead cardiac monitoring using the appropriate patient profile on the bedside monitor and 5 lead cable. Place leads according to the policy. Notify provider if the patient is not in sinus rhythm – team will evaluate the need for additional cardiac monitoring and evaluation including possible transfer to an adult unit covered by the Cardiac Monitoring Center.



Intravenous push adult appendix

Reference #12544

Cardiac Arrest

Reference #2300

Will be called overhead - Call 33333 and tell the operator adult code blue and unit. The adult code team will respond.

Acute Change in Patient Condition (RRT, Stroke, Chest Pain)

Reference #13403

For any acute patient change an AWARE should be called first, in the event the provider determines further response is needed:

Call the hospital operator at 33333 and make one of the following requests

1: RRT

The operator will be notified of unit, floor, and room number to deploy the Rapid Response Team. The RRT members are expected to respond within 5 minutes.

2: Chest Pain Response

The operator will notify the Hospital Supervisor of the location of the patient having the chest pain by sending unit and room number to the pager.

3: Stroke Response

The operator will be notified of unit, floor, and room number to deploy the Stroke Response Team. The Stroke Response Team members are expected to respond within 5 minutes.

****RRT, Chest Pain response, and Stroke response team members will carry a pager at all times for the duration of their assignment.**

Definitions

Rapid Response Team or RRT (formerly known as RAP)- Equivalent to an AWARE in peds.

This can be activated for any patient requiring evaluation and provision of interventions for a change in the patient's condition or according to evidence based modified early warning scores, also known as PEWS. Requesting a RRT is appropriate regardless of a patient's Do Not Resuscitate (DNR) status. RRT calls for DNR patients can provide assistance in emergent care that does not require resuscitation efforts. The **Rapid Response Team** includes an BW Physician, Licensed Respiratory Therapist (LRT), Pharmacist, and Hospital Supervisor. RRTs are in response to a patient's physiological change or care provider's concern regarding a patient's condition.

Chest Pain Response

Any patient having chest pain needs rapid assessment to determine if they are having an ST Elevation Myocardial Infarction (STEMI -"heart attack") and requires emergent intervention to restore coronary blood flow. Chest pain may be experienced as a new onset or acute episode of chest pain, shortness of breath, or other symptoms that may represent an unexpected cardiac event. Cardiac symptoms may be evidenced by those other than chest pain, including **sudden** dyspnea, weakness, diaphoresis or nausea, especially in elderly, diabetic and female patients. The **Chest Pain response** is the Hospital Supervisor and a STAT 12 lead electrocardiogram (ECG) performed within 10 minutes of the onset of new or unexpected chest pain. If the patient is having a STEMI (ST Elevation MI), Hospital Supervisor will activate the RRT team and they will activate other resources as needed.

Stroke Response

A stroke response should be activated by any member of the healthcare team for any patient who is experiencing new stroke symptoms. The purpose of the stroke response is to stabilize and to evaluate candidacy for acute stroke interventions. Stroke symptoms are sudden neurological deficits related to cerebral vascular ischemia or hemorrhage, which include: numbness/weakness of face/arm/leg, especially on one side of the body; confusion, trouble speaking/understanding; trouble seeing in one or both eyes; trouble walking, dizziness, loss of balance/coordination; severe headache with no known cause. The Stroke Response Team is the Hospital Supervisor, RRT physician, pharmacist and phlebotomist for the initial assessment who will then activate other resources as needed.

- There are packets on the crash cart that the response teams can use for STEMI or stroke patients
- There are ACLS algorithms in each crash cart binder
- Code narrator will default to ACLS medications based on the patient's age