

UCLA Department of Nursing

Pediatric Intensive Care Unit

Nursing Expectations

1. BEDSIDE SETUPS

All patients must be admitted on the following monitors with age appropriate alarm limits set, unless otherwise ordered and at level of 7. Tachycardia, Bradycardia alarms set to red. All other arrhythmia alarms set as appropriate to patient:

1. Cardio-respiratory
2. Blood Pressure
3. O2 Saturation
4. End Tidal CO2 when on vent

All patients must have:

1. Venous access (unless a physician order is written to supercede this)
2. Two (2) **UCLA** identification bands on separate limbs of patient
3. Ambu O2 bag connected to flowing O2 with the appropriate size face mask setup at bedside
4. Suction setup ready for use
5. Weight specific emergency drug sheet at bedside and taped to bed/crib. Drug sheets are based on **dry admission weight**
6. Allergies should be noted on an allergy ID band, documented in HER

2. VITAL SIGNS/ ASSESSMENT AND MEASURES

1. Heart rate, respiratory rate, blood pressure, pulse oximetry, and end tidal CO2 (when vented). Presence of Etco2 waveform.
 - a. Monitor and document Q1 hour for acuity 1:1 and Q2 hours on acuity 1:2 patients. Variations must be ordered by MD/designee.
 - b. Monitor the above more frequently when indicated i.e. the patient becomes unstable or during the titration of vasoactive drips. This will be done Q15 minutes or more frequently as the patient condition dictates.
 - c. VS can be ordered less frequently for periods of rest if patient is stable
2. Pain: Pain assessment, using one age or condition appropriate scale selected during the pediatric admission assessment, completed during the shift and repeated after non-pharmacologic and pharmacologic interventions. ([HS G 1006](#), [HS 1341](#))
3. Temperatures: Measure and record Q1 hour on temperature sensitive patients and Q2 -4 hours on other patients
 - a. Temperatures should be taken via the oral route in children over age 5 unless contraindicated by medical or developmental issues. In these cases, axillary or rectal route may be used.
 - b. Oral route is contraindicated in patients with buccal, oral or mandibular surgeries, or tracheostomy.
 - c. The rectal route is contraindicated in heme/onc patients and in patients with low platelets, GI bleeding, rectal surgery, or neutropenia
 - d. Temperatures may also be measured by PA catheter or by a Foley

- e. Document other warming/cooling devices on EHR and note temperature settings.
4. Weight (kg): Document on admission and Q day per MD/designee order.
Contraindications to daily weights may include: unstable patients, some post-operative patients such as open-heart and neurosurgery patients with bolts & drains in-situ to the head.
 - a. Re-weigh patient after hemodialysis or after liver transplantation
5. Height (cm): Obtain on admission and document in EHR
6. Head Circumference – Obtain on admission for patients <18 months, every Sunday thereafter.
7. Patient Acuity will be documented Q12 hours

ASSESSMENT ([POLICY# 1310](#))

A comprehensive head to toe assessment will be completed at the beginning of each shift, prn, and per MD/designee order as per these guidelines:

1. General Appearance
 - a. Position of the patient
 - b. Position of the head of the bed (flat or elevated to a certain degree)
 - c. Type of bed/support surface
 - d. Position of the side rails
 - e. Restraint Use & current MD/designee order ([HS 1321](#), [NG 1008](#))
2. Neurological
 - a. Patient's level of consciousness and orientation
 - b. Anterior fontanel in children <18 months and also posterior fontanel in children <6months
 - c. Glasgow Coma Scale
 - d. PERRLA
 - e. Extremity strength, equality and purposefulness
 - f. Reflexes, gag, cough
 - g. Neurosurgical drains: Type and description of drainage, insertion site, leaking, and signs of infection
 - h. ICP monitoring: Type of monitor and level in cm H2O. ICP and CPP are monitored and documented per acuity. Significant changes reported to MD/designee. ICP precautions are implemented as indicated (decreased environmental/noxious stimuli, HOB elevated 30 degrees) ([Nur HS 132](#))
 - i. Pupillometer
 - Keep pupillometer in charging station
 - Turn on by pressing 
 - Position SmartGuard on front of Pupillometer
 - Manually type in MRN
 - After initial scan just verify MRN by hitting accept
 - Position pupillometer with SmartGuard in place at 90 degree angle to the patients axis of vision

- Press and hold either right or left until eye is centered on screen and green circle is around pupil. Release button and hold in place for 3 seconds until display screen displayed.
 - Repeat for other eye
 - Document NPi:
 - NPi 3.0-4.9 Normal “Brisk”
 - NPi <3.0 Abnormal “Sluggish”
 - 0 Non-reactive
- A difference in NPi between right and left pupils of ≥ 0.7 may also be considered an abnormal pupil reading

3. Respiratory

- a. Rate, effort, breath sounds, chest excursion, presence or absence of nasal flaring. Document any retractions and location of retraction.
- b. ET tube: Assess/Document Size, cuffed or uncuffed, where taped (in cm) at the nare or lip. Assess the skin integrity of the nare/gums. ([HS G1023](#))
- c. Trach: Assess/Document size, cuffed or uncuffed. Assure a replacement trach, and a size smaller are at the bedside. Assess skin integrity at trach insertion site and security of trach ties. ([Nur HSG3006](#), [HS 129](#))
- d. Oxygen: Oxygen administration must be ordered by an MD/designee. Document O₂ delivery and device Q 1 to Q 2 hours and with any changes.
- e. Nasal/oral secretions: Describe color, consistency, quantity, odor and any other significant respiratory findings (i.e. signs and symptoms of any respiratory distress)
- f. Chest Tubes: check site and position, amount of suction, check water seal chamber for presence of air leak. Check dressings and record the amount and description of drainage from the tube/s. Dressing is changed every other day. Number/label chest tube drainage system. Assure tube is securely anchored to patient’s skin.
 - i. Have at bedside at all times: two smooth edge chest tube clamps, two inch adhesive tape, gauze sponges, sterile water or normal saline. ([Nur- HS G1041](#))

4. Cardiovascular

- a. Heart rate and rhythm, heart sounds, precordium activity.
- b. Nail beds, capillary refill, clubbing, quality of peripheral pulses.
- c. Assess color of lips and mucous membranes
- d. Skin color and temperature of the core versus extremities, presence of edema
- e. Arterial lines ([Nur HS G1024](#))
 - i. Assess waveform and report any changes from baseline to the physician
 - ii. Check and document a non-invasive cuff pressure Q shift and PRN (for correlation with arterial line pressure).

- iii. For non-sutured catheters, secure with steristrips and have PICU Fellow suture line. (radial art lines are usually not sutured)
 - f. Pacemaker: Type, internal or external. Verify setting with MD/designee order: Mode, mA, rate, and sensitivity. Check batteries and change when battery light indicates less than 24 hours of battery life by flashing red. Have extra batteries at bedside.
 - g. Pacer wires: Must be identified and labeled correctly by Peds cardiac surgeons. Secure and insulate in finger cot/latex free glove finger, to be easily accessible at all times, when not attached to the pacemaker. Handle wires with gloves.
5. Gastrointestinal
- a. Abdominal girth: Measure at the umbilicus with the patient flat Q12 hours and PRN for the following:
 - i. Liver transplant patients
 - ii. Abdominal surgery patients
 - iii. Patients on tube feedings
 - iv. Measure abdominal girth PRN for all other PICU patients
 - b. Abdomen: Firm or distended, flat.
 - c. Enteral tube (NG, OG, NJ, GT, JT, GJT): Document in EHR: type, size and location; to gravity or suction; intermittent or continuous; securement of tube and placement verification. Make sure tube is marked with correct placement with appropriate label.
 - d. Gastric secretions: Color, type, amount, consistency and pH .
 - e. Bowel sounds: Present or absent/ hyper or hypo-active, present in all quadrants
 - f. Stool: Amount, color and consistency, occult blood.
 - g. Ostomy: color and perfusion, effluent.
 - h. Guaiac q shift and prn
 - i. Feeding: Mode of delivery, type of feeding. Verify fluid requirements and amount to be delivered (in ml) to patient.
6. Genitourinary
- a. Voids: Spontaneously or use of urinary catheter/device (suprapubic, mitrofanoff, etc)
 - b. Characteristics of the urine: color, clarity and smell
 - c. Urine output: Calculate ml/kg/hr Q6 hours
 - d. CRRT Patients: **(CC HS 253)**
 - i. Document every 2 hours and prn as changes occur:
 - 1. Blood flow rate, replacement fluid, replacement rate, dialysate, dialysate flow rate, anti-coagulation (heparin or Citrate), UF goal
 - ii. Document the following q 2 and with change:
 - 1. Access pressures, filter pressure, effluent pressure, return pressure, ultrafiltration
7. Skin **(Nur HS G1027)**
- a. Temperature, color, turgor, rashes, petechiae or edema
 - b. Location and condition of any incision/insertion sites
 - c. Skin integrity - any breakdown, sores or ulcers.

- i. Utilize Skin and wound care treatment guidelines grid for product use on specific wounds.
 - ii. Complete event report for pressure ulcers/ skin injury found on admission and/or when they occur.
 - d. Surgical drains - type, location, color and consistency of any drainage
 - e. IV sites, location and condition
 - f. Presence of transdermal patches (chart in nursing clinical note), location and date changed
8. Psych-Social (**Nur-HS G4000**)
- a. Observe patient and visitor contact/interactions and document as appropriate. Document family/guardian/friend visits or telephone calls in EHR.
 - b. Assess the need for referral to other disciplines e.g. Social Work, Child Life, Chaplain, to provide additional resources for the patient and family.
 - c. Parents are encouraged to be with their child as soon as possible after admission. Prior to the first visit, anticipatory information regarding their child's appearance and behavior is provided. When the parents are emotionally accessible, they receive an orientation to the unit and a discussion of parental rights.
 - d. Notify Scan Team if necessary by page and send referral in EHR.

3. LABORATORY AND BEDSIDE TESTING (HS 1311, HS 1328)

- 1. Accuchecks
 - a. Perform once per shift with lab draws (perform accucheck with MD order or concern for glucose changes)
 - b. With Dextrose changes greater than 10%, perform 1 hour after change.
 - c. Consider more frequent intervention for patients less than 30 days old, postoperatively, those on NPO status, liver failure, sepsis, signs of cold stress, or on insulin drips. (**Nur HS 164**, **Nur HS G-6016**)
- 2. Hemocue: Perform daily with lab draws (perform more frequently with an MD order or concern for bleeding)
- 3. Urine Dipstick/specific gravity: Per MD order
- 4. Hemoccult/Gastroccult: daily on all patients, more frequently prn, or per MD order. Perform and document ICA (internal control accepted).
- 5. Awareness of Potassium (K+) level prior to the administration of Digoxin, Amphotericin B, Furosemide, Ethacrynic Acid and Bumetanide or other medications known to impact K+ levels.
- 6. ACT's are performed per MD order
- 7. Co-ox blood gas with Met Hgb every 12 hours or per MD order when patient on inhaled Nitric oxide (iNO).

4. COMFORT MEASURES/SAFETY

- 1. Parents/Guardians are encouraged to participate in the following patient care with RN assistance:

- a. Daily baths, chlorhexidine treatments on all patients > 2 months of age ([Nur HS 137](#)). Pre-op CHG treatment for all patients and those infants > 72 hours old and > 36 weeks gestational age.
 - b. Oral care
 - i. Non-ventilated patients: toothbrush BID and prn. Foam swabs should be used for hematology and oncology, patients with bleeding tendencies, and craniofacial patients.
 - ii. Ventilated patients: Oral care q 4 hours and prn
 - iii. Shampoos weekly, when appropriate and prn
 - c. EKG electrodes change Q 24 hours; date individual electrodes.
 - d. Turn/reposition the patient Q2 hours and PRN, as appropriate
2. Placement of nasal cannula for infants and patients unable to change their position without assistance:
 - a. For infants, place infant/pediatric cannula in nares then overhead with clasp at the back of the head. Make certain head is not resting on the clasp. Use Pectin based barrier (duoderm) over cheek area, tape cannula down over the barrier.
 - b. The entire tubing should be visible at all times, away from the patient's neck and chest area towards the head of the bed. Do not place the tubing under the patient's chin or behind the neck.
 - c. Assess that the O2 tubing is visible and untangled at start of shift and throughout
 - d. Toddler/school- aged, same as above, but use appropriate size nasal cannula making certain head is not resting on clasp and tubing.
 3. Eye care on chemically paralyzed/immobilized patients will include cleansing with sterile Normal Saline and then installation of a lubricant q 4 hrs, and PRN with an MD/designee order.

5. DOCUMENTATION ([HS 250](#))

1. Pediatric admission assessment: Should be completed within 24 hours. Report to oncoming RN info required and complete admission assessment if incomplete.
 2. Individualized Plan of Care will be implemented upon admission and updated q shift.
 3. Orders will be entered into EHR by MD/designee and the bedside RN will check for orders and acknowledge them at least every hour for unstable patients and Q 2 for stable.
 - a. RN's should only accept voice/telephone orders in emergent situations. The order should be written down and read back to the Physician to confirm content. ([HS 1304](#))
 - b. Orders should not be accepted from non-PICU physicians/designee without approval of PICU physician/designee. **Exception: Liver team writes immunosuppression orders, trauma service will write trauma orders and nephrology team writes dialysis orders.**
 4. Signing off at change of shift: Oncoming and Off-going RN
 - i. IV's
 - i. Labeling will be checked Q12 hours by on-coming and off-going RN.
 - ii. The RN accepting the patient assumes full responsibility that the drips are correct and infusing when the RN places hand off in the EHR.
 5. IV drips are checked for the following:
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- a. Patient name
 - b. Drug name, dose and volume
 - c. Type and volume of solution
 - d. Concentration of drug
 - e. Date hung
 - f. Time hung
 - g. Total volume in syringe
 - h. Initial rate of administration
 - i. Initials of RN who prepared the infusion
 - j. Initials of RN who doubled checked infusion
6. Chart Check includes the following:
- a. Check that all orders are acknowledged in EHR
 - b. Verify all medication orders during shift were given and no future medication charting
 - c. Labs, procedures and equipment services that are ordered have been processed
7. Any waste of narcotics and narcotic drips must be recorded and witnessed by a second RN.

6. INVASIVE MONITORING ([Nur HS 104](#), [Nur HS G1031](#))

1. All hemodynamic monitoring lines are transduced and the waveform, systolic/diastolic, or mean pressures are continuously monitored. Alarms are always on and audible. The transducer is zeroed and recalibrated at the beginning of the shift and PRN. **Arterial line waveforms are always monitored.**
2. Initial documentation of invasive line insertion shall include: Site, type of line, inserted by MD/designee, initial pressures and patient's tolerance of procedures in EHR
3. Invasive line measurements: Document in EHR the vital signs based on patient's acuity, Q1 hour for 1:1 patients and Q2 hours for 1:2 patients. If patient's condition is unstable, monitor more frequently as indicated.
4. Waveforms: Save in EHR at beginning of shift and prn.
5. Arrhythmias: Save in EHR when occurs, may also print out strip

7. IV THERAPY ([Nur HS 116](#))

1. Verify that all IV infusions are the correctly prescribed drug, rate and dosage. Assess at the beginning of each shift and PRN. Glucose concentration not to exceed D12.5 in peripheral IV administration.
2. Calcium chloride will not be administered peripherally IV, unless during code situation (never in scalp PIV even during a code).
3. IV Drip administration
 - a. Before initial administration of IV drips, a second RN will:
 - i. Independently double-check the solution and calculate dose against the CURRENT MD/DESIGNEE ORDER. All MD/designee orders for drips must include the following:
 1. Patient Name
 - a. Drug
 - b. Solution
 - c. Drug concentration

- d. Rate
 - e. mcg/kg/min or mg/kg/hr, or other - based on patients calculated (dry) weight.
 - f. Incomplete orders will not be accepted by the RN
2. Check the pump the drip is attached to, the line attachment, the rate of infusion and the patient, clamps open and stopcock open
 - ii. Both RN's will initial on the syringe/bag and in EHR.
 - iii. All pumps will be labeled with correct drug name
 - iv. Minimum fluid rate should total 2 ml/° per lumen (neonates < 28 days, see NICU guidelines), unless Remodulin infusing. Large bore catheters (such as cordis, Mahurkar, portacath, IVC) require min of 5 mL/°.
4. Do not infuse intermittent medications in IV line with inotropes

8. KCL BOLUS ([Policy #1381](#))

Rate of administration

Non cardiac 0.5-1 mEq/kg/hour

Cardiac 0.25-0.5mEq/kg/hour

MAXIMUM DOSE

Do not exceed 20mEq/hour for the weight of any child.

Only 2 hours worth of KCl bolus may be ordered at a time.

9. HYDRATION

Full maintenance

Example:

Full Maintenance	35 Kg child
4ml/kg/hour for 1st 10kg	40 ml (1 st 10kg)
2ml/kg/hour for 2nd 10kg	20 ml (2 nd 10kg)
1ml/kg/hour for remaining weight	+15ml (remaining weight) = 75ml/hour

Example:

Half Maintenance	35 kg child
2ml/kg/hour for 1st 10kg	20 ml (1 st 10kg)
1ml/kg/hour for 2nd 10kg	10 ml (2 nd 10kg)
0.5ml/kg/hour for the remaining weight	+ 7.5 ml (remaining)= 37.5 ml/hr

10. VENTILATION ([HS 1323](#), [Nur-HS G1023](#))

1. Pulse oximeters: Place on all patients and document oxygen saturation Q1 hour or Q2 hours based on acuity. Assess the probe site Q2 hours for perfusion. Change the probe site and document Q 4 hours and prn. The probe may be re-used when moved to a different site, clean with alcohol if needed.
2. Artificial airways: Assess need for suctioning Q1-2 hours
3. Ventilator settings: Verify ventilator settings at change of shift and with each vent change.
4. Endotracheal tubes: Secure with cloth tape; tape should be completely changed (never reinforced) PRN with either an RT or another RN

5. The endotracheal tube size and centimeter placement at the lip; verify as part of the initial assessment and with each tape change
6. FiO2 changes: May be made by the bedside RN with a MD/designee's titration order. All other ventilation changes must be made by a respiratory therapist
7. End tidal CO2 monitoring: All ventilated patients will receive ET CO2 monitoring with alarm. Document ETCO2 reading Q1 hour or Q2 hours based on acuity, along with proper waveform present. Verify equipment failure by using the pedicap.
8. ETCO2 must not be removed during resuscitation efforts. Continue to bag the patient with the ETCO2 attached and note readings.

Contact anesthesia STAT if the PICU attending is not immediately available.

9. ETCO2 must be used in the transport of intubated patients to and from the PICU.
10. CXR for ETT or trach verification:
 - a. Assure patient is in midline position
 - b. Head in neutral position
 - c. Assure chest and head is free of all artifacts (i.e. warming blanket, gel pillow, tubes, wires)

11. TUBING/SOLUTIONS ([Nur-HS116](#))

1. All peripheral IV's and arterial lines: IV extensions should be attached to all IV's and arterial lines if possible.
2. Change TPN and infusions with glucose concentration >D10 and lipid tubing Q24 hours, label & document in the EHR.
 - a. For patients with labile hemodynamic vital signs, clinical decision-making is needed to change bags, syringes, drips, stopcocks, and should be discussed with the attending/fellow prior to changing.
 - b. In hemodynamically unstable patients, it may be necessary to prime TPN, IL, and drips with secondary pumps and run for at least an hour prior to infusing. Drip/tubing change should be coordinated with TPN/IL changes.
3. Cyclosporine tubing: Change Q24 hours with the new bottle of IV Cyclosporine (entire solution along with flush must be administered prior to new bottle hung).
4. Propofol tubing: Change Q6 hours when in a syringe, Q 12 hours if in bottle.
5. Pentobarbital drip change Q 12 hours
6. HCL drip change Q 12 hours
7. Stopcocks and extension tubing: Change with line change
8. PCA/PCEA tubing: change Q96 hours
9. Pressure (arterial, CVP, Swan Ganz) line solution: Place 500ml of NS in a pressure bag at 200mmHg unless physician orders otherwise (PA lines and some patients may need heparin in bag 1:1 concentration, neonates only have 250units heparin/500 ml bag 0.45 NS)
 - a. Change Art/CVP/PA tubing q 96 hours.
10. Change blood tubing after 4 hours or after 2 units of blood.
11. Albumin tubing change after 4 hours
12. All line sites: Examine Q2 hours for signs of infiltration, blanching, inflammation, phlebitis and the general integrity of the line and site (Q1 hour for all vasoactive infusion)

13. Filter needles: Use to draw-up medications out of opened glass medication ampules, Dilantin, and mannitol. Infusions: Do not use metal needles in access ports
14. Air filters: Use on infusions for all cardiac patients with mixing lesions.

12. DRESSING CARE ([Nur HS-104](#))

1. Tegaderm clear plastic dressings: Change every week unless otherwise indicated. Any dressings with gauze should be changed Q48 hours
2. Chest tube dressings: Change 48 hours and PRN. Use Vaseline gauze with insertion and removal only. Change to gauze and tape with first dressing change. The dressing must be occlusive with either adhesive tape or Elastoplast. Place one piece of white cloth tape to anchor the chest tube (use mesentery style application)
3. PICC line dressings: change stat lock and tegaderm weekly or more frequently as needed.
4. Huber needles (portacath access): Change Q week along with dressing change. If gauze under tegaderm, then change dressing Q 48 hours.

13. URINARY CATHETERS

1. Secure Foley to the thigh with stat lock or tape
2. Foley care: Q 4 hours
3. Peri care: soap and water Q 4 hours and prn

14. INTERNAL NUTRITION ([NurHS 114](#)) and BREAST MILK ([Nur-HS 105](#))

1. Feeding, Corpak and Salem sump tubes: Date and time the tube itself with a piece of tape around the tube. Tape the tube in a neutral position (don't pull up on the nares). Examine skin integrity at the tape site Q shift. Inspect site Q shift for signs of redness, induration, drainage, or dislodgement.
 - a. NG tube placement: Check Q shift and prior to any medication administration into the tube. Consider changing NGT site if irritation develops.
 - b. Change Vygon feeding tubes q 72 hours
 - c. Change Corpak feeding tubes monthly
 - d. Change Salem Sump tubes weekly; unless abdominal surgical patient then do not replace check with surgical team
 - e. Jejunal tube: Placed by a physician and placement confirmed by x-ray. Measure abdominal girth Q shift if feeding.. Document measurements at nares Q shift. . Flush with sterile water q 6 and prn per MD/designee order.
 - f. GT/JT (Liver/Small bowel Transplant Patients): Administer meds, i.e.: Tacrolimus, via JT unless otherwise ordered by MD/designee. Do not reposition or replace tube without checking with Liver Team.
 - g. Administer all continuous feeds via Kangaroo pump, if less than 10 ml/hr place on syringe pump. Change enteral feeding set Q 24 hours.
 - h. Reconstituted formulas are good for 24 hours and are stored in refrigerators.
 - i. Breast milk: Verify correct patient with ID band and ID on milk. Freshly collected breast milk that is refrigerated is good for 72 hours. Thawed breast milk is good for

- 24 hours and cannot be refrozen. Frozen Breast milk is good for 6 months if stored in breast milk freezer. Breast milk tubing change every 4 hours.
- j. Use warmer to warm formula if needed. Discard unused portion once it is warmed.
 - k. For continuous enteral feedings, LIMIT volume of formula/breast milk in feeding bag to that which will infuse over 4 hours.
 - l. If possible, position patient with HOB elevated to prevent aspiration.
 - m. Medications should be given in liquid form if possible. Do not crush time release or enteric coated medications. Contact MD and pharmacy for alternates. Flush feeding tube before and after each medication administration with water. Confirm compatibility before mixing medications with feeds.
 - n. Sucrafate, Carafate, and Topamax Sprinkles have a high potential to clog tubes. Administer separately from other meds and flush tube well.

15. ENVIRONMENTAL STANDARDS ([HS IC 8801](#))

- 1. Bedside carts (cart is clean area): ensure cart is restocked every shift and prn
 - a. Staff are to keep the dirty utility room, lab testing area, medication area and the patient's bedside neat & clean.
 - b. All equipment including cables, bedside tables must be cleaned between each patient use with an appropriate solution
 - c. All items on the bedside cart should be labeled with the patient's name, and date opened including NS and sterile water.
 - d. Do not place linen on floor or hamper lids.

16. EQUIPMENT USE ([HS 5304](#))

- 1. IV Pumps:
 - a. Reset total volume Q shift and assess Q 2 hours for proper infusion
 - b. If syringe pumps are used, assess syringe for proper infusion Q 2 hours
 - c. Inotropes may be placed on mcg/kg/min mode on syringe pumps; assess amount infused from syringe Q2 hours for proper infusion
- 2. Suction:
 - a. Change canister and tubing Q72 hours or more frequently as needed
 - b. Suction to be set at no greater than 80mmHg

17. TRANSPORT WITHIN THE HOSPITAL ([HS 1305](#), [HS 1382](#))

- 1. Transport all ICU patients with the following:
 - a. PICU RN must remain with the patient for the duration of the transport, maintaining ICU care unless a qualified RN/MD is taking over the care
 - b. Cardiac monitor
 - c. Transport bag
 - d. Emergency Medications
 - e. Ambu-bag and appropriate sized face mask
 - f. Intubation tray (If patient intubated)

- g. RT must accompany all intubated patients on transport.
- h. Pulse oximeter
- i. Oxygen tank , if using oxygen in the ICU
- j. Portable suction machine, if indicated
- k. ETCO2 monitor

Caloric Requirements in Children

Normal Neonate 100 to 120 Calories/kg/day

1-2yr 90 to 100Calories/kg/day

2-6yr 80- 90Calories/kg/day

7-9yr 70- 80Calories/kg/day

10-12yr 50 to 60Calories/kg/day

*Note: Ill children (i.e. pain, fever, disease, surgery) may need extra calories above the stated requirements and comatose children may require fewer calories than stated.

PICU FAMILY/PATIENT CARE STANDARDS

1. ORIENTATION STANDARD ([HS 1354](#))

- a. Parents/Child will receive a PICU admission brochure upon admission or transfer to the PICU
- b. Parents/Child will be oriented to any major equipment attached to child, (e.g. ventilator, cardiac monitor, EEG, warming table, IV pumps, etc.)
- c. Documentation of equipment orientation and parent's understanding will be in the EHR.
- d. Bedside RN will screen any visitors < 12 (forms portal 11161) and place form in chart
- e. Parents are invited to watch the Mattel Children's Hospital Pediatric Welcome TV channel
- f. Parents will be given purple ID band to wear

2. TEACHING STANDARD ([HS 1322](#), [Nur G 1002](#))

- a. Teaching of patient progress done Q shift in regard to patient changes.
Documentation of teaching is noted Q shift in the EHR or "no family present" is documented

3. FAMILY INPUT INTO PLAN OF CARE ([Nur G1002](#))

- a. Families are given the opportunity to give input into plan of care Q shift and with significant changes in the patient plan of care
- b. Parents are given the opportunity to assist in care of their child, e.g. assisting with feeding, bed bath or range of motion exercises
** Documentation of family involvement will be noted in the EHR
- c. Family visitation and telephone calls are documented in EHR.

4. PSYCHOSOCIAL SUPPORT

- a. Multidisciplinary rounds are conducted weekly in the PICU. The charge nurse or designee will document outcomes from rounds as appropriate for every patient
- b. Psychosocial aspects of care are discussed in rounds and in change of shift report Q shift ** Documentation is noted in EHR of support given to patient/families and their response

5. DISCHARGE PLANNING ([HS 1361](#))

Planning for discharge should begin in the PICU on admission.

- a. Monday – Friday Daily IDR rounds in the PICU will include discharge planning
- b. Teaching required for discharge will begin as soon as possible. The following discharge teaching will begin on the same day the patient receives the procedure/treatment:

Tracheostomy

Broviac or other central lines

Ostomies (gastrostomy, colostomy, ileostomy, etc.)

Peritoneal Dialysis

Any other special procedure or treatments

** Documentation of teaching and patient/family response will be in the education section of EHR.

- c. The social worker will assess home care requirements as needed
- d. Case Managers will be consulted for DME and other needs as appropriate

REFERENCES

Hazinski, M.F. Nursing Care of the Critically Ill Child, Second Edition.