

Intensive Care Nursery House Staff Manual

Routine ICN Nursing Procedures

INTRODUCTION: For each infant admitted to the ICN, there are routine nursing procedures that are designed to assist in rapid evaluation of the infant's status and to monitor the infant appropriately for his/her medical condition. These procedures are performed in addition to any physicians' orders and vary according to the status of the patient. These routine procedures assist the House Officer by providing important patient data shortly after the infant has been admitted to the ICN and in preparing an infant for discharge from the ICN.

I. ADMISSION PROCEDURES:

A. Outborn infant transported from another facility:

1. Arterial pH and blood gas tensions while infant is in transport incubator
2. Weigh infant and transfer to ICN radiant warmer bed.
3. Apply monitors:
 - Leads for cardio-respiratory and temperature monitors
 - Probe for Pulse Oximeter (oxygen saturation)
 - Skin electrode for continuous measurement of transcutaneous CO₂
4. Measure and record vital signs and do physical assessment.
5. Connect IV fluids.
6. Obtain blood for the following:
 - Hematocrit, CBC with differential, platelet count, and type, Rh & antibody screen
 - If infant's age ≥ 12 h, blood is also sent for electrolytes, calcium, BUN, creatinine, and bilirubin (total and direct)

B. Inborn infant admitted from Resuscitation Room (Set-up Room)

1. Plug warmer bed into electrical outlet
2. Apply monitors:
 - Leads for cardio-respiratory and temperature monitors
 - Probe for Pulse Oximeter (oxygen saturation)
 - Skin electrode for continuous measurement of transcutaneous CO₂
3. Measure and record vital signs
4. Connect IV fluids
5. Unless obtained during resuscitation, send blood for Hematocrit, CBC with differential, platelet count, and type, Rh & antibody screen.

C. Infant with known or suspected cardiac disease: In addition to above, obtain:

1. 12 lead ECG
2. 4 limb blood pressures
3. Pre- and post-ductal saturation monitors (right upper limb and a lower limb)

II. DAILY ROUTINES:

A. AM shift:

1. 7:00 to 7:15 AM: Shift change and nursing bedside report
2. 8:00 to 9:00 AM: X-rays and ultrasounds done (Requisitions are to be filled out by the Resident or NNP and posted near the Secretary's Desk before 7:00 AM.)
3. Vital signs either q2h or q3h according to feeding schedule; if unstable, q1h
4. Bed meeting 8:30 AM daily: Charge nurse discusses planned admissions, discharges and off-unit procedures as well as status of patients in Labor/Delivery
5. IV fluids changed in afternoon (*i.e.*, intra-venous alimentation and lipids)

B. PM shift:

1. 7:00 to 7:15 PM: Shift change and nursing bedside report
2. Baths and weight done between 8:00 and 11:00 PM
3. Dressing changes for central catheters (Broviac q72h; femoral q48h)
4. Midnight: 24h intake and output totals calculated (based on current weight)
5. ~4:00 AM: routine labs are sent

III. DISCHARGE PROCEDURES:

- A. Complete "bumble bee" sheets (Discharge forms)
- B. Discharge physical exam (may be done ≤ 24 h prior to discharge)
- C. Discharge medications: Complete prescription form ≈ 24 h prior to discharge. These are to include:
 1. Vitamins with iron for premature infants
 2. Iron for infants with cardiac disease
- C. Discharge feedings:
 1. Be sure that, for 2-3d before discharge, the infant is on the feeding routine (volume, strength, frequency) which he/she will receive at home.
 2. For growing VLBW infants (*i.e.*, birthweight ≤ 1500 g):
 - If formula fed, change to 22 calorie/oz Neosure Advance™.
 - If breast fed, fortify supplemental breast milk to 22 calorie/oz with Neosure Advance™ powder.
 3. The bedside Nurse or Discharge Coordinator will provide formula mixing instructions and discharge education materials.
- D. Cardiac patients need chest radiograph and 12 lead ECG ≈ 24 h prior to discharge
- E. Goal is to discharge patient by 11 AM.