**Scope of critical care nursing practice**

**Definition of critical care nursing practice**

The American Association of critical Care Nurses ( AACN) define the critically ill patient as the following : the critically ill patient is characterized by the presence of actual or potential health problems – And the patient are in need for continuous observation and intervention for his health condition and for prevention of complications .

For these reasons the patient are in need for the basic physiological needs ( air – nutrition and elemenation ) and non physiological needs

Non - physiological needs may include : social ( for improving the patient's self – esstem and interaction between the health team and the patient's also family , spiritual and physiological needs to avoid stresses related to the sounds of the high voice of the health team or alarm of machines .

**Definition of Critical Care Nurse :**

Is a licensed professional is responsible for assessment . clinical judgment , immediate , early intervention in problems .

Must be based on a sound understanding of anatomy and physiology and follow up care for all critically ill patients – the application of this knowledge requires skills in clinical assessment and appropritate nursing and technological intervention .

The critical care nurse must be skillful for using observing the emergency equipments , machines and tubes .

Legal and Ethical Issues in Critical Care the practice of the professional nursing must be based on the legal rules with human responsibilities and related to patient's health problems the nurse has an obligation to provide continues observation and nursing intervention based on knowledge's and skills . These duties involve a higher standard of care and the courts are applying the professional malpractice nursing negligence punishments .

Negligence : is the failure to meet an ordinary standard of car . resulting in injury to the patient .

Malpractice : is a negligence of a duty or standard of care failure for clinical procedure which lead to harm for the patient's condition .

**Examples of critical care nursing actions in negligence laws .**

- Neglect to inform the doctor about the patient's health status .

- Neglect to follow up the patient's condition . Neglect to apply the protocol of treatment for the patient's condition according to the hospital protocol .

- Neglect the clinical assessment for the patient's condition Neglect to respond for the machine's alarms – Neglect to maintain accurate time . complete medical record

- Neglect out the patient's treatment and evaluate the results of treatment .

- Failure to use safe the equipment's connected with the patient .

**To avoid critical care nursing practice negligence**

It is common nursing practice to which and document the procedure.

Written permission given by patient to receive treatment or by his family if he was unconscious or mentally ill or a child .

**Legal critical care nursing duties**

Observation – Assessment – Reporting – Planning , implementation and evaluation – Resending to changes – Carrying out orders – Keep the patient safety – Follow hospital policies and procedures – Record and document .

**Icu psychosis**

**Educational objectives :**

**At the end of this unit the student will be able to :**

1- Identify delirium at ICU .

2- define what is the meaning of ICU psychosis .

3- discuss the nursing intervention to minimize delirium at ICU .

**Delirium at ICU**

**What is ICU psychosis ?**

Is a documented disorder experienced by patients in an intensive care patients are unable to sleep at night , anxiety , the condition has been formally defined as ( acute brain syndrome ) involving intellectual functioning which occur in patients who are being treated within a critical care unit sensory deprivation – being put in room that often has no windows , and is away from family and friends , sleep deprivation and unfamiliar people .

Painful procedures are among the factors believed to ICU psychosis .

Anxiety and restlessness from the disorientation and disturbed states that accompany delirium in ICU .

Is important to treat and manager delirious patients .

**What are the symptoms of ICU psychosis ?**

Extreme excitement , anxiety restlessness . hearing voices . clouding of consciousness , hallucinations , nightmares , paranoia , disorientation , agitation , delusions , disturbance of consciousness which include aggressive or passive behavior – The symptoms vary greatly from patient to patient .

Medical causes includes pain which may not be adequately controlled in an ICU .

**How is ICU psychosis diagnosed ?**

The diagnosis of ICU psychosis can decrease the symptoms of ICU psychosis .

**What is ICU psychosis ?**

The term ICU psychosis also implies that the signs and symptoms are associated with a psychiatric disorder .

**How common is ICU psychosis ?**

33% or 1 in 3 patients experience ICU / CCU psychosis . a form of delirium .

**ICU psychosis include :**

Increased patient stress . disorientation and delirium

Increased mortality - Increased length of hospital stay – Reduced level of functioning . especially in the elderly - Increase stress response syndrome after hospitalization .

**Hospitals are taking action to reduce ICU psychosis through the following :**

Family visiting - minimized shift changes of the nursing staff

Relaxation techniques ( hearing music , Koran , praying )

Patients who are less anxious have less need for sedation . over sedated Patients or patients experiencing unexpected side effects or complications from medical treatments or procedures will probably have an increase in the hospital length of stay and an increase in their hospital bills .

An over sedated patient cannot be weaned from a ventilator with extubation performed .

The risk for a hospital acquired nosocomial infection increase each day that a patient cannot to weaned .

Invasive catheter or tube in places .

Nosocomial pneumonia also prevent a patient's separation from a ventilator .

These complications can add days or even weeks to a hospital length of stay .

Anything that the heath team can do to prevent these types of complications such as decreasing the frequency and / or the dosage of sedatives and narcotics or preventing nosocomial infection has the potential for decreasing the hospital length of stay and hospital cost .

**Delirium :**

Is defined as an acute , reversible organic mental syndrome .

Disturbance in mental status , nighttime disorientation , agitation , or insomnia .

**Care plan for minimizing factors that contribute to Delirium**

1- Sleep disruption : minimize noise .

2- Noise : minimize conversation among staff at the bedside .

3-Ineffective communication : avoid terminology net familiar to the patient - encourage rational believes .

4- Disorientation : time - orientating devices .

5- Pain : encourage normal bowel and bladder function .

6- Disordered cognitive : which includes alteration in perception .

Thinking and memory , dysfunction of the autonomic nervous system .

**Three patterns are proposed of acute confusion**

1- cognitive : low sensory - environmental changes in case of brain trauma stroke dementia .

2-physological

3- metabolic 1- disturbance of consciousness ( reduced of awareness of the environment ) 2- a - change in cognitive such as memory disorientation , language disturbance ) 3- observed cognitive disturbance 4- sleep disturbance .

**Types of Delirium :**

1- hyperactive delirium

2- hypoactive delirium

3-mixed ( between hypo -hyperactivity)

Incidence rate generally between 20% to 50% among individuals 60 years of age or older .

Develop within the first two days of hospitalization , or after 6 days .

Length of rang from less than 1-7 days

**Factors may lead to development of acute confusion or Delirium**

Fluid and electrolyte disturbances - dehydration - hypocalcaemia - hypokalemia - abnormal sodium level - low serum albumin - high blood urea nitrogen - elevated creatinine - proteinuria - chronic renal failure - pain - low BP - cardiovascular disease - elevated prothrombin time - abnormal arterial blood gases -respiratory hypoxia - metabolic disturbances - abnormal blood glucose