APPENDIX C:

CRITICAL INDICATORS

&

DISCUSSION

APPENDIX C: CRITICAL INDICATORS

CRITICAL INDICATORS: GENERAL

Vital Signs (Manual TPR, BP)

Acuity Code		Frequency	Point Value	Page C-7
1	Vital Signs	q.i.d. or less	1 points	
2	Vital Signs	q4h or x 6	2 points	
3	Vital Signs	q3h or x 8	3 points	
4	Vital Signs	q2h or x 12	4 points	
5	Vital Signs	q1h or x 24	8 points	
6	Rectal or Axillary Temp or Apical Pulse	q.i.d. or more	2 points	
7	Femoral, Pedal or Popliteal Pulses or FHT	q.i.d. or more	2 points	
8	Tilt tests	q4h or more	2 points	
9	Post-op, Post-partum, or Post delivery (Infants)		6 points	

Monitoring

Acuity Code		Frequency	Point Value	Page C-11
10	Intake and Output	q8h	2 points	
11	Intake and Output	q2h	8 points	
12	Circulation or Fundus checks	q2h or x 12	2 points	
13	Neuro checks	q4h or x 6	3 points	
14	Neuro checks	q2h or x 12	6 points	
15	CVP or ICP (manual)	q2h or x 12	2 points	
16	Cardiac/apnea/pressure monitors (not cumulative)		6 points	
17	Transcutaneous monitor/ oximeter		6 points	
18	A-line or ICP (monitor) or Swan Ganz set-up		4 points	
19	A-line or ICP (monitor) reading	q2h or x 12	2 points	
20	Swan Ganz PAP/PA Wedge reading	q4h or x 6	2 points	
21	Swan Ganz PAP/PA Wedge reading	q2h or x 12	4 points	
22	Cardiac Output	t.i.d. or x 3	2 points	
23	Care - Infant/Toddler Care (0-5 Years of Age)		6 points	
24	Care - Self/Minimal (6 Years of Age or More)		2 points	
25	Care - Assisted (6 Years of Age or More)		6 points	
26	Care - Complete (6 Years of Age or More)		14 points	
27	Care - Total (6 Years of Age or More)		32 points	

28	Extra Linen Change And Partial Bath (x2 per Shift)		4 points
29	Turning Frame (2 Staff Members)	q2h	14 points
30	Peds recreation/observation - age 0-12		8 points
31	Spoon Feed meals - age 6 or more x 3		6 points
32	Spoon Feed meals - age 5 or less x 3		10 points
33	Infant/Neonate bottle x 1 feeding		2 points
35	Infant/Neonate bottle	q4h or x 6	12 points
35	Infant/Neonate bottle	q3h or x 8	16 points
36	Tube Feed	q4h or x 6	5 points
37	Tube Feed	q3h or x 8	8 points
38	Tube Feed	q2h or x 12	10 points
39	Tube Feed, Continuous	per bottle change	2 points

IV Therapy

Code		Frequency	Value	Page C-25
40	Start IV		2 points	
41	Change bottle/bag	bid or less	4 points	
42	Change bottle/bag	tid or q.i.d.	6 points	
43	Change bottle/bag	x 5 or more	8 points	
44	Heparin Lock or Broviac		4 points	
45	IV Medication	q8h or x 3	2 points	
46	IV Medication	q6h or x 4	3 points	
47	IV Medication	q4h or x 6	4 points	
48	Blood products	each unit	2 points	
49	Infusion Controller/pump		2 points	

Treatments/Procedures/Medications

Acuity Code		Frequency	Point Value	Page C-29
50	Insert NG		2 points	
51	O.R. prep or enema or ace wrap/teds		2 points	
52	Catheterization - Foley/straight		2 points	
53	Tube care (exclude trach)	x 2	2 points	
54	Dressing - Simple	5 - 7 mins x 2	2 points	
55	- Complex	30 minutes x 1	4 points	
56	Lab tests performed on the nursing unit	x 3	2 points	
57	Do EKG		2 points	
58	Venipuncture, Arterial puncture	x 2	2 points	
59	Medications - exclude IV	q3h - q8h	2 points	
60	12 or more trips	q2h	4 points	
61	Irrigations or Instillations	x4 or less	2 points	
62	Restraints, 2 point, 4 point, posey		2 points	
63	Assist OOB to chair/gurney x 3		2 points	
64	Assist OOB, ambulate	x 1	2 points	
65	Infant circumcision or phototherapy		2 points	
66	Isolation - gown & glove x 8		2 points	
67	Chest tube insertion or lumbar puncture		4 points	
68	Thoracentesis or paracentesis		4 points	
69	Range of Motion Exercises	x 3	4 points	
70	New Admission-assessment & orientation		12 points	
71	Transfer - In-House		4 points	
72	Accompany patient off unit	15 minutes	2 points	

Code	Activity	Frequency	Point Value
73	Accompany patient off unit	30 minutes	4 points
74	Accompany patient off unit	45 minutes	6 points
75	Other activities	15 minutes	2 points
76	Other activities	30 minutes	4 points
77	Other activities	45 minutes	6 points
78	Each hour requiring continuous staff attendance		8 points

Respiratory Therapy

Acuity Code		Frequency	Point Value	Page C-40
79	Oxygen therapy or oxyhood		2 points	
80	Incentive spirometer or C & DB	q4h or x 6	2 points	
81	IPPB or Maximist	bid or x 2	2 points	
82	IPPB or Maximist	q6h or x 4	4 points	
83	IPPB or Maximist	q4h or x 6	6 points	
84	Croup tent or mist tent		8 points	
85	Chest pulmonary therapy	bid or x 2	2 points	
86	Chest pulmonary therapy	q6h or x 4	4 points	
87	Chest pulmonary therapy	q4h or x 6	6 points	
88	Suctioning	q4h or x 6	2 points	
89	Suctioning	q2h or x 12	4 points	
90	Ventilator		10 points	
91	Tracheostomy care	x 3	4 points	

Teaching

Acuity Code		Frequency	Point Value	Page C-44
92	Group Teaching	per hour	2 points	
93	Individual Teaching	per 30 minutes	4 points	

Emotional Support

Acuity Code		Frequency	Point Value	Page C-44
94	Patient/Family support	per 30 minutes	4 points	
95	Lifestyle modification	per 30 minutes	4 points	
96	Sensory Deprivation - blind, deaf, retarded, etc.		6 points	
97	Maximum points for emotional support		10 points	

Continuous

Acuity Code		Frequency	Point Value	Page C-46
98	Patient requiring 1 to 1 coverage all shifts		96 points	
99	Patient requiring greater than one to one coverage all shifts		146 points	

CRITICAL INDICATORS: PSYCHIATRIC

Vital Signs (Manual TPR, BP)

Acuity Code		Frequency	Point Value	Page C-47
100	Vital Signs	q.i.d. or less	1 points	
101	Vital Signs	q4h or x 6	2 points	
102	Vital Signs	q3h or x 8	3 points	
103	Vital Signs	q2h or x 12	24 points	
104	Vital Signs	q1h or x 24	48 points	
105	Tilt tests	q4h or more	2 points	

Monitoring

Acuity Code		Frequency	Point Value	Page C-48
106	Intake and Output	q8h	2 points	
107	Circulation checks	q2h or x 12	2 points	
108	Patient checks	q30 minutes x 8	8 points	
109	Patient checks	q15 minutes x 8	16 points	
110	Neuro checks	q4h or x 6	3 points	

Activities Of Daily Living

Acuity Code		Frequency	Point Value	Page C-50
111	Care - age 6 or more - Self		2 points	
112	Care - Assisted		6 points	
113	Care - Complete		14 points	

Feeding

Acuity Code		Frequency	Point Value	Page C-53
114	Spoon Feed or one to one at meals	x 3	6 points	
115	Tube Feed - Bolus	q4h or x 6	5 points	
116	Escort patient to dining hall	x 3	2 points	

Treatments/Procedures/Medications

Acuity Code		Frequency	Point Value	Page C-54
117	Start IV or Ace wraps or tube care		2 points	
118	Dressing - Simple	15 minutes	2 points	
119	Dressing - Complex	30 minutes	4 points	
120	Lab tests performed on the nursing unit	x 3	2 points	
121	Electrocardiogram		2 points	
122	Venipuncture, Arterial puncture	x 2	2 points	
123	Medications - ex. IV	3 - 11 trips	2 points	
124	Medications - ex. IV	12 or more trips	4 points	
125	Restraints, 2 point, 4 point, posey		4 points	

Code	Item	Frequency	Point Value
126	New Admission-assessment & orientation		12 points
127	Transfer - Between psy units		4 points
128	Accompany patient off nursing unit	15 minutes	2 points
129	Accompany patient off nursing unit	30 minutes	4 points
130	Accompany patient off nursing unit	45 minutes	6 points
131	Other activities	15 minutes	2 points
132	Other activities	30 minutes	4 points
133	Other activities	45 minutes	6 points
134	Each hour requiring continuous staff attendance		8 points

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Therapeutic Interventions/Activities

Acuity Code		Frequency	Point Value	Page C-62
135	Purposeful Interaction	15 minutes	2 points	
136	Purposeful Interaction	30 minutes	4 points	
137	Purposeful Interaction	45 minutes	6 points	
138	Purposeful Interaction	1 hour	8 points	
139	Sensory Deprivation-blind, deaf, retarded,etc.		6 points	
140	Group Activity-on unit ratio 1:4-5	minutes-1 hour	2 points	
141	Group Activity-off unit ratio 1:4-5	45 minutes-1 hour	2 points	
142	Group Activity-meetings ratio 1:4-5	45 minutes - 1 hour	2 points	

Teaching

Acuity Code		Frequency	Point Value	Page C-64
143	Group Teaching	per hour	2 points	
144	Individual - teaching	per 30 minutes	4 points	

Continuous

Acuity Code		Frequency	Point Value	Page C-64
145	Patient requiring 1:1 coverage all shifts		96 points	

DEFINITIONS OF CRITICAL INDICATORS

GUIDELINES FOR INTERPRETING THE GENERAL CRITICAL INDICATORS:

The following information provides operational descriptions of each specific activity included under a critical indicator heading.

For each operational definition, time is included for the following activities as appropriate:

- Identifying and screening the patient;
- Explaining the procedure to the patient;
- Raising, lowering, or adjusting the bed before and after the nursing activity;
- Cleaning and straightening area;
- Recording activity on bedside records; and
- Spending time at the patient's bedside providing information, answering questions and interacting with patients.

NOTE: A certain amount of time is already built into the direct and indirect care time formulas for "teaching" and "emotional support". Nurses routinely teach and provide emotional support for patients during the normal course of delivering nursing care. Because of this, the indicators relating to patient teaching and emotional support should not be used routinely for all patients. These indicators should be used when the nurse identifies a need for teaching and/or emotional support beyond the amount provided to patients during the routine delivery of nursing care. While these indicators should not be used routinely, nurses should not hesitate to use them when the situation warrants. The need for these critical indicators should be clearly documented.

Operational descriptions are given for each critical indicator. This is to describe the nursing activity that is associated with that particular indicator.

Operational descriptions linked by the "+" symbol are included in the time allowance (point value) for that critical indicator. To obtain the points for a specific critical indicator, each operational description within the critical indicator may not be required. If a patient does not require all activities within a critical indicator linked by a +, points may still be taken. Use the critical indicator which best reflects the patient's needs. The format for this symbol is: +

Operational descriptions linked by the word "or" indicate that the same time allowance (point value) is to be assigned to each of the operational descriptions. The format for this is:

or

Special considerations or explanations are designated by the header Note:

VITAL SIGNS (MANUAL TPR, BP)

Vital Signs: (Manual Temp, Pulse, Respiration and Blood Pressure)

AC1 . . . . VS . . . . q.i.d. or less . . . . .1 point
AC2 . . . . VS . . . . q 4 h or x 6. . . . . . 2 points
AC3 . . . . VS . . . . q 3 h or x 8. . . . . . 3 points
AC4 . . . . VS . . . . q 2 h or x 12 . . . . . 4 points

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AC5 . . . . VS . . . . q 1 h or x 24 . . . . . 8 points

Note

- "Vital Signs q.i.d. or less" is the only critical indicator with a one point value.
- "Vital Signs q 4 h or x 6" in a 24 hour period is equal to 2 points. "Vital signs q 2 h or x 12" is twice as often, therefore equal to twice as many points--4 points, and "vital signs q 1 h or x 24" is equal to 8 points. Vital signs taken every 30 minutes x 24 h would be valued at 16 points.
- Select point allowance to fit vital sign frequency. Add points when using an alternate method of taking pulses or temperatures if they are taken q.i.d. or more often.

Example:

VS q 4 h = 2 points

Rectal temps = 2 points (see AC 6)

Apical pulses = 2 points (see AC 6)

Total = 6 points

Operational Description

1. Oral Temperature, Pulse and Respiration: Place equipment at bedside and position temperature probe or thermometer. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial pulse, record results of measurements, and remove equipment from area.

+

2. Blood Pressure, Manual: Place equipment at bedside, place cuff around extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

3. Blood Pressure, Arteriosonde: Apply electrode gel to cuff, position cuff around extremity, measure blood pressure, remove cuff, cleanse gel from extremity, record results, and store equipment at bedside.

Rectal or Axillary Temperatures or Apical Pulse

AC6 . . . Rectal or Axillary Temp or Apical Pulse . q.i.d. or more . 2 points

Note

- Use this critical indicator only if taken q.i.d. or more often.
- Do not increase point value for increased frequency. If rectal temperatures are taken at least q.i.d., then count 2 points, but even if taken more frequently, (e.g., q 4 h) still only count 2 points.
- If rectal temperature and apical pulse are both taken q.i.d. or more frequently, take 2 points for each for a total of 4 points.

Operational Description

1. (2 points) Temperature - Rectal, Electronic/Mercury: Place equipment at bedside, adjust clothing, lubricate and insert temperature probe or thermometer in anus, measure temperature, remove temperature probe or thermometer, record, and remove equipment from area.

or

2. (2 points) Temperature - Axillary, Electronic/Mercury: Place equipment at bedside, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record, and remove equipment from area.

or

3. (2 points) Pulse - Apical: Place equipment at bedside, place stethoscope over apex of heart and count rate, remove stethoscope, record pulse rate, and remove equipment from area.

Femoral, Pedal, or Popliteal Pulses or Fetal Heart Tones

AC7 . . . Femoral, Pedal, or Popliteal Pulses or FHT q.i.d. or more . 2 points

Note

- Use only if taken at least q.i.d. or more often.
- Do not increase allowance for increased frequency.
- Add 2 points for each activity required.
- Femoral or pedal pulses or fetal heart tones must be taken at least q.i.d. before you count the 2 points, but once again, since the critical indicator states "q.i.d. or more" you would not get additional points if they were done more frequently.
- If you had a patient with pedal pulses q.i.d. and fetal heart tones q.i.d., you would count 2 points for each activity for a total of 4 points.
- Double points for multiple gestation pregnancies.

Operational Description

1. (2 points) Pulse - Femoral or Pedal or Popliteal: Place fingers on the femoral or pedal or popliteal pulse, count rate, remove fingers from area, and record results.

or

2. (2 points) Pulse - Doppler: Place equipment at bedside, apply conducting gel, place sensor over pulse area, assess and record pulse rate, and remove equipment from area.

or

3. (2 points) Fetal Heart Tones, Manual: Expose abdominal area, assess FHTs with stethoscope, record FHTs, and remove equipment from area.

or

4. (2 points) Fetal Heart Tones, Doppler: Expose abdominal area, locate FHT with fetoscope, apply conducting gel, assess FHTs utilizing the doptone, record results, and remove equipment from

area.

Tilt Test

AC8 . . . Tilt Test . . . . q 4 h or more . . . . . . 2 points

Note

- Use only if taken at least q 4 h or more often.
- Do not increase allowance for increased frequency.
- This allows for a lying, sitting and standing value. Use this critical indicator even if only lying and sitting tests are done.

Operational Description

1. Blood Pressure, Lying : Place equipment at bedside, place cuff around exposed extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

2. Blood Pressure, Sitting: Place equipment at bedside, place cuff around exposed extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

3. Blood Pressure, Standing: Place equipment at bedside, place cuff around exposed extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

4. Assist With Position Change: Assist patient from lying position to a sitting position or to a standing position.

Post-Operative, Post-Partum, or Post-Delivery Newborn Vital Signs

AC9. . Post-op., Post-partum, or Post-delivery newborn Vital Signs. . 6 points

Note

- Refers to a decreasing frequency of vital signs that typically has the following pattern: Every 15 minutes x 4, then every 30 minutes x 4, then every 1 hour x 4, then q 4 h for the remainder of the 24 hour period.
- Includes vital signs taken after surgery, after delivery (mother), and for the first 24 hours of the newborn's life.
- Refers to vital signs of decreasing frequency following any special procedure e.g. post-arteriogram. (e.g., q 15 minutes x 4, q 30 minutes x 4, q 1 h x 4, then q 4 h).
- Use this critical indicator even if the described pattern is not exact, for example, if you must check the vital signs every 30 minutes x 4 then q 1 h x 2, then q 4 h

Operational Description

1. Oral Temperature, Pulse and Respirations: Place equipment at bedside and position temperature probe or thermometer. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial pulse, record results of measurements, and remove equipment from area.

+

2. Blood Pressure, Manual: Place equipment at bedside, place cuff around exposed extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

3. Blood Pressure, Arteriosonde: Apply electrode gel to cuff, position cuff around exposed extremity, measure blood pressure, remove cuff, cleanse gel from extremity, store equipment at bedside, and record results.

MONITORING

Intake and Output

AC10. . Intake and Output . . . . q 8 h . . . . 2 points
AC11. . Intake and Output . . . . q 2 h . . . . 8 points

Note

- Intake and output must be measured at least q 8 h
- Increase point allowance for increased frequency, but must be done at least q 8 h or once a shift in order for you to use this indicator.
- Intake and output includes time to measure all forms of intake and output, including diaper weights.
- Patients on just intake or just output will not receive any points.

Operational Description

1. Measuring and Recording Intake: Place calibrated cylinder/container at bedside, measure or calculate fluids, record amount on intake and output record, and remove equipment from area.

+

2. Measuring and Recording Output - Urine: Place calibrated cylinder at bedside, measure or calculate volume, record amount on intake and output record, then remove equipment from area.

+

3. Measuring and Recording Output - Liquid Feces: Remove bedpan from patient's bedside, measure feces in calibrated cylinder, and record amount on intake and output record.

+

4. Measuring and Recording Output - Vomitus: Remove container from

patient's bedside, measure vomitus in calibrated cylinder, and record amount on intake and output record.

+

5. Measuring and Recording Output - Drainage Bottles/All Types: Place calibrated cylinder at bedside, pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on intake and output record, and remove equipment from area.

+

6. Output Weight, Diaper or Bed Linens: Complete the procedure for diaper change and bed linen change, remove items to be weighed, weigh on weight scales, and record results.

Circulation or Fundus Checks

AC12 . . Circulation of Fundus Checks . . . q 2 h or x 12 . . . . . 2 points

Note

- Add points for each activity required.
- Circulation or fundus checks must be done at least q 2 h or x12 in a 24 hour period before they count. Circulation checks include checking for movement and sensation.

Operational Description

1. (2 points) Circulation Check: Arrive at bedside, check extremity for swelling, numbness, and tingling, evaluate temperature and color of the skin, assess the patient's ability to move the part, and record results.

or

2. (2 points) Fundus Massage: Arrive at the bedside, expose patient's lower abdominal area, massage fundus and assess height of uterus, then record type and amount of lochia.

Neurological Checks

AC13 . . Neuro Checks . . . . q 4 h or x 6 . . . . 3 points
AC14 . . Neuro Checks . . . . q 2 h or x 12. . . . . 6 points

Note

- Neuro checks include checking pupils, mental alertness, orientation, sensory discrimination and motor and sensory testing.
- Neuro checks must be done at least q 4 h (x 2 in a shift) or x 6 in a 24 hour period in order to count. Increase the point value for corresponding increases in frequency (e.g., neuro checks q 1 h would equal 12 points).

Operational Description

1. Pupil Reflexes: Place equipment at the bedside, adjust room lighting, assess pupillary reflexes with flashlight, and remove equipment from area.

+

2. Mental Alertness: Arrive at the bedside, make inquiries within framework of interview that will give information about the patient's level of consciousness, memory, intellectual performance and judgment, and record results.

+

3. Orientation: Arrive at the bedside, make inquiries within the framework that will give information about patient's orientation to time, place, and person, and record results.

+

4. Sensory Discrimination: Screen for pain, vibration, light touch, and stereognosis, and record results.

+

5. Motor or Sensory Testing: Arrive at the bedside and assess extremities for sensation awareness and muscle strength.

Central Venous Pressure or Intracranial Pressure Monitoring (manual)

AC15 . . .CVP or ICP Monitoring (manual) . . q 2 h or x 12 . . . . 2 points

Note

- Must be done q 2 h or x 12 in a 24 hour period.
- Add points for each activity required.
- Manual means you use a manometer, not a Swan Ganz or electronic ICP machine.
- Increase the point value for a corresponding increase in frequency. For example, CVP q 1 h would equal 4 points.

Operational Description

1. (2 points) Central Venous Pressure: Set up equipment for measurement of pressure, position patient and assess sternal angle, measure pressure, restore equipment to original position, and record results. Does not include insertion time.

or

2. (2 points) Intracranial Pressure: Set up equipment, measure pressure, restore equipment to original position, and record results. Does not include insertion time.

Cardiac/Apnea/Temperature/Blood Pressure Monitoring Electronically

AC16 . Cardiac/Apnea/Temp Probe/Blood Pressure Monitors . . . . . 6 points

Note

- (Not Cumulative)
- If the patient is on one or more of the following: cardiac/apnea/ temperature/blood pressure monitors, a total of 6 points is counted. Six points are earned regardless of the number of monitors in use. Points are not additive.

Operational Description

1. Adjusting Monitors or Connecting Leads or Reset Alarms: Upon arrival at the bedside, adjust monitor, connect leads or reset the alarm, then depart the area. Also includes time for observation of monitors.

+

2. Off Nursing Unit Telemetry: Patient located on one nursing unit but monitored at a different location. Includes time for the patient's unit to check patient, adjust telemetry unit, connect leads, or reset telemetry unit.

NOTE: Both the patient's unit and the monitoring unit may take 6 points for this critical indicator (if both units are involved). The monitoring unit ascribes six points for a "Telemetry Patient" on a Patient Acuity Worksheet and classifies them as Category I.

Transcutaneous Monitor/Oximeter

AC17 . Transcutaneous Monitor/Oximeter . . . . 6 points

Operational Description

1. (6 points) Transcutaneous Monitor: Place equipment at bedside, apply new probe, check monitor calibration, and remove equipment from area q 4 h Also includes time for observation of monitor.

or

2. (6 points) Oximeter: Includes time to obtain an oximeter reading at the bedside at least q 4 h

Arterial Line or Intracranial Pressure (ICP) Line or Swan Ganz Set-up

AC18. . Arterial Line or ICP Monitor or Swan Ganz Setup . . . . . 4 points

Note

- This critical indicator is to be used when actually setting up the equipment at the bedside.

- Add points for each activity required.

Operational Description

1. (4 points) Arterial Line Set-up or Transducer Exchange: Place equipment at bedside, set up transducer tray, IV solution, and cardiac monitor, calibrate the monitor and measure the transducer current with a mercury sphygmomanometer, measure and record pulmonary artery pressure and/or pulmonary artery wedge, and remove equipment from area. Does not include insertion time.

or

2. (4 points) ICP Line Set-up or Transducer Exchange: Set up transducer tray, IV solution, and ICP monitor, calibrate the monitor and measure transducer current with mercury sphygmomanometer, and remove equipment from area. Does not include insertion time.

or

3. (4 points) Swan Ganz Catheter Set-up or Transducer Exchange: Place

equipment at bedside and set up transducer tray, IV solution, and cardiac monitor, calibrate the cardiac monitor and measure the transducer current with a mercury sphygmomanometer, measure and record pulmonary artery pressure and/or pulmonary wedge pressure, and remove equipment from area. Does not include insertion time.

Arterial Line Or Intracranial Pressure Monitor Reading

AC19 . . .Arterial Line or ICP Monitor Reading. . q 2 h or x 12 . . 2 points

Note

- This must be done at least every 2 hours or 12 times in a 24 hour period.
- Add points for each of the above activities.
- A-line or ICP monitor readings performed and documented q 2 h or x 12 equals 2 points. If done every hour, it equals 4 points.

Operational Description

1. (2 points) Blood Pressure Arterial Line: Arrive at the bedside, flush line, assess, calculate pressure, and record results.

or

2. (2 points) Intracranial Pressure (Monitor): Arrive at the bedside, flush line, assess, calculate pressure, and record results.

Swan Ganz Pulmonary Artery Pressure and Pulmonary Artery Wedge Pressure Readings

AC20 . . PAP/PA Wedge Readings . . . . q 4 h or x 6 . . . . . 2 points
AC21 . . PAP/PA Wedge Readings . . . . q 2 h or x 12. . . . . 4 points

Note

- This must be done at least q 4 h or x 6 in a 24 hour period.
- Pulmonary artery pressure and wedge pressure readings must be recorded to count.

Operational Description

1. Pulmonary Artery Pressure: Arrive at the bedside, assess the patient and record findings.

+

2. Pulmonary Artery Pressure Wedge: Arrive at the bedside, flush line, slowly inject air into Swan-Ganz catheter, assess and calculate wedge pressure, and record results.

Cardiac Output

AC22 . . Cardiac Output . . . . t.i.d or x 3 . . . . 2 points

Note

- This must be done at least x 3 in a 24 hour period.
- Cardiac outputs must involve nursing personnel time to count. If

the physician performs the test without assistance, it does not count.

Operational Description

1. Cardiac Output Measurement: Place equipment at bedside, assist or complete measurement, record results, and remove equipment from area.

ACTIVITIES OF DAILY LIVING (ADL)

Note

- All patients must be ascribed points for at least one ADL critical indicator except Category 0 patients (those patients on pass or subsisting elsewhere). Points may not be doubled.

- Count ADL for all patients even if the family provides this care. (The nursing staff is still responsible for the care.) The family must be instructed about the care, and the professional nurse monitors the care provided. The family member cannot be held responsible for the care.

Care - Infant and Toddler (for Children less than or equal to 5 Years of Age)

AC23 . . Care - Infant/Toddler Care (0-5 Years of Age) . . . . 6 points

Note

- Infant or toddler care (less than or equal to 5 years of age) includes neonates and premature infants.

- Newborns/Infants/Toddlers with rooming in should be allotted 6 points to account for nursing staff time required to access and oversee the child and parent even when parent is providing the care.

- Infant or toddler care includes time to give a complete bath or tub bath, AM care, PM care, washing face and hands routinely and p.r.n., diaper changes or assisting child to the bathroom, changing clothes and linens, ambulatory weight or infant weight, serving the meal tray, and doing routine nursing assessments. Also includes the administration of non-intravenous medication - b.i.d. or less.

Operational Description

1. Bathing, Complete: Place equipment at bedside, remove shirt and diaper, bathe face, chest, abdomen and extremities, change water, bathe back, perineal area and buttocks, replace shirt and diaper, comb hair, and remove equipment from area.

+

2. Tub Bath: Arrive in the bathroom, assist patient in undressing, entry into bathtub, with bathing, and redressing, and return to bed.

+

3. AM Care: Place equipment at the bedside, assist patient with bathing face and hands and brushing teeth, comb hair and remove equipment from area.

+

4. PM Care: Place equipment at the bedside, bathe face and hands, brush teeth, and rub back, comb hair, tighten and straighten bed linens, and remove equipment from area.

+

5. Umbilical Cord Care: Place equipment at bedside, cleanse umbilicus with antiseptic solution, expose to air and dry, and remove equipment from bedside.

+

6. Bathing, Face and Hands (Routine and p.r.n.): Arrive at the bedside, bathe face and hands, comb hair, and remove used equipment from the area.

+

7. Diaper Change: Arrive at the bedside, expose baby, remove soiled diaper, cleanse genitalia and buttocks, diaper baby, position and cover baby, and remove equipment from area.

+

8. Assist to Bathroom: Assist toilet trained toddler to bathroom, remove pants, cleanse genitalia and buttocks, and replace pants.

+

9. Changing Shirt: Arrive at the bedside, change soiled shirt, and remove soiled shirt from area.

+

10. Occupied Bed: Place linen at the bedside, turn patient on side, roll linen to one side of bed, replace with clean linen, turn patient to freshly made side of bed, remove soiled linen, complete bed making, and remove soiled linen from bed.

+

11. Unoccupied Bed: Place linen at the bedside, remove soiled linen, place bottom sheet on mattress, place top sheet, change pillow cases, and remove soiled linen from area.

+

12. Ambulatory Weight: Place equipment at the bedside, balance scale, assist patient onto the scale, read and record weight reading, assist patient off the scale, and remove equipment from area.

+

13. Weight - Infant: Arrive at the bedside, remove clothing, place baby on balanced Infant Weight Scales, read weight, return baby to bed, dress baby, and remove equipment from area.

+

14. Serving Meal Tray, Preparation Required: Place tray at the bedside, prepare food and utensils, and place towel or napkin as bib.

+

15. Nursing Assessment: Make bedside assessment of patient, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

Care - Self/Minimal (Adult or Child 6 Years of Age or More)

AC24 . Care - Self-Minimal (6 Years of Age or More) . . . . 2 points

Note

- Self/minimal care (6 years of age or more) includes time for administration of non-intravenous medications b.i.d. or less, providing equipment for a self-bath, serving the meal tray, making an unoccupied bed and routine nursing assessments.

Operational Description

- Bathing: Place equipment at the bedside, allow time for patient to bathe and change pajamas, and remove equipment from area.

+

- Serving Meal Tray: Place tray at bedside and assess adequacy of dietary intake.

+

- Unoccupied Bed: Place linen at bedside, remove soiled linen, place bottom sheet on mattress, place top sheet, change pillow cases, and remove soiled linen from area.

+

- Nursing Assessment: Make bedside assessment of patient, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

Care - Assisted (Adult or Child 6 Years of Age or More)

AC25 . . Care - Assisted (6 Years of Age or More) . . . . 6 points

Note

- Able to position self.
- Assisted care (adult or child 6 years of age or more) includes time for administration of non-intravenous medications b.i.d. or less, assisting with bathing back and legs or assisting with a shower or tub bath, AM care, PM care, serving the meal tray with some preparation of the food, checking ambulatory weight, making an unoccupied bed, routine nursing assessment and answering patient questions.

Operational Description

1. Bathing, Assist With Back and Legs: Place equipment at the bedside, remove pajamas, allow for patient bathing, change water, bathe back and lower extremities, replace pajamas, and remove equipment from area.

+

2. Sitting Shower or Shower With Assistance: Arrive in the shower room, assist patient in undressing, with showering, with bathing and hair shampooing, assist in redressing, and return to bed.

+

3. Tub Bath: Arrive in the bathroom, assist patient in undressing, into bathtub, with bath and assist in redressing, and back into the bed.

+

4. AM Care: Place equipment at the bedside, assist patient with bathing face and hands and brushing teeth and remove equipment from area.

+

5. AM Care, Partial: Place equipment at the bedside, prepare bath water, put toothpaste on tooth brush, and remove equipment from area.

+

6. PM Care: Place equipment at the bedside, assist patient to bathe face and hands and brush teeth, give back rub, tighten and straighten bed linens, and remove equipment from area.

+

7. Serving Meal Tray, Preparation Required: Place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib.

+

8. Ambulatory Weight: Place equipment at the bedside, balance scale, assist patient onto the scale, read and record weight, assist patient off the scale, and remove equipment from area.

+

9. Unoccupied Bed: Place linen at the bedside, remove soiled linen, place bottom sheet on mattress, add top sheet, change pillow cases, and remove soiled linen from area.

+

10. Answering Patient's Questions: Answer patient's questions or respond to the patient's call system.

+

11. Nursing Assessment: Make assessment of patient, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

Care - Complete (Adult or Child 6 Years of Age or More)

AC26 . .Care - Complete (6 Years of Age or More) . . . . 14 points

Note

- Needs assistance with positioning.
- Complete care (adult or child 6 years of age or more) includes time for administration of non-intravenous medications b.i.d. or less, a complete bed bath, AM and PM care, weighing the patient, giving the bedpan and/or urinal, making an occupied bed, serving the meal tray with preparation required, assisting with positioning and repositioning the patient, answering the patient's questions and routine nursing assessments.

Operational Description

1. Bathing, Complete: Place equipment at bedside, remove pajamas, bathe face, chest, abdomen and extremities, change water, bathe back, perineal area, and buttocks; replace pajamas, comb hair, and remove equipment from area.

+

2. AM Care: Place equipment at bedside, assist patient with bathing face, hands, and brushing teeth, comb hair, and remove equipment from area.

+

3. PM Care: Place equipment at bedside, assist patient to bathe face, hands, and brush teeth, comb hair, rub back, tighten and straighten bed linens, and remove equipment from area.

+

4. Weight: Place equipment at the bedside, balance scale, assist patient onto the scale, read and record weight, assist patient in getting off the scale, and remove equipment from area.

+

5. Giving a Bedpan: Place a bedpan at the bedside, place patient onto bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area. Assist patient with washing hands.

+

6. Giving a Urinal: Place urinal at the patient's bedside, remove cover, adjust patient's pajamas for placement of urinal, remove urinal from patient, replace cover, and remove urinal from area. Assist patient with washing hands.

+

7. Occupied Bed: Place linen at bedside, turn patient on side, roll linen to one side of bed and replace with clean linen, turn patient to freshly made side of bed, remove soiled linen and complete bed making, and remove soiled linen from bed.

+

8. Serving Meal Tray, Preparation Required: Place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib.

+

9. Assist with Positioning: Remove support pillows and assist patient

to new position.

+

10. Answering Patient's Questions: Answer patient's questions or respond to the patient's call system.

+

11. Nursing Assessment: Make assessment of patient, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

Care - Total (Adult or Child 6 Years of Age or More)

AC27 . . Care - Total (6 Years of Age or More) . . . . . . 32 points

Note

- Total (adult or child 6 years of age or more) includes administration of non-intravenous medications b.i.d. or less, complete bath, AM and PM care, skin care q 2 h, oral hygiene q. 4 h., making an occupied bed, turning the patient q 2 h., giving a bedpan and/or urinal, weighing the patient, answering patient questions and routine nursing assessment.

Operational Description

1. Bathing, Complete: Please equipment at the bedside, remove pajamas, bathe face, chest, abdomen, and extremities, change water, bathe back, perineal area, and buttocks, replace pajamas, and remove equipment from area.

+

2. AM Care: Place equipment at the bedside, assist patient with bathing face, hands, and brushing teeth, comb hair, and remove equipment from area.

+

3. PM Care: Place equipment at the bedside, bathe face, hands, and brush teeth, rub back, adjust bed linens, comb hair, and remove equipment from area. +

4. Skin Care: Place equipment at the bedside, cleanse and dry areas for special care (buttocks, hips, shoulders and heels), apply lotion and remove equipment from area, q. 2 h.

+

5. Oral Hygiene: Place equipment at the bedside, turn patient to side, cleanse gums, teeth and mouth with applicators, and remove equipment from area, q. 4 h.

+

6. Occupied Bed: Place linen at the bedside, turn patient on side, roll linen to one side of bed and replace with clean linen, turn patient to freshly made side of bed, complete bed making, remove soiled linen from bed, b.i.d.

+

7. Turn Patient: Remove support pillows, reposition patient, and replace support pillows, q 2 h

+

8. Giving a Bedpan: Place bedpan at the bedside, place patient onto bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove bedpan from area. Assist patient with washing hands.

+

9. Giving a Urinal: Place urinal at the patient's bedside, remove cover, adjust patient's pajamas for placement of urinal, remove urinal from patient and replace cover, and remove urinal from area. Assist patient with washing hands.

+

10. Bed Scale Weight: Place equipment at bedside, balance scale, assist patient onto the scale, read and record weight, assist patient in getting off the scale, and remove equipment from area.

+

11. Answering Patient's Questions: Answer patient's questions or respond to the patient's call system.

+

12. Nursing Assessment: Make assessment of patient, formulate nursing care plans, and evaluate effectiveness of interventions.

Extra Linen Change And Partial Bath (2 x Per Shift)

AC28 . . Extra Linen Change And partial Bath . (x2 per Shift) . . 4 points

Note

- Any time a patient requires an extra linen change and partial bath twice per shift for any reason (e.g., vomiting, incontinence, diaphoresis), take these 4 points in addition to any of the ADL critical indicators previously listed.

Operational Description

1. Incontinence Care: Place equipment at the patient's bedside, bathe buttocks, perineum, and thighs, change bedding, and remove equipment and soiled linen from area, 2 x per shift.

+

2. Diaphoresis Care: Place equipment at the bedside, dry patient's skin, change pajamas, change bedding, and remove equipment from area, 2 x per shift.

Turning Frame q 2 h

AC29 . Turning Frame (2 Staff Members) . . . q 2 h . . . 14 points

Note

- This critical indicator includes time for 2 people to turn the patient q 2 h.

Operational Description

1. Turning Frame, All Types: Remove or secure support pillows and devices, place and secure restraining straps, unlock frame, turn frame according to specifications, lock frame, remove restraining straps, adjust pillows and support devices.

Pediatric Recreation And Observation (Children 0-12 Years of Age)

AC30 . . Pediatric Recreation and Observation (Age 0-12) . . . . 8 points

Note

- Includes newborn nursery but not neonatal intensive care where patients may be given continuous care points.

- Pediatric recreation and observation (less than or equal to 12 years of age) includes nursery babies as well as other pediatric patients. This critical indicator includes time spent in supervising recreational activities, answering patient's questions, responding to patient's crying, visiting with the child, and holding the child. This critical indicator is not to be given automatically to any child less than 12 years of age unless documented in the medical or nursing orders.

Example

A mother (or family member) rooming in with the child may provide recreational activities and/or supervisory activities without staff involvement. Hence points for this critical indicator would not be taken.

Operational Description

1. Planned Recreational Activity Session: Supervise recreational activity.

+

2. Answering Patient's Questions and Responding to Crying: Answer patient's questions or respond to the patient's call system or patient's crying.

+

3. Visiting with Patient or Purposeful Interaction: Includes time spent at patient's bedside without providing any direct physical care to patient but which is not in response to patient call system or patient questions.

+

4. Holding - Infant: <Holding - Infant> Arrive at the bedside, wrap baby in blanket, pick up and hold baby. When completed, position in bed and cover with blanket.

FEEDING

Note

- o Parenteral nutrition (parenteral hyperalimentation) lines are to be treated as IV lines.

Spoon-Feed Meals

AC31 . Spoon-Feed Meals - Age 6 or More . . . x 3 . . . . 6 points
AC32 . Spoon-Feed Meals - Age 5 or Less . . . x 3 . . . . 10 points

Note

- Count adult or child meals only if the patient must be spoon-fed each meal. Otherwise, time to serve and prepare the tray is included in the Activities of Daily Living critical indicators.

Operational Description

1. Spoon-feeding: Place meal tray at bedside, place towel or napkin as bib, prepare the food, feed the patient slowly, and remove the tray from the area, x 3.

Infant/Neonate - Bottle Feeding

AC33 . . Infant/Neonate - Bottle . . . . x 1 Feeding . . . . . 2 points
AC34 . . Infant/Neonate - Bottle . . . . q 4 h or x 6. . . . .12 points
AC35 . . Infant/Neonate - Bottle . . . . q 3 h or x 8. . . . .16 points

Note

- Well baby nurseries with rooming in should allot 2 points for each infant feeding given by nursery personnel.

Operational Description

1. Feeding - Graduated Feeder: Place equipment at the bedside, pick up baby, wrap in blanket, hold in feeding position, feed baby, bubble baby, reposition in bed (isolette, incubator, etc.), and remove equipment from area.

+

2. Feeding - Bottle: Place equipment at the bedside, pick up baby, wrap in blanket, hold in feeding position, feed baby, bubble baby, reposition in bed and remove equipment from area.

Tube Feeding Bolus

AC36 . . Tube Feed . . . . q 4 h or x 6 . . . . 5 points
AC37 . . Tube Feed . . . . q 4 h or x 8 . . . . 8 points
AC38 . . Tube Feed . . . . q 4 h or x 12. . . . . 10 points

Note

- Count each feeding.
- Includes nasogastric tube feedings as well as gastrostomy tube feedings.

Operational Description

1. Nasogastric: Place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and remove feeding equipment from area.

+

2. Gastrostomy: Place feeding at the bedside, uncoil and unclamp tube, assess for placement, administer feeding, flush tube with water, clamp tube, replace tube, and remove feeding equipment from area.

Tube Feeding Continuous

AC39 . . Tube Feed Adult/Child/Neonate . . (continuous) . . . 2 points

Note

- Count each bottle change.
- Continuous tube feedings or enteral hyperalimentation includes continuous feedings through nasogastric tubes, oral gastric tubes, oral-jejunostomy tubes, and gastrostomy tubes.
- Count 2 points each time the bottle/bag of feeding is changed or filled.

Operational Description

1. Nasogastric or Enteral Hyperalimentation (Continuous) Feeding With Gastric Feeding Equipment: Place equipment at bedside, assess for tube placement, connect to feeding tube/nasogastric tube, adjust flow rate, record on intake and output record, and remove equipment as necessary.

+

2. Nasogastric, Continuous With Infusion Pump: Place equipment at bedside, remove and/or position feeding bottle, assess placement of tube, connect to feeding tube, set up through flow rate adjuster or equipment, establish flow rate, record on intake and output record, and remove equipment from area.

+

3. Oral Gastric Tube: Place equipment at bedside, position baby, insert feeding tube, assess placement, check stomach for residual, instill feeding, remove feeding tube, bubble baby, position, and remove equipment as necessary.

+

4. Oral-Jejunostomy Tube: Place equipment at bedside, uncoil and unclamp tube, assess placement, administer feeding, flush tube with water, clamp tube, replace tube, and remove feeding equipment from area.

IV THERAPY

Note

- Hyperalimentation is to be included in this section. The appropriate IV indicator depends upon the frequency of the bottle change.
- Count appropriate number of points for each IV site.
- Determine what critical indicator should be used by counting the number of bottle/bag changes you must do in a 24 hour period of time

for that IV site.

- Count Volutrol refills as bottle/bag changes.

Start IV

AC40 . . Start IV . . . . 2 points

Note

- Multiply point value by the number of personnel required to perform the procedure.

Operational Description

1. Intravenous Infusion - Initiating: Place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture, connect IV tubing, apply ointment (if used) and dressing, and tape securely. Time, date and initial dressing. Calculate and regulate flow rate, record on an intake and output record, and remove equipment from the area.

Change Bottle/Bag/Volutrol

AC41 . Change Bottle/Bag/Volutrol . . b.i.d. or less . . 4 points

Operational Description

1. Intravenous Infusion - Changing IV Bottle: Place equipment at bedside, remove used IV container and replace using new IV container, calculate and regulate flow rate, record on intake and output record, and remove equipment from area.

+

2. Infusion - Flow Rate: Upon arrival at bedside, calculate and adjust flow rate and/or fill Volutrol.

+

3. Intravenous Infusion - IV Catheter Care: Place equipment at bedside, remove dressing from IV catheter site, cleanse skin, apply ointment and replace dressing. Date, time and initial the dressing. Change IV tubing every day or every other day and remove equipment from area.

Change Bottle/Bag/Volutrol

AC42 . . Change Bottle/Bag/Volutrol . . . t.i.d. or q.i.d. . . . 6 points

Note

- Use this critical indicator for intravenous lines with a single insertion site that are going at such a rate that the IV bottle/bag needs to be changed x 3-4 in a 24 hour period. This includes time to adjust the flow rate every hour, give daily dressing care, and make necessary tubing changes.

- Should an intravenous line have more than one bottle of fluid coupled into the same insertion site, count the total number of bottle/bag changes required for that insertion site and use that total frequency to select the correct critical indicator. For example, should one insertion site have a bottle of fluid that required changing t.i.d. and another bottle is hung for a once a day

infusion, then that insertion site required four bottle changes for the 24 hours and would be worth 6 points.

Operational Description

1. Intravenous Infusion - Flow Rate: Upon arrival at bedside, calculate and adjust flow rate, and/or fill Volutrol.

+

2. Intravenous Infusion - Changing IV Bottle: Place equipment at bedside, remove used IV container and replace with new IV container, calculate and regulate flow rate, record on intake and output record, and remove equipment from area.

+

3. Intravenous Infusion - IV Catheter Care: Place equipment at bedside, remove dressing from IV catheter site, don gloves if needed, cleanse skin and apply ointment if used, replace dressing, date, time and initial the dressing, change IV tubing every day or every other day, and remove equipment from area.

Change Bottle/Bag/Volutrol

AC43 . Change Bottle/Bag/Volutrol . . x 5 or more . . . . . 8 points

Note

- Use this critical indicator for intravenous lines with a single insertion site that requires the IV bottle/bag be changed five or more times in a 24 hour period. This includes time to adjust the flow rate every hour and give daily dressing care and tubing changes.

- Should an intravenous line have more than one bottle of fluid coupled into the same insertion site, count the total number of bottle/bag changes required for that insertion site and use that total frequency to select the correct critical indicator. For example, should one insertion site have a bottle that required changing b.i.d. and another fluid is piggybacked into the line that requires changing t.i.d., then that insertion site requires five bottle changes in a 24 hour period and would receive 8 points.

Operational Description

1. Intravenous Infusion - Changing IV Bottle: Place equipment at bedside, remove used IV container and replace with new IV container, calculate and regulate flow rate, record on intake and output record, and remove equipment from area.

+

2. Intravenous Infusion - Flow Rate: Upon arrival, calculate and adjust flow rate, and/or fill Volutrol.

+

3. Intravenous Infusion - IV Catheter Care: Place equipment at bedside, remove dressing from IV catheter site, cleanse skin and apply ointment (if used), and replace dressing. Date, time and initial the dressing. Change IV tubing every day or every other day, and remove equipment from area.

Heparin Lock or Broviac Catheter

AC44 . . Heparin Lock or Broviac . . . q 4 h or x 6 . . . . . 4 points

Note

- This critical indicator includes time to administer a Heparin flush q 4 h and to give daily dressing care and tubing changes.

Operational Description

1. (4 points) Heparin - Flush Solution: Place equipment at bedside, select site for injection of Heparin flush solution, administer Heparin flush solution, and remove equipment from area q 4 h.

or

2. (4 points) Intravenous Infusion - IV Catheter Care: Includes time to place equipment at bedside, remove dressing from IV catheter site, cleanse skin and apply ointment (if used), and replace dressing. Date, time and initial the dressing. Change IV tubing every day or every other day, and remove equipment from area.

Intravenous Medication Piggyback and Push

AC45 . . . . Medication . . . . q 8 h or x 3 . . . . 2 points
AC46 . . . . Medication . . . . q 6 h or x 4 . . . . 3 points
AC47 . . . . Medication . . . . q 4 h or x 6 . . . . 4 points

Note

- IV medications include IV push medications and IV piggyback medications.
- Score the appropriate number of points for each IV medication given.
- Each IV medication counts separately. Example: Keflin q 6 h and Gentamicin q 6 h equals 3 points each for a total of 6 points.
- IV Heparin to flush Heparin locks is not counted with this critical indicator, since this is included in the point value for Heparin locks.

Operational Description

1. Intravenous Infusion - IV Push Medication: Place equipment at bedside, select site for administration of solution, administer solution, record on intake and output record, and remove equipment from area.

+

2. Intravenous Infusion - Hanging IV Piggyback Bottle: Place equipment at bedside, remove used IV container and replace with new IV container, calculate and regulate flow rate, record on intake and output record, and remove equipment from area.

Blood Products

AC48 . Blood Products . . . . (each unit) . . . . 2 points

Note

- Any patient receiving blood will get 2 points for each unit regardless of the number of units of blood or blood products administered.

- A six pack of platelets counts as one unit.

Operational Description

1. Intravenous Infusion - Blood: Place equipment at bedside, assure correct transfusion, etc., take initial vital signs, connect to present intravenous system, monitor frequently, record on intake and output record, and remove equipment from area. Includes changing IV lines and filters between units.

+

2. Intravenous Infusion - Platelets or Plasma: Place equipment at bedside, connect to present intravenous system, monitor frequently, record on intake and output record, and remove used equipment from area. Includes changing IV lines and filters between units.

Infusion Controller/Pump

AC49. . Infusion Controller/Pump . . . . 2 points

Note

- Count 2 points for each infusion machine required by a patient for a 24 hour period.

Operational Description

1. Infusion Controller/Pump: Place equipment at bedside, set-up IV tubing and adjust flow rate dial. Record on intake and output record. Check frequently in response to machine warning signals.

TREATMENTS, PROCEDURES AND MEDICATIONS

Note

- Activities that require less than 15 minutes in a 24 hour period of time are not included in the critical indicator list and should not be considered.

- Double the points for treatments/procedures/medications that require two nursing staff members. For example, if two people are required to get a patient out of bed and return to bed, grant 4 points; if three people are needed, grant 6 points, etc. This is not to be used for training time such as the orientor - orientee situation.

Nasogastric (NG) Tube

AC50 . . Insert NG . . . . 2 points

Note

- Count 2 points for inserting an NG tube.

- Multiply point value by the number of personnel required to perform the procedure.

Operational Description

1. (2 points) Nasogastric Tube - Insertion: Place equipment at the bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, and remove equipment from area.

Pre-Op Prep/Enema/Ace Wrap/Support Hose

AC51 . . Pre-Op Prep/Enema/Ace Wraps/Support Hose . . . . . . 2 points

Note

- Count 2 points for each: performing a pre-op prep, giving an enema or applying Ace Wraps/support hose.

- Support hose or Ace wraps count 2 points. This includes time to remove and replace them every shift.

- Multiply point value by the number of personnel required.

Operational Description

1. (2 points) Pre-Op Prep: Place equipment at bedside, prepare skin for prep, shave area specified, and remove used equipment from area. or 2. (2 points) Enema - Cleansing: Place equipment at bedside, position patient, administer solution, and remove equipment from area. or

3. (2 points) Enema - Retention: Place equipment at bedside, position patient, administer solution, and remove equipment from area. or

4. (2 points) Support Hose: Place hose at bedside. Expose lower extremities, and put support hose on lower extremities, every shift or x 3.

or

5. (2 points) Ace Wraps: Place equipment at bedside, wrap extremity securely with Ace Wrap, and secure in place with tape or metal hooks, every shift or x 3.

Catheterization - Foley/Straight

AC52 . . Catherterization - Foley/Straight . . . . 2 points

Note

- Foley care is included in AC #53, Tube Care. AC #52 is for insertion of Foley or straight catheter.

- Multiply point value by the number of personnel required.

Operational Description

1. (2 points) Catheterization - Foley: Place equipment at bedside, prepare patient, insert Foley catheter, inflate balloon, tape catheter in position, connect to urinary drainage bag, and remove equipment from room.

or

2. (2 points) Catheterization - Straight: Place equipment at bedside, prepare patient, insert catheter, empty bladder, remove straight catheter, and remove equipment from area.

Tube Care

AC53 . . Tube Care (Exclude Trach) . . . . x 2 . . . . 2 points

Note

- Tube care includes time to change dressings around drainage tubes, such as chest tubes, Penrose drains, gastrostomy tubes, Jackson - Pratt drains, etc. b.i.d.
- Includes same for Foley care x 2
- Do not use this critical indicator for tracheostomy care (see Respiratory Therapy, AC #91.)
- Multiply point value by the number of personnel required.

Operational Description

1. (2 points) Tube Care x 2: Set up equipment at bedside, remove dressing around tube, cleanse skin, replace dressing, tape securely, and remove used equipment from area.

or

2. (2 points) Foley Catheter Care x 2: Place equipment at bedside, cleanse area around catheter, apply ointment (if used), and remove used equipment from area.

Dressing - Simple

AC54. . Dressing - Simple . . . (5 - 7 mins) x 2 . . . . . 2 points

Note

- Simple dressing change is one that can be done in about 5-7 minutes. Count 2 points for such a dressing change done b.i.d.
- Count 2 points for simple tube dressings x 2 in 24 hours if in addition to the routine b.i.d. tube care, AC #53.
- Multiply point value by the number of personnel required.

Operational Description

1. (2 points) Small Dressing Change: Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and remove equipment from area, x 2. Note drainage. or
2. (2 points) Reinforcing Dressing: Place equipment at bedside, apply dressing to present dressing for reinforcement, and remove equipment
- from area, x 2. Note drainage.

Dressing - Complex

AC55 . . Dressing - Complex . . . . (30 mins) x 1 . . . 4 points

Note

- Multiply the point value by the number of staff members required.

Operational Description

- Complex Dressing Change: Place equipment at bedside, remove soiled dressing, note drainage, don gloves, administer irrigation solution if needed, reapply dressing, and remove equipment from area.

Lab Tests Performed on the Unit or Collected for Lab

AC56. . Lab Tests Performed/Collected on the Unit . . x 3 . . . 2 points

Note

- Includes specimens obtained by nursing personnel and processed on the nursing unit or sent to the lab. May be any combination of the tests listed to total 3 in a 24-hour period.
- Multiply point value by the number of personnel required.
- Does not include venipuncture or arterial puncture. (See AC 58.)

Operational Description

1. (2 points) Specific Gravity: Place equipment at bedside, collect sample, measure specific gravity, record results, and remove equipment from area, x 3.

or

2. (2 points) Sugar & Acetone: Place equipment at bedside, collect sample, measure sugar and acetone, record results, and remove equipment from area, x 3.

or

3. (2 points) Occult Blood Testing - Feces or Vomitus or GI Drainage: Obtain sample, test for blood, record results, and remove equipment from area, x 3.

or

4. (2 points) Hematocrit: Obtaining blood sample, process, assess, and record the results, x 3.

or

5. (2 points) Bilirubin Testing: Place equipment at bedside, position infant, stick heel and draw blood into capillary tube, apply bandaid to heel, spin down serum, place serum on slide, and read slide, x 3.

or

6. (2 points) Sputum - Culture: Place equipment at bedside, position patient, obtain specimen, apply label to specimen, and remove equipment from area, x 3.

or

7. (2 points) Urine Specimen: Place equipment at bedside, instruct patient on how to collect specimen or collect sample from Foley catheter, label specimen, and remove specimen from area, x 3.

or

8. (2 points) Urine Specimen - Clean Catch/Foley: Place equipment, instruct patient on how to collect specimen, or collect sample from

Foley catheter, label specimen, and remove specimen from area, x 3.

Electrocardiogram

AC57 . . Do EKG . . . . 2 points

Note

- Count 2 points for doing an EKG.

Operational Description

1. (2 points) 12 Lead EKG: Place equipment at bedside, connect leads to patient and obtain EKG. Record name, date, and time on EKG. Remove leads and clean skin, and remove equipment from area, x 1.

Venipuncture, Arterial Puncture

AC58 . Venipuncture, Arterial puncture . . . x 2 . . . . 2 points

Note

- Venipuncture for a blood sample and arterial blood gases that are obtained by an arterial puncture are valued at 2 points for two such punctures.
- Includes blood samples obtained from intravascular lines, for example, arterial blood gases obtained from arterial lines.
- Each venipuncture or arterial puncture counts as 1 lab study, regardless of how many blood tubes are filled.
- Multiply point value by the number of personnel required.
- May be any combination of the following to total two punctures for 24 hours.

Operational Description

1. (2 points) Venipuncture - Blood Sample: Place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture, withdraw blood sample, and apply pressure to puncture site. Attach labels on blood tubes and remove equipment from area, x 2.

or

2. (2 points) Intravenous/Arterial Line - Blood Sample: Place equipment at bedside, clear system, obtain blood sample through stopcock, flush system, label samples, and remove equipment from area, x 2.

or

3. (2 points) Arterial Blood Gases: Place equipment at bedside, locate arterial puncture site, perform puncture, draw blood, place sample on ice, apply pressure to puncture site, label sample, and remove equipment from area, x 2.

or

4. (2 points) Blood Culture: Place equipment at bedside, apply tourniquet to extremity, clean site, perform venipuncture and withdraw blood sample, apply pressure to puncture site, apply labels on blood culture bottles, and remove equipment from area, x 2.

Medications - Exclude IV (3 - 11 trips)

AC59 . . Medications-3-11 trips . . . . q 3 h - q 8 h . . 2 points

Note

- Includes p.r.n.s, excludes IV Medication.
- Count the number of trips into the patient's room, not the number of medications administered during each trip. Use this acuity code for patients who receive medications that require a trip into the patient 3 to 11 times in a 24 hour period, that is, medications must be administered q 3-8 h.
- Includes p.r.n. medications when it can be reasonably predicted that the patient will request them. Determine projected needs by past requests and nursing judgement.
- Includes all methods of medication administration except intravenous.
- Patients who receive medication b.i.d. or less (including p.r.n.s) have acuity points built into the ADL codes.

Operational Description

1. (2 points) Oral: Upon contact with patient, obtain a glass of water and administer the oral medication.

or

2. (2 points) Intramuscular: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

3. (2 points) Topical: Place equipment, locate and expose site for topical application of medication, apply medication, and remove equipment from area.

or

4. (2 points) Sublingual: Place equipment, insert medication under patient's tongue, and remove equipment from area.

or

5. (2 points) Subcutaneous: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

6. (2 points) Suppository, Rectal/Vaginal: Place equipment, prepare and administer suppository, and remove equipment from area.

or

7. (2 points) Eye Drops: Position patient, instill eye drops, and remove equipment from area.

or

8. (2 points) Ear Drops: Position patient, instill ear drops, and remove equipment from area.

or

9. (2 points) Nose Drops: Position patient, instill nose drops, and remove equipment from area.

Medications - Exclude IV (12 trips)

AC60 . . Medications - 12 trips or more . . . q 2 h . . . . . 4 points

Note

- Count the number of medication trips you have to make into the patient's room, not the number of medications administered during each trip. Use this acuity code for patients who receive medications that require a trip into the patient x 12 or more in a 24 hour period. Medications must be administered q. 2 h. or more frequently.

- Includes p.r.n. medications, when it can be reasonably predicted that the patient will request them. Determine projected needs by past requests and nursing judgment.

- Includes all methods of medication administration except intravenous.

Operational Description

1. (4 points) Oral: Upon contact with patient, obtain a glass of water, and administer the oral medication.

or

2. (4 points) Intramuscular: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

3. (4 points) Topical: Place equipment, locate and expose site for topical application of medication, apply medication, and remove equipment from area.

or

4. (4 points) Sublingual: Place equipment, insert medication under patient's tongue, and remove equipment from area.

or

5. (4 points) Subcutaneous: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

6. (4 points) Suppository, Rectal/Vaginal: Place equipment, prepare and administer suppository, and remove equipment from area.

or

7. (4 points) Eye Drops: Position patient, instill eye drops and then remove equipment from area.

or

8. (4 points) Ear Drops: Position patient, instill ear drops, and then remove equipment from area.

or

9. (4 points) Nose Drops: Position patient, instill nose drops, and then remove equipment from area.

Irrigations/Instillations

AC61 . . Irrigations or Instillations . . . x 4 or less . . . 2 points

Note

- Irrigations or instillations include all types of tube irrigations or instillations.
- Increase point value as frequency increases.

Operational Description

1. (2 points) Irrigation: Place irrigation solution at bedside, unclamp or disconnect tube, irrigate, reclamp or reconnect tube, and remove equipment from area.

or

2. (2 points) Instillation: Place medication and/or normal saline at bedside, unclamp or disconnect tube, instill solution, reclamp or reconnect tubing, and remove equipment from area.

Restraints

AC62. . Restraints (2 or 4 Point Restraints or Posey) . . . . 2 points

Note

- Includes time to apply restraints and conduct periodic circulation checks.
- Use the critical indicator for Circulation Checks (AC #12) if circulation checks are required q. 2 h. or more frequently.

Operational Description

1. Restraints 2 or 4 Point or Posey: Upon arrival at bedside, replace or apply 2 or 4 point restraints or a Posey restraint and conduct periodic checks for circulation.

Assist out of Bed to Chair or Stretcher and Return

AC63. . Assist to Chair or Gurney and Return . x 3. . . 2 points

Note

- This counts for 2 points if done x 3 in a 24 hour period. This critical indicator includes only the transfer. It does not include assisting with ambulation (see AC #64).
- Increase point value with increased frequency.

- Multiply point value by the number of staff members required.

Operational Description

1. Bed to Stretcher: Place stretcher at bedside, transfer patient to stretcher, fasten safety straps or adjust side rail, remove stretcher from bedside, and reverse procedures, x 3.

+

2. Bed to Chair or Bedside Commode: Position chair/wheelchair/commode at bedside, assist patient into sitting position, bring patient into an upright standing position, assist into chair, and reverse process, x 3.

Assist Out of Bed, Ambulate and Return

AC64. .Assist to Ambulate and Return . . x 1 . . . 2 points

Note

- Count 2 points each time a patient is assisted by a staff member.
- Multiply point value by the number of staff members required.

Operational Description

1. Assistance While Walking: Assist patient into a sitting position on side of bed, bring patient into an upright standing position, assist with ambulation, and assist back into bed, x 1.

Infant Circumcision/Infant Phototherapy

AC65 . . Infant Circumcision or Phototherapy . . . . . 2 points

Note

- Multiply the point value by the number of staff members required.

Operational Description

1. (2 points) Circumcision: Place equipment in treatment room, secure baby in restraints, assist physician with procedure, apply dressing to surgical site, remove restraints, and return baby to newborn nursery.

or

2. (2 points) Phototherapy Treatment: Place equipment at bedside, expose baby, apply and maintain eye pads, position phototherapy lights, and assess infant frequently.

Isolation Gown and Glove

AC66. . Isolation - Mask, Gown, and Gloves . . x 8 . . 2 points

Note

- This critical indicator is to be used for a patient requiring mask, gown, and gloves, not just wound isolation requiring only gloves.

Operational Description

1. Isolation, Gown, and Gloves: Upon arrival at isolation area, wash hands, put on isolation gown, mask and gloves, and on departing the isolation area, remove isolation gown, mask and gloves, then wash hands, x 8.

Chest Tube Insertion or Lumbar Puncture

AC67 . . Chest Tube Insertion Or Lumbar Puncture . . . . . . 4 points

Note

- Multiply the point value by the number of nursing staff members required.

Operational Description

1. (4 points) Chest Tube Insertion: Place all equipment at bedside, prepare water-sealed drainage bottles, assist physician with insertion of chest tube, tape all connections and drainage bottles, and remove equipment from area.

or

2. (4 points) Lumbar Puncture: Place equipment at bedside, assist physician with procedure, and remove equipment from area.

Thoracentesis or Paracentesis

AC68 . . Thoracentesis or Paracentesis . . . . 4 points

Note

- Multiply the point value by the number of nursing staff members required.

Operational Description

1. (4 points) Thoracentesis: Place equipment at bedside, obtain vital signs, assist physician, support patient during the procedure, repeat vital signs, measure and record aspirated fluids, and remove equipment from area.

or

2. (4 points) Paracentesis: Place equipment at bedside, measure vital signs, prepare patient and tray for procedure, assist physician, support patient during the procedure, measure vital signs, measure and record aspirated fluids, and remove equipment from area.

Range of Motion Exercises

AC69 . . Range of Motion Exercises . . . x 3 . . . . 4 points

Note

- Must be done or supervised by nursing personnel to be counted.
- Count 4 points for every three times this is done.

Operational Description

1. (4 points) ROM Exercise - Active: Supervise the patient actively

performing the prescribed exercise program.

or

2. (4 points) ROM Exercise - Passive: Manually move the patient's extremities through the prescribed exercise program.

New Admission - Assessment and Orientation

AC70. . New Admission - Assessment and Orientation . . . .12 points

Note

- Used for all new admissions and includes time for admission assessment and orientation activities.

- Patients who are admitted after classification is completed will have the twelve points added to their acuity score the following day.

Operational Description

1. New Admission (Assessment and Orientation): Construct nursing database, including physical and emotional assessment and nursing history, write nursing care plan, patient profile, etc. Orient to nursing unit and hospital policies and procedures.

Transfer - In-house

AC71. Transfer - In-house (Receiving Unit) . . . . 4 points

Note

- Transfer points go the receiving unit only.

Operational Description

1. Transfer - In-House (Assessment and Orientation): This indicator is to be used for any patient transferred from one nursing unit to another. The points include time for reviewing the patient's record, assessing the patient, and orienting the patient to the new nursing unit and its personnel.

Accompany Patient Off Unit

AC72. . Accompany Patient Off Unit . . . . 15 minutes . . . 2 points

Note

- Count 2 points for every 15 minutes a nursing staff member is off the nursing unit with a patient.

Operational Description

1. Accompany Patient Off Unit 15 Minutes: This indicator is to be used any time a nursing staff member is required to accompany a patient off the nursing unit for 15 minutes, e.g., accompany patient to lab, etc.

AC73. . Accompany Patient Off Unit . . 30 minutes. . . 4 points

Note

- Count 4 points for every 30 minutes a nursing staff member is off the nursing unit with a patient.

Operational Description

1. Accompany Patient Off Unit 30 Minutes: This indicator is to be used any time a nursing staff member is required to accompany a patient off the nursing unit for 30 minutes, e.g., accompany patient to lab, etc.

AC74. . Accompany Patient Off Unit . . . 45 minutes . . . 6 points

Note

- Count 6 points for every 45 minutes a nursing staff member is off the nursing unit with a patient.

Operational Description

1. Accompany Patient Off Unit 45 Minutes: This indicator is to be used any time a nursing staff member is required to accompany a patient off the nursing unit for 45 minutes, e.g., accompany patient to lab, etc.

Other Required Activities

AC75. . Other Activities Requiring . . . 15 minutes . . 2 points

Note

- Multiply the point value by the number of staff members required.

- These activities must be listed on the nursing care plan or activity sheet.

Operational Description

1. Other Activities Requiring 15 Minutes : Points may be given for direct care activities that require greater than 15 minutes but less than 30 minutes and are not found on the critical indicator list. These activities must be documented in the patient's medical record.

AC76 . . . Other Activities Requiring . . . 30 minutes . . . 4 points

Note

- Multiply the point value by the number of staff members required.

- These activities must be listed on the patient care plan or activity sheet.

Operational Description

1. Other Activities Requiring 30 Minutes: Points may be given for direct care activities that require 30 minutes but less than 45 minutes and are not found on the critical indicator list. These activities must be listed on the patient profile or patient care plan.

AC77. . Other Activities Requiring . . . 45 minutes . . . 6 points

Note

- Multiply the point value by the number of staff members required.

- These activities must be listed on the patient care plan or activity sheet.

Operational Description

1. Other Activities Requiring 45 Minutes: Points may be given for direct care activities that require 45 minutes but less than 1 hour and are not found on the critical indicator list. These activities must be listed on the patient profile or patient care plan.

Each Hour Requiring Continuous Staff Attendance

AC78 . . Each Hour Requiring Continuous Staff Attendance . . . . 8 points

Note

- Count 8 points for each hour of continuous care required up to 4 hours. After that, use critical indicator AC #98 or AC #99.

- Multiply by the number of staff members required.

Operational Description

1. Continuous Staff Attendance - Each Hour: Assignment of one member of the nursing team to observe and provide direct nursing care to the patient during a specific activity. Examples of when this indicator should be used include:

   - Cardiac arrest (CPR).

   - Unstable patient awaiting transfer to an ICU.

   - Severely agitated patient requiring staff attendance while sedation takes effect.

RESPIRATORY THERAPY

Oxygen Therapy or Oxyhood

AC79. . Oxygen Therapy or Oxyhood . . . . . 2 points

Note

- Count 2 points for oxygen therapy, regardless of how the oxygen is administered, such as by nasal prongs, mask, nasal cannula, collar, face tent, or oxyhood.

- This critical indicator is not increased by the number of types of oxygen administration. If oxygen is administered by nasal prongs and a face mask both, it is still only worth 2 points.

Operational Description

1. Oxygen Administration - Prongs: Place equipment at bedside, fit nasal prongs and adjust headband, regulate oxygen rate, and evaluate patient's adjustment to oxygen and equipment.

+

2. Oxygen Administration - Mask: Place equipment at bedside, turn on oxygen, fit the mask over the mouth and nose, adjust headband,

evaluate fit and patient's adjustment to the equipment, and regulate oxygen flow rate.

+

3. Oxygen Administration - Nasal: Place equipment at bedside, turn on oxygen, lubricate and insert nasal catheter, secure with tape, evaluate patient response, and regulate oxygen flow rate.

+

4. Oxygen Administration - Mist with Collar or Face Tent: Place equipment at bedside, turn on oxygen, position equipment, secure equipment, evaluate patient response, and regulate oxygen flow rate.

+

5. Oxyhood - Application or Replacement: Place oxyhood over infant's head, position oxygen sensor, assess the oxygen concentration using the oxygen analyzer, adjust the oxygen flow if indicated, evaluate patient response, and record results.

Incentive Spirometer or Cough and Deep Breathe

AC80. . Incentive Spirometer or Cough & Deep Breathe. q 4 h or x 6 . 2 points

Note

- Multiply point value with increased frequency.

Operational Description

1. (2 points) Incentive Spirometer: Place spirometer at bedside, assist patient during the procedure, determine proper usage of spirometer, then secure equipment at bedside for next treatment.

or

2. (2 points) Blow Bottles: Place equipment at bedside, assist with placement of bottles, have patient perform procedure, then secure equipment at bedside for next treatment.

or

3. (2 points) Cough And Deep Breathe: Upon arrival at the bedside, have patient cough and deep breathe. If cough is productive, then dispose of sputum.

IPPB or Maximist

AC81. . IPPB or Maximist . . . b.i.d. or x 2 . . . 2 points
AC82. . IPPB or Maximist . . . q 6 h or x 4 . . . 4 points
AC83. . IPPB or Maximist . . . q 4 h or x 6 . . . 6 points

Note

- IPPB or maximist or nebulizer must be administered by nursing personnel to count.

Operational Description

1. IPPB Treatment: Upon arrival at bedside, prepare nebulizer, position patient, assure proper breathing technique, and administer treatment.

or

2. Maximist Treatment: Upon arrival at bedside, prepare nebulizer, position patient, assure proper breathing technique, and administer treatment.

Croup Tent or Mist Tent

AC84. . Croup Tent or Mist Tent. . . . . . . 8 points

Note

- This includes time to check the tent q 4 h.

Operational Description

1. Croup Tent or Mist Tent: Place equipment at bedside, position equipment over the bed, fill vaporizer with solution, place thermometer, assess status of patient's adjustment to croup tent, and assess temperature inside croup tent, q 4 h.

Chest Pulmonary Therapy

AC85. . Chest Pulmonary Therapy . . . b.i.d. or x 2. . . 2 points
AC86. . Chest Pulmonary Therapy . . . q 6 h or x 4 . . . 4 points
AC87. . Chest Pulmonary Therapy . . . q 4 h or x 6 . . . 6 points

Note

- Multiply point value as frequency increases.

Operational Description

1. Chest Pulmonary Therapy - Frappage With Postural Drainage: Upon arrival at bedside, position patient and auscultate lung fields, perform percussion to each involved segment followed by vibration, and evaluate patient response.

Suctioning

AC88. . Suctioning . . . . q 4 h or x 6. . 2 points
AC89. . Suctioning . . . . q 2 h or x 12 . . . 4 points

Note

- Suctioning includes oral, tracheostomy, or endotracheal.

- Multiply the point value times the number of nursing staff personnel required.

- Increase the p-int value as the frequency increases.

Operational Description

1. Suctioning - Oral: Place equipment or set up equipment at bedside, suction oral cavity with suction catheter or oral suction tip, flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area. Includes oral bulb syringe suctioning for infants.

+

2. Suctioning - Tracheostomy: Set up equipment, put on sterile gloves, suction and flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area.

+

3. Suctioning - Naso-tracheal: Set up equipment at bedside, put on sterile gloves, pass nasal catheter and suction, flush catheter before and after each aspiration, replace used equipment, and remove used equipment from area.

+

4. Suctioning - Endotracheal: Set up sterile equipment at bedside, put on sterile gloves, suction through endotracheal tube, flush catheter before and after each use, bag breathe between each aspiration (as needed), remove gloves, replace used equipment, and remove used equipment from area.

Ventilator

AC90. . Ventilator . . . . 10 points

Operational Description

1. Oxygen Administration - Ventilator: Upon arrival at bedside, assess and/or regulate oxygen and ventilator pressures, assess all tubing for patency and collection of fluids within tubing, assess fluid level in water vapor container, and assess proper position of alarms q 1 h

+

2. Responding to Ventilator Alarm: Upon arrival at the bedside, assess situation and reset alarm.

Tracheostomy Care

AC91. . Tracheostomy Care . . . . x 3 . . . 4 points

Note

- Increase the point value as the frequency increases.
- Multiply the point value by the number of nursing staff members required.

Operational Description

1. Tracheostomy - Cleaning Cannula: Place equipment at bedside, put on sterile gloves, complete tracheostomy suction, remove, clean and replace inner tube, remove soiled equipment and replace with clean equipment.

+

2. Tracheostomy - Dressing Change: Place equipment at bedside, put on sterile gloves, remove soiled dressing, cleanse skin, replace dry dressing, change tracheostomy ties as indicated, and remove soiled equipment from area.

TEACHING

Group Teaching

AC92 . . Group Teaching . . . . 1 hour . . . . 2 points

Operational Description

1. Special Structured Teaching - Group: Each patient attending group instruction will receive 2 points for each hour of structured teaching.

Individual Teaching

AC93 . . Individual Teaching . . . . 30 minutes . . 4 points

Note

- This allows for 30 minutes of direct individual patient/family instruction. Multiply point value in 30 minute increments, that is, one hour of direct, patient/family individual instruction is equal to 8 points, etc.

Operational Description

1. Pre-op Teaching: Provide individual instruction to patient and family and answer questions.

+

2. Teaching Patient/Family on Diabetic Care, Newborn Care, Cardiac Care, Colostomy Care, Post Partum Care, Medications, Discharge Instructions, etc.: Provide individual instruction regarding the nature and scope of health or disease process or a recent event (post-delivery), special care requirements, limitations and/or restrictions related to illness, and answer questions.

EMOTIONAL SUPPORT

Note

- Maximum point allowance for this factor group of critical indicators (Emotional Support) is 10. See AC 97.

Patient/Family Emotional Support

AC94 . . Patient And Family Emotional Support . 30 minutes . . 4 points

Note

- Includes dealing with anxiety, loneliness, denial, restlessness.
- Emotional support must be documented on patient care plan and/or nursing notes.
- Increase the point value as needed in 30-minute increments.

Operational Description

1. Patient and Family Support: Interact with a patient or family member and provide emotional support.

Lifestyle Modification

AC95 . . Lifestyle Modification . . . . 30 minutes. . . 4 points

Note

- Concerns prostheses, behavior, image etc.
- Support must be documented on patient care plan and/or nursing notes.
- Increase the point value as needed in 30-minute increments.

Operational Description

1. Modification of Lifestyle: Provide individual support regarding limitations and restrictions of a new prothesis, the necessary alteration of lifestyle, and coping with a body image change or illness.

Sensory Deprivation

AC96. . Sensory Deprivation . . . . 6 points

Note

- Includes retarded, deaf, blind, etc.
- This support must be documented on patient care plan and/or nursing notes.

Operational Description

1. Sensory Deprivation: Interact with a sensory deprived patient, e.g., retarded, deaf or hearing impaired, blind, foreign speaking, mute or unable to speak, bilaterally patched, mentally confused, etc.

Maximum Points for Emotional Support

AC97. . Maximum Points for Emotional Support . . . . . 10 points

Note

- Points in the Emotional Support area cannot exceed 10. Use this critical indicator to quickly indicate that a patient requires maximum emotional support. If this critical indicator is taken, do not use any of the other critical indicators listed under Emotional Support (ACs #94-97).

CONTINUOUS

Note

- This section is to be used for patients who require 1:1 or greater care.

Patient Requiring 1:1 Coverage

AC98 . . Patient Requiring 1:1 Coverage All Shifts . . . . 96 points

Note

- Use this critical indicator for patients who require one staff

member continuously each shift.

Operational Description

1. (96 points) Includes time for one professional nurse to render ALL care to a specific patient, to include managing the IV, administering medications/ treatments, performing assessments, etc.

or

2. (96 points) Includes time for one paraprofessional to be assigned to a patient requiring continuous care and observation. The paraprofessional will provide care within his/her scope of practice in the areas of vital signs, monitoring, activities of daily living, treatments, and feeding. Do not count additional critical indicators for these activities. Additional critical indicator points may be taken for activities of the professional nurse as required in the areas of treatments, IVs, and teaching.

Patient Requiring Greater than 1:1 Coverage All Shifts

AC99. . Patient Requiring Greater Than 1:1 Coverage All Shifts . . . 146 points

Note

- Use this critical indicator when more than one staff member is required to give care to a patient on all shifts.

Operational Description

1. Provide continuous care to a patient on all shifts.

GUIDELINES FOR INTERPRETING THE PSYCHIATRIC CRITICAL INDICATORS:

As with the General Indicators, for each operational definition, time is included for the following activities as appropriate:

- Identifying and screening the patient;
- Explaining the procedure to the patient;
- Raising, lowering, or adjusting the bed before and after the nursing activity;
- Cleaning and straightening area;
- Recording activity on bedside records; and
- Spending time at the patient's bedside providing information, answering questions and interacting with patients.

VITAL SIGNS (MANUAL TPR, BP)

Vital Signs

AC100. VS. . . . . . q.i.d.or less . . . . 1 point
AC101. VS. . . . . . q 4 hor x 6 . . . . 2 points
AC102. VS. . . . . . q 3 hor x 8 . . . . 3 points
AC103. VS. . . . . . q 2 hor x 12 . . . . 4 points
AC104. VS. . . . . . q 1 hor x 24 . . . . 8 points

Note

- Vital Signs q.i.d. or less is the only critical indicator with a one point value.
- Instructions: select point allowance to fit vital sign frequency. Vital Signs q 4 h or x 6" in a 24 hour period is equal to 2 points. Vital Signs q 2 h or x 12" is twice as often, therefore equal to twice as many points (4 points), and Vital Signs q 1 h or x 24" is equal to 8 points. It follows that Vital Signs taken every 30 minutes x 24 hours would be valued at 16 points.

Operational Description

1. Oral Temperature, Pulse and Respirations: Place equipment, position temperature probe or thermometer. Place fingers over radial artery pulse and count rate. Count respiratory rate while fingers are in place over radial artery pulse. Remove fingers from radial artery, record results of measurements, and remove equipment from area.

+

2. Blood Pressure, Manual: Place equipment, place cuff around extremity and fasten, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

+

3. Blood Pressure, Arteriosonde: Apply electrode gel to cuff, position cuff around extremity, measure blood pressure, remove cuff, cleanse gel from extremity, store equipment at bedside, and record results.

Tilt Test

AC105. Tilt Test. . . . . 2 points

Note

- Tilt test must be taken at least q 4 h or more often. Do not increase allowance for increased frequency. Includes additional time for repeating and recording blood pressure and pulse in the sitting, standing, and lying position.

Operational Description

1. Measure Blood pressure: Place equipment at bedside, place cuff around extremity, position stethoscope, measure blood pressure, assist patient with position change, remeasure blood pressure, remove cuff, record results, and remove equipment from area.

MONITORING

Intake and Output

AC106. Intake and Output . . . . . q 8 h . . . 2 points

Note

- Increase point allowance for increased frequency, but must be done at least q 8 h in order for you to use this indicator.
- Intake and output includes time to measure all forms of intake and output.
- Patients on just intake or just output will not receive any points.

Operational Description

1. Measuring and Recording Intake: Place calibrated cylinder/container at bedside, measure or calculate fluids, record amount on intake and output record, and remove equipment from area.

+

2. Measuring and Recording Output - Urine: Place calibrated cylinder at bedside, measure or calculate volume, record amount on intake and output record, and remove equipment from area.

+

3. Measuring and Recording Output - Liquid Feces: Remove bedpan from patient's bedside, measure feces in calibrated cylinder, record amount on intake and output record.

+

4. Measuring and Recording Output - Vomitus: Remove emesis from patient's bedside, measure vomitus in calibrated cylinder, record amount on intake and output record.

Circulation Checks

AC107. Circulation Checks . . . . q 2 h or x 12 . . 2 points

Note

- Circulation checks must be done at least every 2 hours before points are counted.

- Extra points for circulation checks are not ascribed when the patient is in restraints since this activity is already included in the point value for AC #125.

Operational Description

1. Circulation checks: Upon arrival at bedside, check extremity for swelling, numbness, and tingling, evaluate temperature and color of skin, and assess the patient's ability to move the part, and document assessment.

Patient Checks

AC108. Patient Checks . . . . . q 30 mins x 8 . . 8 points

Note

- Formal monitoring of a patient for sleep patterns is one example of this action. This critical indicator is NOT to be used if a nursing staff member is simply making night rounds on all patients every 30 minutes unless there is a corresponding physician or nursing order to assess q. 30 minutes. Ascribe 8 points for each period a patient requires (30 minute checks times 8) for whatever purpose. This activity usually includes interaction to determine orientation and emotional and cognitive status.

Operational Description

1. Patient Checks: This code should be used for any condition that requires a nursing assessment every 30 minutes. Assessment must be documented every 30 minutes on nursing notes, flow sheet, etc.

AC109. Patient Checks. . . . . q 15 mins x 8. . . 16 points

Note

- An example of this activity may be assessments made during the time a patient is in the seclusion room. Assessment must be documented every 15 minutes.

Operational Description

1. Patient Checks: Includes time to approach and assess the patient and record observations every (15 minutes X 8).

Neuro Checks

AC110. Neuro Checks . . . . . q 4 h or x 6 . . . 3 points

Operational Description

1. Pupil Reflexes: Place equipment, adjust room lighting, assess pupillary reflexes with flashlight, and remove equipment from area.

+

2. Mental Alertness: Arrive at bedside, make inquiries within the framework of interviewing that will give information about the patient's level of consciousness, memory, intellectual performance and judgment, and record results.

+

3. Orientation: Arrive at bedside, make inquiries within the framework of interviewing that will give information about patient's orientation to time, place and person and record results.

+

4. Sensory Discrimination: Screen for pain, vibration, light touch and stereognosis, and record results.

+

5. Motor/Sensory Testing: Arrive at the bedside and assess extremities for sensation awareness and muscle strength.

ACTIVITIES OF DAILY LIVING

Note

- All patients must be ascribed at least one critical indicator in this factor group, except Category 0 patients. Points may not be doubled.

Self Care

AC111. Self Care - Age 6 or more . . . . 2 points

Note

- This category includes patients that are able to sign off the nursing unit unaccompanied and patients that are allowed to sign off the nursing unit in the company of another patient.
- Patient is able to perform activities of daily living, but requires nursing supervision of those activities. This category includes time allowances for direct nursing care to support the following activities:

Operational Description

1. Bathing: Place equipment at the bedside, allow time for patient to bathe and change pajamas, and remove equipment from area. Provide general supervision of patient's ability to perform personal hygiene activities to include personal grooming and attire.

+

2. Serving Meal Tray: Place tray at bedside, supervise and monitor the patient's nutritional intake and social behaviors at meals.

+

3. Unoccupied Bed: Place linen at bedside, remove soiled linen, place and secure bottom sheet on mattress, place top sheet, change pillow cases, and remove soiled linen from area. Provide general supervision and monitoring of patient's ability to maintain his/her living area (bed, bedside stand, locker, bathroom, etc.) in accordance with nursing unit policies.

+

4. Nursing Assessment: Assess patient's condition and problems, formulating nursing diagnoses and interventions, and evaluate

effectiveness of interventions.

+

5. Administering Medication (b.i.d. or less): Administer medications via route ordered. Applies to all routes except IV and includes p.r.n.s.

Assisted Care

AC112. Assisted Care . . . . 6 points

Note

- This category includes patients who are limited to the nursing unit or may leave the nursing unit only if accompanied by a staff member. Patient is able to perform activities of daily living only with continual encouragement and direct nursing supervision of those activities.

- This category includes patients who must be encouraged and directly supervised with oral hygiene, shaving and grooming activities. Involves direct supervision of patient use of hazardous items and the selection, wear, and maintenance of clothing.

Operational Description

This category includes time allowances of direct nursing care to support the following activities:

1. Bathing, Assist with Back and Legs: Place equipment at the bedside, remove pajamas, allow for patient bathing, change water, bathe back and lower extremities, replace pajamas, and remove equipment from area.

+

2. Sitting Shower or Shower with Assistance: Assist patient in undressing, getting into shower, bathing and shampooing hair, redressing, constantly supervising the patient.

+

3. Tub Bath: Assist patient in undressing, getting into bathtub, and bathing, assist in redressing, constantly supervising the patient.

+

4. AM Care: Place equipment at the bedside, assist patient with bathing face, and hands and brushing teeth, comb hair, and remove equipment from area.

+

5. AM Care, Partial: Place equipment at the bedside, prepare bath water, put toothpaste on tooth brush, comb hair, and remove equipment from area.

+

6. PM Care: Place equipment at the bedside, assist patient to bathe face and hands and brush teeth, give back rub, straighten and tighten bed linens, and remove equipment from area.

+

7. Serving Meal Tray, Preparation Required: Place tray at the bedside, prepare food and utensils, and prepare towel or napkin as bib. Allows for assisting the patient in selecting appropriate nutritional selections and supervising patient's social behaviors during meals.

+

8. Ambulatory Weight: Place equipment at the bedside, balance scales, assist patient onto the scales, read and record weight, assist patient off the scales, and remove equipment from area.

+

9. Unoccupied Bed: Place linen at the bedside, remove soiled linen, place and secure bottom sheet on mattress, place top sheet, change pillow cases, and remove soiled linen from area. Provide direct supervision and monitoring of patient while patient maintains his living area. Includes bedmaking, linen changes, and keeping bedside stand and locker in order.

+

10. Answering Patient's Questions: Answer patient's questions or respond to the patient's call system.

+

11. Nursing Assessment: Assess patient's condition and problems, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

+

12. Administering Medication (b.i.d. or less): Applies to all routes except IV. Include p.r.n.s when they can be reasonably predicted.

Complete Care

AC113. Complete Care . . . . 14 points

Note

- This category includes patients who are unable to participate in activities of daily living and require total nursing care to provide those activities. The psychiatric patient whose condition requires this level of direct nursing care would most likely require continuous monitoring (AC #145). Do not double count. In some cases, a patient may require bed bath, AM and PM oral care, bedpan/urinal, etc. but does not require continuous monitoring. In this situation, award acuity points for complete care, and use other acuity codes as appropriate.

- Although many psychiatric patients in this category will be ambulatory, they will be unable to satisfactorily perform these activities of daily living, and staff must perform them for the patient.

Operational Description

Allows time for direct nursing support of the following activities:

1. Bathing, Complete: Place equipment at the bedside, remove pajamas, bathe face, chest, abdomen and extremities, change water, bathe back, genital area, and buttocks, replace pajamas, and remove equipment from area.

+

2. AM Care: Place equipment at the bedside, assist patient with bathing face, hands, and brushing teeth, comb hair, and remove equipment from area.

+

3. PM Care: Place equipment at the bedside, bathe face, hands, and brush teeth, comb hair, rub back, straighten and tighten bed linens, and remove equipment from area.

+

4. Occupied Bed: Place linen at the bedside, turn patient on side, roll linen to one side of bed and replace with clean linen, turn patient to freshly made side of bed, complete bed making, remove soiled linen from bed, b.i.d.

+

5. Giving a Bedpan: Place urinal or bedpan at the patient's bedside, remove cover, adjust patient's pajamas for placement of urinal or bedpan, remove urinal or bedpan from patient and replace cover, and remove urinal or bedpan from area. Assist patient in washing hands.

+

6. Answering Patient's Questions: Answer patient's questions or respond to the patient's call system.

+

7. Nursing Assessment: Assess patient's condition and problems, formulate nursing diagnoses and interventions, and evaluate effectiveness of interventions.

+

8. Administering Medication b.i.d. or less: Applies to all routes except IV. Includes p.r.n.s when they can be reasonably predicted.

FEEDING

Spoon Feed

AC114. Spoon Feed or 1:1 at meals . . t.i.d. . . . . 6 points

Note

- Use this code for all patients requiring 1:1 nursing supervision during meals. Do not use if AC #145 is used. When other nursing care is provided in association with this activity, use other acuity codes as appropriate.

Operational Description

1. Spoon-feeding: Place meal tray at bedside, place towel or napkin as bib, prepare the food, feed patient slowly, and remove tray from area.

Tube Feed

AC115. Tube Feed (Bolus) . . . . . q 4 h or x 6 . . 5 points

Note

- Includes nasogastric feedings as well as gastrostomy feedings.

Operational Description

Includes time for the following:

1. Place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and remove feeding equipment from area.

Escort Patient to Dining Hall

AC116. Escort Patient to Dining Hall . . x 3 . . . 2 points

Note

- Award 2 points to each patient requiring escort to and supervision at the dining facility.
- This activity requires a one staff to four patient ratio.

Operational Description

1. Escort Patients to Dining Hall: Includes time for one staff member to accompany a group of up to four patients to the dining facility, remain with them for 30 minutes, then return to the nursing unit, x 3 in a 24 hour period.

TREATMENTS, PROCEDURES, AND MEDICATIONS

Instruction: Procedures or tasks that require less than 15 minutes should not be counted. A time allowance has been included under indirect care. All treatments, procedures, medications must be documented to receive points.

Start IV/Ace Wraps/Tube Care

AC117. Start IV/Ace Wraps/Tube Care . . . . 2 points

Note

- Also used for nasogastric tube insertion, enema, pre-op prep and urinary catheterization (straight or Foley).

Operational Description

1. (2 points) Intravenous Infusion-Initiating: Place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture and connect IV tubing, apply ointment and dressing, and tape securely. Calculate and regulate flow rate, record on intake and output record, and remove equipment from area.

or

2. (2 points) Support Hose: Place support hose at bedside. Expose lower extremities and put on elastic stockings.

or

3. (2 points) Ace Wraps: Place equipment at bedside, wrap extremity securely with Ace Wrap and secure in place with tape or metal hooks.

or

4. (2 points) Catheterization - Foley/Straight: Place equipment at bedside, prepare patient and insert catheter, inflate balloon, tape catheter in position, connect to urinary drainage bag, and remove used equipment from area.

or

5. (2 points) Nasogastric Tube - Insertion: Place equipment at the bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, and remove equipment from area.

or

6. (2 points) Pre-Op Prep, Local: Place equipment at bedside, prepare skin for prep, shave area specified, and remove equipment from area.

or

7. (2 points) Enema - Cleansing: Place equipment at bedside, position patient, administer solution, and remove equipment from area.

or

8. (2 points) Enema - Retention: Place equipment at bedside, position patient, administer solution, and remove equipment from area.

or

9. (2 points) Foley Catheter Care: Place equipment at bedside, cleanse area around catheter, apply ointment, and remove equipment from area, b.i.d.

Dressing - Simple

AC118. Dressing - Simple . . . . (5-7 minutes x 2). . . . . . 2 points

Operational Description

Includes time for the following:

1. Small Dressing Change: Place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and remove equipment from area, x 2. Note drainage.

+

2. Reinforcing Dressing: Place equipment at bedside, apply reinforcement to present dressing, and remove equipment from area, x

2. Note drainage.

Dressing - Complex

AC119. Dressing - Complex . . . . . (30 minutes) x 1 . . . 4 points

Note

- Multiply the point value by the number of staff members required.

Operational Description

1. Dressing - Complex: Place equipment at bedside, remove soiled dressing, don gloves, administer an irrigation solution if needed, reapply dressing, and remove equipment from area.

Lab Tests Performed on the Unit or Collected for Lab

AC120. Lab Tests Performed/Collected on Unit . x 3 . . . 2 points

Note

- Includes specimens obtained by nursing personnel and processed on the nursing unit or sent to the lab. May be any combination of tests listed to total three activities per 24 hours. If a total of six tests are performed on the unit, double the points.

Operational Description

Includes time to perform three of the following listed studies:

1. (2 points) Specific Gravity: Place equipment at bedside, collect sample, measure specific gravity, record results, and remove equipment from area, x 3.

or

2. (2 points) Sugar and Acetone: Place equipment at bedside, collect sample, measure sugar and acetone, record results, and remove equipment from area, x 3.

or

3. (2 points) Occult Blood Testing: Feces or vomitus or GI drainage: Obtain sample, test for blood, record results,and remove equipment from area, x 3.

or

4. (2 points) Hematocrit: Obtain blood sample, process, assess, and record results, x 3.

or

5. (2 points) Bilirubin Testing: Place equipment at bedside, position infant, stick heel and draw blood into capillary tube, apply bandaid to heel, spin down serum, place serum on slide, and read slide, x 3.

or

6. (2 points) Sputum - Culture: Place equipment at bedside, position patient, have patient cough to obtain sputum, apply label to sputum

specimen, and remove equipment from area, x 3.

or

7. (2 points) Urine Specimen: Place equipment, instruct patient on how to collect specimen, label specimen, and then remove specimen from area, x 3.

or

8. (2 points) Urine Specimen - Clean Catch/Foley: Place equipment, instruct patient on how to collect specimen, or collect sample from Foley catheter, label specimen, and remove specimen from area, x 3.

Electrocardiogram

AC121. Do EKG . . . . 2 points

Note

- Count 2 points for doing an EKG.

Operational Description

1. (2 points) 12 Lead EKG: Place equipment at bedside, connect leads to patient and obtain EKG. Record name, date, and time on EKG. Remove leads and clean skin, and remove equipment from are x 1.

Venipuncture, Arterial Puncture

AC122. Venipuncture, Arterial Puncture . . x 2 . . . . 2 points

Operational Description

1. (2 points) Venipuncture - Blood Sample: Place equipment. Apply tourniquet to extremity, cleanse site, perform venipuncture and withdraw blood sample, and apply pressure to puncture site. Apply labels on blood tubes and remove equipment from area.

or

2. (2 points) Blood Culture: Place equipment at bedside, apply tourniquet to extremity, clean site, perform venipuncture, withdraw blood sample, apply pressure to puncture site, apply labels on blood culture bottles and remove equipment from area.

or

3. (2 points) Intravenous/Arterial Line Blood Sample: Place equipment at bedside, clean system, obtain sample through stopcock, flush system, label specimens, and remove equipment from area.

or

4. (2 points) Arterial Puncture: Place equipment at bedside, locate arterial puncture site, perform puncture, obtain sample, place on ice, apply pressure to the puncture site, label specimen, and remove equipment from the area.

Medications - Exclude IV

AC123. . Medications - 3-11 trips or more . . q 3 h - 1 8 h (Includes p.r.n.s). 2 points

Note

- Count the number of trips you have to make into the patient's room, not the number of medications administered during each trip. Use this acuity code for patients who receive medications that require a trip into the patient 3 to 11 times in a 24 hour period, that is medications must be administered q 3-8 h.
- This includes p.r.n. medications but only if the patient is receiving them on a predictable schedule. Determine projected needs by past requests and nursing judgement.
- Includes all methods of medication administration except intravenous.
- Patients who receive medication b.i.d. or less (including p.r.n.s) have acuity points built into the ADL codes.

Operational Description

1. (2 points) Oral: Upon contact with patient, obtain a glass of water and administer the oral medication.

or

2. (2 points) Intramuscular: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

3. (2 points) Topical: Place equipment, locate and expose site for topical application of medication, apply medication, and then remove equipment from area.

or

4. (2 points) Sublingual: Place equipment, place medication under patient's tongue, and remove equipment from area.

or

5. (2 points) Subcutaneous: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

6. (2 points) Suppository, Rectal/Vaginal: Place equipment, prepare and administer suppository, and remove equipment from area.

or

7. (2 points) Eye Drops: Position patient, instill eye drops and remove equipment from area.

or

8. (2 points) Ear Drops: Position patient, instill ear drops, and then remove equipment from area.

or

9. (2 points) Nose Drops: Position patient, instill nose drops, and remove equipment from area.

AC124. Medications . 12 trips or more - q 2 h (Includes p.r.n.s). . . 4 points

Note

- Count the number of trips you have to make into the patient's room, not the number of medications administered during each trip. Use this acuity code for patients who receive medications that require a trip into the patient 12 times or more in a 24 hour period, that is, medications must be administered q 2 h or more frequently.
- This includes p.r.n. medications but only if the patient is receiving them on a predictable schedule. Determine projected needs by past requests and nursing judgement.
- Includes all methods of medication administration except intravenous.

Operational Description

1. (4 points) Oral: Upon contact with patient, obtain a glass of water and administer the oral medication.

or

2. (4 points) Intramuscular: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

3. (4 points) Topical: Place equipment, locate and expose site for topical application of medication, apply medication, and remove equipment from area.

or

4. (4 points) Sublingual: Place equipment, place medication under patient's tongue, and remove equipment from area.

or

5. (4 points) Subcutaneous: Place equipment, locate site for injection, administer medication, and remove equipment from area.

or

6. (4 points) Suppository, Rectal/Vaginal: Place equipment, prepare and administer suppository, and remove equipment from area.

or

7. (4 points) Eye Drops: Position patient, instill eye drops and remove equipment from area.

or

8. (4 points) Ear Drops: Position patient, instill ear drops, and remove equipment from area.

or

9. (4 points) Nose Drops: Position patient, instill nose drops, and remove equipment from area.

Restraints

AC125. Restraints, 2 Point, 4 Point, or Posey. . . . . 2 points

Note

- Includes time to apply restraints and conduct q 2 h circulation checks.
- Also use the critical indicator for Circulation Checks (AC#107) if circulation checks are required q. 2h or more frequently.

Operational Description

1. Restraints 2 or 4 Point or Posey: Upon arrival at bedside, replace or apply 2 or 4 point or a Posey restraint and conduct periodic checks for circulation.

New Admission - Assessment and Orientation

AC126. New Admission - Assessment and Orientation . . . . . 12 points

Note

- Used for all new admissions and includes time for nursing admission, assessment and orientation activities.
- If a patient is transferred from a medical/surgical unit to a psychiatric unit, count as a new admission since the entire psychiatric assessment and orientation must be done.

Operational Description

1. New Admission: Construct nursing database, including physical and emotional assessment and nursing history. Write nursing care plan, patient profile, etc. Orient to nursing unit and hospital policies and procedures.

Transfer - Between Psychiatric Units

AC127. Transfer - Between Psychiatric Units (Receiving unit only). . 4 points

Note

- This factor is to be used for any patient transferred from one psychiatric unit to another. If a patient is transferred from a Medical/Surgical Unit to a psychiatric unit, count as a new admission since the entire psychiatric assessment and orientation must be done. Only the gaining unit takes credit for the transfer.

Operational Description

1. Transfer - In-House (Assessment and Orientation): This indicator is to be used for any patient transferred from one psychiatric nursing unit to another. The points include time for reviewing the patient's record, assessing the patient, and orienting the patient to the new nursing unit and its personnel.

Accompany Patient Off Unit

AC128. Accompany Patient Off Unit. . . 15 minutes. . . . 2 points

Operational Description

1. Any absence from the unit requiring 15 minutes, e.g., accompany patient on 1:1 ratio to X-ray (remain with patient) lab, clinic appointments, snack bar/PX, to visit with family off nursing unit, etc.

AC129. Accompany Patient Off Unit . . 30 minutes . . . . . 4 points

Operational Description

1. Any absence from the nursing unit requiring 30 minutes 1:1, e.g., accompany patient to lab, etc.

AC130. Accompany Patient Off Unit. . . . . 45 minutes . . . . 6 points

Operational Description

1. Any absence from the unit requiring 45 minutes 1:1, e.g., accompany patient to lab, etc.

Other Activities

AC131. Any Other Activity. . . . 15 minutes. . . . 2 points

Note

- Patient care planning meetings can be counted here if patient is present in the meeting. Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Used for any other treatment/procedure requiring 15 minutes of nursing time.

AC132. Any Other Activity. . . . . 30 minutes . . . . 4 points

Note

- Patient care planning meetings can be counted here if patient is present in this meeting. Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Used for any other treatment/procedure requiring 30 minutes of nursing time. These activities must be listed on the patient profile or patient care plan.

AC133. Any Other Activity. . . . 45 minutes . . . . . 6 points

Note

- Patient care planning meetings can be counted here if patient is present in this meeting. Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Used for any other treatment/procedure requiring 45 minutes of nursing time. These activities must be listed on the patient profile or patient care plan.

Each Hour Requiring Continuous Staff Attendance/Assistance

AC134. Each Hour Requiring Continuous Staff Attendance/Assistance. . 8 points

Note

- Award 8 points for each hour requiring continuous staff attendance up to 4 hours. After that, use AC #145, one to one coverage all shifts.

Operational Description

1. Assignment of one member of the nursing team to observe and provide direct nursing care to the patient during a specific activity up to 4 hours. This care and observation is specific to a given activity and time limited. Examples of when this indicator should be used include:

    - Cardiac arrest (CPR).
    - Unstable patient awaiting transfer to an ICU.
    - Severely agitated patient requiring staff attendance while sedation takes effect.
    - Accompany patient off the nursing unit 1 - 4 hours.

THERAPEUTIC INTERVENTIONS/ACTIVITIES

Purposeful Interaction

AC135. Purposeful Interaction. . . . 15 minutes. . . . . 2 points

Note

- This may include activities such as 1:1 counseling, discharge planning therapy, modification of lifestyle, reality orientation, redirection, regulation or crisis intervention.
- Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Time spent with patient by a staff member without providing any direct physical care to the patient which is not in response to patient call system or patient questions.

AC136. Purposeful Interaction. . . . 30 minutes. . . . 4 points

Note

- This may include activities such as 1:1 counseling, discharge planning therapy, modification of lifestyle, reality orientation, redirection, regulation, or crisis intervention.
- Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Time spent with patient by a staff member without providing any direct physical care to the patient which is not in response to patient call system or patient questions.

AC137. Purposeful Interaction. . . . 45 minutes. . . . 6 points

Note

- This may include activities such as 1:1 counseling, discharge planning therapy, modification of lifestyle, reality orientation, redirection, regulation, or crisis intervention.

- Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Time spent with patient by a staff member without providing any direct physical care to the patient which is not in response to patient call system or patient questions.

AC138. Purposeful Interaction. . . . . 1 hour. . . 8 points

Note

- This may include activities such as 1:1 counseling, discharge planning, therapy, modification of lifestyle, reality orientation, redirection, regulation, or crisis intervention.

- Activity must be listed on the patient profile or patient care plan.

Operational Description

1. Time spent with patient by a staff member without providing any direct physical care to the patient which is not in response to patient call system or patient questions.

Sensory Deprivation

AC139. Sensory Deprivation. . . . . 6 points

Operational Description

1. Includes the extra time that must be taken for interaction with certain patients, e.g., retarded, deaf, blind, foreign speaking, mute or confused. Includes assessment of and protection from environmental hazards.

Group Activity - On Nursing Unit

AC140. Group Activity - On Nursing Unit - Staff ratio 1:4-5. . 2 points

Note

- Other disciplines may participate without losing points. Award 2 points for each patient, per hour, with a staff patient ratio of 1:4-5. Use AC #134 for each hour a patient requires individual nursing care/supervision within the group activity.

Operational Description

1. Use this category for those group interventions or activities on the nursing unit which require nursing staff participation, supervision and/or monitoring.

Group Activity - Off Nursing Unit

AC141. Group Activity - Off Nursing Unit - Staff Ratio 1:4-5. . . . 2 points

Note

- Other disciplines may participate without losing points. Award 2 points to each patient, per hour, with a staff patient ratio of 1:4-5. Use AC #134 for each hour a patient requires individual nursing care/supervision within the group activity.

Operational Description

1. Use this category for those group interventions or activities off the nursing unit which require nursing staff participation, supervision and/or monitoring. Examples in this category include picnics, movies, softball, bowling, tours, OT, PT., etc.

Group Activity - Meetings

AC142. Group Activity - Meetings - Staff Ratio 1:4-5. . . 2 points

Note

- Other disciplines may participate without losing points. Award 2 points to each patient, per hour, with a staff patient ratio of 1:4-5. Use AC #134 for each hour a patient requires individual nursing care/supervision within the group activity.
- In specialized groups such as group therapy, communication skills groups, psycho drama, etc., a staff patient ratio of 1:4-5 should be utilized as the standard. Award 2 points for each patient, per 1 hour group. In a nursing unit meeting such as a community meeting at which the nursing staff act as facilitators, resource persons, providers of feedback to the assembled patient community, award 2 points per patient per hour of group.

Operational Description

1. Includes time for the nursing staff to participate as leaders, facilitators, or resource persons for a group.

TEACHING

Group Teaching - Per Hour

AC143. Group Teaching. . . . . Per Hour. . . . . . 2 points

Note

- Points for teaching should be given only for structured instruction. Classes must be documented in the patient's medical record.
- Count 2 points for each patient in a group class for each hour of instruction.
- One hour of group instruction, to include nature and scope of the health/disease process, special care requirements, limitations and/or restrictions related to a disease or illness and to answer questions.

Operational Description

1. Special Structured Teaching - Group: Each patient attending group instruction will receive 2 points for each hour of structured teaching.

Individual Teaching

AC144. Individual - Teaching. . . . 30 minutes. . . . 4 points

Note

- This allows for 30 minutes of direct individual patient/family instruction. Multiply point value in 30 minute increments, one hour of direct instruction to patient or family members is equal to 8 points, etc.

Operational Description

1. Individual Teaching: 30 minutes of individual 1:1 or family member instruction, to include nature and scope of the health/disease process, special care requirements, limitations and/or restrictions related to a disease or illness and to answer questions.

CONTINUOUS

Patient Requiring 1:1 Coverage

AC145. Patient Requring 1:1 Coverage All Shifts. . . . . 96 points

Note

- The continuous section is used to classify the patient who requires 1:1 or greater care.

Operational Description

1. (96 points) Professional Nurse Coverage: Includes time for one professional nurse to render all care to a specific patient requiring continuous 1:1 or line-of-sight observation, supervision, and support. Examples include suicide patients who must be kept within arms reach or within line of sight, or patients in four point restraints.

or

2. (96 points) Paraprofessional Coverage: Includes time for one paraprofessional to be assigned one-to-one to such a patient to provide continuous observation, line-of-sight supervision, support and to render care in the areas of vital signs, monitoring, activities of daily living, and feeding. Do not take additional points for these activities when patient is classified continuous. Additional critical indicators may be ascribed for professional nurse interventions in the areas of treatments / procedures / medications / therapeutic interventions and teaching as required when a paraprofessional provides the continuous monitoring.

Discussion of Specific Indicators

1. Phototherapy:

Question: Are two points for phototherapy given (Acuity Code #65) each time the infant is put back under the lights, or are 2 points given per 24-hour period?

Answer: Once phototherapy is initiated, the patient will get the two points each day for the duration of the phototherapy. If the infant is taken out to be fed, bathed, etc., and then placed back under the lights, this does not earn an additional two points. However, should the therapy be discontinued for two or three days and then restarted, two points are again taken.

2. Umbilical lines:

Question: Are umbilical artery catheters in newborn infants considered arterial lines or IV therapy?

A: It depends on what the umbilical catheters are being used for. If an IV is being infused through the catheter, then treat it as an IV (depending on how many times in the 24 hours you change the bottle). If drawing periodic arterial bloods from the catheter for ABGs, etc., then count this activity as appropriate (Acuity Code #58).

Question: How should umbilical cord lines that are inserted for IVs be counted? Should it be a KVO or a simple IV depending on the rate?

Answer: If the cord line is being used as an IV, then count it as you would any other IV.

3. Diaper counts & Intake & Output:

Question: The pediatric unit does not weigh diapers for intake and output unless the patient is on strict I&O. Instead, they count the number of diaper changes. Can they still take points for I&O (Acuity Codes #10 and 11)?

Answer: Both intake and output must be measured and recorded to take credit. When patients are on strict I&O, and the diapers are being weighed and weights recorded along with the amount of intake, take the appropriate number of points. Just the counting of voidings does not fit the definition of I&O.

4. Ventilator patients:

Question: Do ventilator patients have to be on the ventilator for the full 24 hours to capture the points for ventilator care (Acuity Code #90)?

A: No. If patients have already been classified for that day, and the appropriate ventilator care has been given, take the points. However, if the patient comes off the ventilator before he is classified and before being given ventilator care for that shift, do not count the points. Likewise, if a patient goes on a ventilator for a few hours during a shift, and then comes off before he has been on a full 24 hours, do not count the points. NOTE: Historically, some facilities have automatically placed all patients on ventilators in Category V. This is inappropriate. Many patients who are on ventilators are chronic and stable who classify (accurately and appropriately) as Category III. Assess these types of situations carefully.

5. OB patients delivering after the daily batch cycle runs:

Question: Post delivery patients who return to the post-partum unit - can we capture the same points as we do for surgical patients who return to their unit following surgery?

A: A patient returning to the post-partum unit from delivery does not get

transfer-in points if she returns to the same unit. If she returns to a different unit, then transfer-in points may be taken. When she returns to the same unit, points are taken only for the care which has been ordered. If the patients are returning to the same unit, then anticipate the critical indicators needed for those patients and classify them accordingly. This is the procedure we use on surgical units for patients expected to be released from the recovery room and returned to the unit on the evening shift. If new patients are admitted to postpartum after the cycle runs, it is still appropriate to take the appropriate admission or transfer-in points the following day.

6. Albumin & blood components:

Question: Are we to capture albumin or blood components as a simple IV change?

A: Refer to Acuity Code # 48. Two points are taken for each administration of a blood product, e.g., albumin, platelets (a six pack of platelets counts as one unit). Do not count these as simple IV's. If an IV is infusing, count the IV accordingly.

7. Convalescent Leave (CVL) Patients:

Question: How are patients classified who are returning from convalescent leave?

Answer: They are counted as new admissions if they are readmitted to the unit and a full assessment and nursing care plan are done. If they are not actually readmitted, but instead pick up their charts and go to clinic appointments and then return to convalescent leave, do not count them.

Question: Do CVL patients need to be readmitted to the unit and entered in UCAPERS WMSN if they are being discharged the same day?

Answer: No. If, however, A&D admits the patient in AQCESS you may have to discharge them if you call up the patient in WMSN for any reason.

Question: When patients return from CVL and are subsequently discharged from the unit, nurses often spend a lot of time doing discharge paperwork and teaching. Is there a way to capture this workload in UCAPERS WMSN for the day patients return from CVL?

Answer: No. There is no acuity code for discharges because the majority of discharge work is indirect care (with the exception of discharge teaching which is best counted prior to the initial discharge to CVL). The amount of direct (hands on) care is minimal at the time of actual discharge. Furthermore, if the patient is admitted and discharged the same day, UCAPERS WMSN does not capture acuity.

8. Responsibility for patient classification:

Question: Will the WMSN always be the responsibility of the professional nurse or can it be delegated to administrative personnel?

Answer: It will always be the responsibility of the professional nurse to classify patients. However, the ward clerks and paraprofessional personnel may enter the data into the computer.

9. Accounting for activities of daily living:

Question: It is difficult to perform inter-rater reliability testing (IRR) for critical indicators related to activities of daily living (ADL), Acuity Codes 23 through 30, based on physician orders, nursing orders or nursing care plans alone without scanning the entire chart and/or doing a bedside assessment. In such an objective system, this section requires a subjective response. How would you recommend this be done?

Answer: Each and every patient will always receive points in the ADL area.

Rarely will the physician write an order designating the appropriate ADL; this is usually a nursing determination. The best way to determine which ADL critical indicator to use is to look at the chart, look at the patient, and talk to the nursing staff. Then make the best determination.

Question: Does the nursing order have to be written on the green sheets in order to take points for ADLs?

Answer: No. Although, a nursing order identifying ADL on the DA 4678 is desirable for consistency and better interrater reliability, it is not required. Remember, however, that sufficient information/documentation must be available to support the more complex levels of ADL, e.g. comments on skin integrity, ROM, bed weights, etc.

Question: Does AM care have to be documented?

Answer: No. This type of AM care to be provided (self, partial bath, complete bath) should be reasonable based on nursing assessment and the category of ADL chosen for that patient.

10. Transfer-in points from the recovery room:

Question: Can patients returning to the unit from the Recovery Room (Post Anesthesia Care Unit) receive Transfer In points (Acuity code #70)?

Answer: If a patient goes from a unit to the O.R. and returns to that same unit via the Recovery Room, do not count transfer-in points. Simply count the appropriate points for the new physical care that may be ordered. If the patient goes to a different unit after surgery, it would then be appropriate to count transfer-in points. Note: If the patients are returning to the same unit from surgery, the unit should anticipate the critical indicators needed for those patients and classify them accordingly.

11. Unlicensed staff, nurse interns, Red Cross volunteers, reservists:

Question: In what staff category do nurse interns and those who have failed the licensing exam, etc., fall?

Answer: Carry them on the Daily Summary Sheet in the Orientee section because they cannot work independently.

Question: How would you count the work performed by a Red Cross Volunteer? Are they to be counted as actual staff?

Answer: Count them in the Orientees section of the Daily Summary Sheet, since they cannot be counted as regular staff.

Question: Are reservists counted as orientees?

A: Yes. The exception to this is when the reservist is familiar enough with the unit operation to work alone. They may then be counted as regular staff members on the Daily Summary Sheet.

12. Mentally retarded patient requirements:

Question: Can mentally retarded adults be given 8 points for Acuity Code #30 (Peds recreation/observation - age 0-12)?

Answer: No. Use Acuity Code #96 (Sensory deprivation - blind, deaf, retarded, etc.).

13. Mother's assistance with infant care:

Question: Can post-partum unit nurses assign points for infant feeding on the mom's acuity worksheet if she (the mom) actually feeds the baby?

Answer: Yes. Use Acuity Code #33 and document the time, amount and type of formula given and how the feeding was tolerated. Remember, that the WMSN identifies (prospectively) the most probable activities that are going to occur that staff will need to perform. We cannot always anticipate the availability of family members to assist with member care.

14. Staff time when involved continuously with a patient on/off unit:

Question: What critical indicator is used when a staff member is continuously with a patient, (e.g., an ambulance run to another hospital for a test up to 8 hours or just 1:1 coverage for an 8-hour shift) so that the time is greater than 4 hours but less than all shifts?

Answer: If the staff member is on an ambulance run with a patient from that staff member's unit, capture that workload under the patient's name by using Acuity Code #78 if the time is greater than 1 hour but less than 4 hours. If the time is greater than 4 hours, use Acuity Code #98.

Question. What if a nursing staff member from a different unit goes on an ambulance run with another unit's patient. Are points still taken for critical indicator #98?

Answer: No. The unit providing the staff member should show a minus 0.5 or a minus 1.0 (-0.5 for up to 4 hours, -1.0 for the entire shift) on the Daily Summary Sheet in the Changes block under either the professional or paraprofessional column, depending on whether the patient was accompanied by a nurse or a technician. For example, SGT Lindsey goes on an ambulance run for another unit and is gone from 1100 to 1500 hours. Since Lindsey was gone for four hours, account for her absence by putting -0.5 in the Changes column for that shift on the Daily Summary Sheet. Since the patient's own unit provided no care for the patient during the ambulance run, they take no points for that activity.

15. Pediatric recreation/observation:

Question: If pediatric recreation is a standard order, does there need to be documentation elsewhere in the chart?

Answer: Yes. This critical indicator is not automatically given for every infant or child less than 12 years old. There must be documentation in the nursing orders or evidence in the chart that indicates a need for nursing staff to spend time with the patient.

Question: Pediatric unit staff spend a lot of time in the area of Acuity Code #30, Pediatric Recreation/Observation, even though parents may be rooming in (full or part time). Can points still be taken here?

Answer: Yes, if staff members are actually providing recreation/observation. Not every pediatric patient would require this. If credit is taken for this activity, it must be documented as being necessary on the nursing care plan.

16. Mixed patient types on the same unit:

Question: When we have pediatric patients on the medical surgical unit, psychiatric patients on medical units, nursery patients on OB, etc. how can we account for these patients and get the appropriate nursing care hours identified?

Answer: In UCAPERS WMSN program, two different WMSN types of patients (M/S, OB, Peds, NBN, Psych, ICU, NICU) can be identified for any given unit. The UCAPERS WMSN program currently counts the number of patients classified for each of these two types and calculates the nursing care hours separately for those two groups. The NCHs are added together and the staff breakout for the day/month is identified based on what has been previously identified as the predominant WMSN type for that unit. (This is in the ANU table maintained by the MEPRS personnel.) Unfortunately, there is no way to break out from your printed reports, what the actual patient mix was by type. In order to ensure that you receive credit for the right mix of patients, you would need to report the monthly number of patients classified by category for the two WMSN types on your unit. For example, you might report 100 category I OB patients and 50 category 1 NBN, 200 category II OB and 200 category II NBN, etc. Future revisions planned for the UCAPERS system would show the breakout of the two WMS types on your daily and monthly reports. These monthly reports could then be forwarded to the MACOM so the appropriate staffing formulas can be used to adjust the requirements on your hospital's TDA.

Question: If a patient is admitted to the ICU and has a psychiatric and a medical diagnosis, can both acuity worksheets be used to determine his/her acuity category?

Answer: Yes. Simply use both the general and psychiatric Patient Acuity Worksheets, and tally up the points to arrive at the patient's category.

17. Counting retrospective workload:

Question: Can workload be counted retrospectively?

Answer: No. The only exception to this is an admission. Those 12 points may be taken the following day when the patient is first classified. This is because the Standards of Practice allow 24 hours to complete the assessment, care plan, etc. If the admission (on evenings or nights) was known about on the day shift and projected to occur and the 12 points credit were already taken on the day shift, the 12 points are not taken again the next day.

Question: If you take credit for a one-time-only event that occurred earlier on my shift, is this considered retrospective?

Answer: No. If you start an IV, insert an NG tube, etc. that was just ordered on your shift, it is important to capture that workload. It is not, however, appropriate to take credit for events performed on prior shifts--even if they were new orders since the last classification. These prior events are considered "lost workload".

18. Transcribing patient orders:

Question: If the total amount of time required to take off a long list of stat orders on an ICU patient takes 30 minutes to one hour to complete, can Acuity Code #77 be used, even though each individual order would take less than 15 minutes?

Answer: No Acuity Codes may not be used for taking off orders because taking off orders is a part of indirect care. That time is already accounted for in the NCH calculations and subsequent staffing tables. The patient acuity worksheet is used for capturing direct care only.

19. Newborn stimulation requirements in the NICU & nursery:

Question: The staff in the NICU perform frequent interactions appropriate for gestational age which they term infant stimulation (stroking, direct eye contact, range of motion, etc.). The interventions are documented in the chart

as nursing orders. Because this is a purposeful, planned nursing activity, can points for infant stimulation be counted under Peds Recreation/Observation (Acuity Code #30), as purposeful interaction?

Answer: No. For the neonate in the NICU, do not use Acuity Code #30. Using this indicator would cause an inflated score because the nurse is already in constant attendance, and the activities described can be done without taking additional time away from other activities. However, Acuity Code #30 may be used in the normal newborn nursery for some of the reasons you describe and also for picking up the baby, holding, rocking, bonding, when the baby is crying, etc. Be conservative here since not every infant in the NBN would need these activities on a regular basis. Experience shows that most normal newborns are classified as Category I after the day of delivery.

20. Head Nurse and Ward Master as additives:

Question: Are the Head Nurse and Ward Master included in the WMSN math charts?

Answer: No. One additional professional nurse and one licensed practical nurse should be added to the chart numbers for the day shift, Monday through Friday, to account for their duties. The chart shows the number and mix of personnel required to provide the direct and indirect care for that specific group of patients. The Head Nurse and Ward Master are added to provide the administrative support required.

21. Conducting IRR by a unit's own staff member:

Question: Is it OK for a unit staff member (Charge Nurse) to conduct IRR testing on his/her own unit?

A: Yes and no. It is good management for Head/Charge Nurses to spot check the accuracy of their staffs' classifications. However, for the required quarterly IRR testing, it is essential that an outside person conduct the test. Head/Charge Nurses can exchange units and perform the IRR on each others' units.

22. Accounting for events such as cardiac arrest:

Question: When a cardiac arrest occurs on an evening or night shift, how is this counted?

Answer: It is not counted. This is considered lost workload, one of the unpredictable activities which cannot be planned for.

23: Psychiatry and the use of the critical indicators for staff attendance off the unit:

Question: How do you count escorting psychiatric patients off the unit for smoking breaks, bowling trips, etc? Can you count 2 points for each patient in the group for each trip the patient takes?

Answer: Critical indicator 141 can only be used for patients who require a staff ratio of 1 staff for 4-5 patients. It is not for every outing for example when only 1 staff member is in attendance for 10-12 patients. Clarification: If you have 10 patients you would technically earn 20 points but eight points equates to 60 minutes (8 x 7.5 min/point) of direct staff time with the patient. These 60 minutes give you the necessary credit for tying up that staff member for one hour of patient care.

Further discussion: (Remember that if an activity doesn't take at lease 15 minutes of direct care time for a patient, it isn't counted.) If we had 10 patients, for example, who each received 2 points for that hour of activity, we would be saying that there were 20 acuity points needed. Twenty times 7.5 minutes per acuity point is overstating the nursing care hours drastically. In actuality, those 10 patients had, at most, 6 minutes of nursing care each (60 minutes divided

by 10). You can see, then, how taking 2 points for every patient for every trip overstates the NCHs. If these patients are off the unit 3 or 4 times a day, then a maximum of 2 points might be appropriate for each patient. Another thing to think about is the fact that while one staff member is off the unit with 10 or 12 patients who do not require nursing intervention, the patients still on the unit can receive more nursing care by the staff who are there.

24. Documentation for emotional support:

Question: Is a nursing order on the DA 4678 sufficient documentation for taking emotional support?

Answer: Yes, for IRR purposes. Since the use of critical indicators 94, 95, and 96, and 97 are designed for patients requiring emotional support in excess of 30 minutes per 24 hours, there must be documentation in order to take credit. From a WMSN use standpoint, however, continued use of an emotional support critical indicator should also be supported in the nurses notes. If additional support is required, there should be something in the chart which identifies the patient's emotional status or reason for needing emotional support. Lack of this documentation is a QI issue, but can undermine credibility for the WMSN. Standard overprints on the "green sheets" identifying emotional support are not appropriate, since not all patients require additional support. This is supposed to be an individualized indicator. Remember that a maximum of 10 points for emotional support can be taken.

Question: If there is a comment in the nurses notes saying that the patient is anxious and the RN allowed the patient to verbalize, is this enough documentation to take emotional support?

Answer: Yes

Further Discussion: A certain amount of time is already built into the direct and indirect care time formulas for "teaching" and "emotional support". Nurses routinely teach and provide emotional support for patients during the normal course of delivering nursing care. Because of this, the indicators relating to patient teaching and emotional support should not be used routinely for all patients. These indicators should be used when the nurse identifies a need for teaching and/or emotional support beyond the amount provided to patients during the routine delivery of nursing care. While these indicators should not be used routinely, nurses should not hesitate to use them when the situation warrants. The need for these critical indicators should be clearly evident and documented.

25. Same day surgery patients on inpatient units:

Question: How do you take credit for same day surgery patients or outpatients cared for on inpatient units?

Answer: We cannot take credit in WMSN for same day surgery patients because they are not anticipated to remain in the hospital for the next 24 hours. We can, however, admit them in AQCESS, not classify them, but annotate in the comments field that they are SDS patients. These patients will show up as an admission and discharge in the WMSN batch cycle on the Ward Activity Report, but we will have a "hard copy" record of how many and how frequently these patients are being seen on our inpatient units. We can use this information to either develop manpower additives for the inpatient units or to justify additional requirements for establishment of a centralized same day surgery function.

26. Telemetry Monitoring:

Question: How can the unit doing telemetry monitoring take credit for monitoring patients off their unit?

Answer: They can't in WMSN. The unit which physically has the patient is the unit that classifies the patient in UCAPERS WMSN. Since the parent unit is not

doing telemetry monitoring, there is no way to capture that workload. The monitoring unit should keep track of how many "remote" patients they are monitoring so this information can be used to identify additives for manpower for performing this extra function.

27. Patient controlled analgesia (PCA) pumps:

Question: How do you count a PCA pump?

Answer: Use critical indicator 49, Infusion Pump/Comptroller. Count each syringe change as an IV bag/bottle change.

28. Ostomy care:

Question: Can you count ostomy care a as a complex dressing change, AC 55? Also, if you flush the ostomy tube 4 or more times a day can you take credit for an irrigation/instillation?

Answer. Yes on both counts. If the dressing change requires 30 minutes, it is appropriate to count it as a complex dressing change. If, however, it takes 5-7 minutes, it should be counted as a simple dressing change if done twice in 24 hours.

29. Admission versus transfer in points:

Question: If you have a preadmission clinic that performs the nursing assessment, admission lab work and pre-op teaching, is it appropriate to take the full 12 admission points, or is it better to take the 4 points for the transfer-in action?

Answer: Take the 4 points for a transfer-in action. If the complete admission process is performed by personnel not belonging to the unit, then it is not appropriate to take the 12 points for admission because the unit staff has not actually been involved in the work. It would be more appropriate to use acuity code 71. This allows enough time to review the patient's assessment and orient the patient to the unit.

30. DD Form 255l & DD Form 2552 -- Patient Acuity Worksheets:

Question: How long do we have to keep these worksheets on file?

Answer: The length of time to maintain the completed forms is determined by local policy. When used, however, they should be available to support the IRR process and to record patient acuity when the UCAPERS system is down so the data can be submitted to your RMO and to the MACOM NMA. During the manual implementation of the WMSN, it is recommended that the sheets be maintained for at least one year.

31. Suicide patients in ICU:

Question: Do we count continuous care for these patients, i.e. make them a category V patient?

Answer: Not automatically. It depends on the need to have a staff member tied up continuously with the patient.

32: Lost workload in the ICU:

Question: How can you account for patients admitted to the ICUs after the daily WMSN cycle runs, but who are discharged from the unit before the next daily cycle?

Answer: If the predetermined time for your MTF daily batch cycle seems to understate your true Nursing Care Hour requirements, you can update your classifications and run an "on demand" cycle on your unit. Keep this information on file, and when your MTF forwards acuity data to the MACOM you can manually

report what your total acuity by category was for your alternate shift. This "updated" picture (if consistently captured) can be used to adjust your manpower requirements. In other words, we can use your evening shift data (if this is your alternate data capture shift) instead of the data reported on the WMSN daily batch cycle to determine your requirements. This is true for any unit that consistently has a "different" acuity projection on a shift other than the one where the batch cycle is run. If your unit chooses not to do the "on demand" report it can still manually report the number of patients who were "lost workload" to the Chief Nurse, who in turn can forward this information to the MACOM with the WMSN monthly data disk.

33. Use of general acuity indicators for psychiatric patients:

Question: How can we account for medical conditions requiring nursing intervention when we have a psychiatric patient and are using the psychiatric acuity indicators.

Answer: Use those critical indicators from the general acuity worksheet to identify nursing interventions that are not listed on the psychiatric acuity worksheet. The UCAPERS computer allows access to indicators l-99, in addition to 100-145 which are the most common psychiatric indicators.

34. Ward work not captured in WMSN:

Question: Nursing personnel spend a lot of time in meetings, making out lab slips, talking on the phone to coordinate patient appointments, running specimens to the lab, putting together and breaking down charts, doing QI activities, etc. for which they can't take acuity points. How can this workload be captured so the units get credit for this?

Answer: The preceding examples represent what is called indirect care. These are the behind the scenes activities which are necessary for the ward to operate, but which are not directly patient related. The critical indicators 1 through 145 represent direct care activities, or time spent in face to face interaction with the patients. It is the direct care activity which determines the category of care (1-6). When nursing care hours are calculated, a second piece of time is added. This is the indirect care time and is different for each type of nursing unit. This is the reason why 5 category II patients on a pediatric unit, for example, generate a different NCH value than 5 category II patients on an ICU, or 5 category II patients on a medical/surgical unit. This indirect times adds an additional 65-75% of time to the direct care time identified by the critical indicators, i.e. patient category. This additional time allows for those direct care activities which you can't specifically count to occur (without having to keep exact track of them). As you can understand from the way wards operate, there is a bigger percentage of indirect care time on the medical/surgical units (where there is a lot of time that must be spent other than at the patients's bedside) than in ICUs or NBNs where a large part of what is done for the patient has an associated critical indicator.