Nursing Handover & Bedside Safety Checks for the Critically Ill Adult in Intensive Care - Full Clinical Guideline

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These are nursing guidelines for use within critical care to support best practice. They are not prescriptive and as with all nursing practice should be utilised in conjunction with the registrant's clinical judgement

Introduction

Critically ill patients are particularly vulnerable to physiological deterioration due to the nature of their illness or injury or as a potential unavoidable consequence of the intensive therapies and care received. It is of paramount importance therefore to maintain the safety of the patient during this time (Newmarch 2006).

Aim and Purpose

The purpose of this guideline is to direct the undertaking of a safe and effective nursing handover and the essential bedside safety checks for critically ill adults within the intensive care unit

It aims to promote the maintenance of a safe environment for patients, relatives and the multidisciplinary team, to direct the delivery of excellent and informed nursing care and to ensure the nurse acts as patient advocate. (NMC. 2018)

Keywords – Nursing Handover, Safety Checks, Critically Ill Adult, Intensive Care Unit

Main Body of Guidelines

Patient Handover and Equipment Safety Checks

1. Ensure that wherever possible a registered nurse is responsible for the patient's care in the following recommended ratio; level 3 - 1:1, level 2 – 1:2, (FICM / ICS 2022)

2. Ensure that the verbal nursing handover provides sufficient information for the oncoming nurse to effectively manage the patient's immediate condition and treatment and ensure that any specific infection control instructions are communicated effectively to prevent cross contamination between patients, their families or the health care team.

3. Perform hand hygiene and don apron, or required infection specific Personal Protective Equipment (PPE) prior to patient contact (NHS England 2023).

4. Undertake the following shift change safety checks and sign to confirm completion (UHDB 2019).

    a) Ensure all infused medications are being administered as prescribed, that they are in date and labelled correctly and that the date for the line change is documented.

    b) Ensure all invasive monitoring lines are transduced using prescribed fluids and pressurised to 300mmHg. Check that they are labelled correctly and that the date for the line change is documented.

    c) Ensure that respiratory device settings are checked and within the prescribed parameters, that any accompanying alarms are engaged and that patient appropriate

alarm limits are set e.g. 10% above and below patient specific target range. Refer to ICU Humidification Guidelines (2024) where humidification of oxygen is in place.

5. Undertake the following bedside safety checks immediately following shift handover and ensure that they are documented correctly (Newmarch 2006, UHDB 2019).

   a) Ensure positive patient identification has been undertaken prior to care commencement and that the patient's actual / estimated weight and height are recorded on the 24-hour observation chart.

   b) Check that all essential equipment is plugged into an appropriate mains supply plug socket and that the bed space is clear from loose lines, cables and clutter that may act as 'trip hazards' to maintain safe working environment.

   c) Ensure that all monitoring and equipment has been calibrated (Magder 2006) and that the arterial line blood pressure is comparable to the Non Invasive Blood Pressure (NIBP). Ensure that the invasive monitoring transducers are at the height of the patient's phlebostatic axis / right atrial alignment (Woodrow 2009) and that all monitoring alarms are engaged and set within safe parameters e.g. 10% above or below the patient specific target range.

   d) Ensure that the appropriate 'Airway' classification card is available in the immediate bed area and can be easily visualised (Royal College of Anaesthetists, 2011, Difficult Airway Society 2015).

   e) Where the patient has a tracheostomy, ensure that a sealed blue 'Tracheostomy Emergency' box is available at the bedside and that all patient specific consumables are stocked up to facilitate required tracheostomy care (ICU tracheostomy Guidelines 2024).

   f) Check that the oxygen (O_2) supply is in full working order and ensure that an AMBU bag, C-Circuit and emergency airway adjuncts are available in the bed space for immediate use.

   g) Check that there is a CD size oxygen cylinder, that is at least ¾ full available in the bed space for immediate emergency use in the event of O_2 supply failure.

   h) Check that 'open' suction equipment is available at the bedside and in full working order and that there is an adequate stock level of 10 & 12 FG suction catheters and clean gloves (National Tracheostomy Safety Project 2024).

   i) Check the suction vacuum pressures are set ≤ 20kPa (National Tracheostomy Safety Project 2024) at between 13 – 20 kPa or 100 – 150mmHg (Royal Marsden 2020) to minimise risk of tracheal damage and suction induced hypoxaemia.

6. Undertake twice daily cleaning of the patient's bed space using appropriate detergent wipes unless patient specific infection control measures state otherwise and change all consumable items as required.

References

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Faculty of Intensive Care Medicine Intensive Care Society (2022)	Guidelines for the Provision of Intensive Care Services (GPICS) version 2.1 http://www.ficm.ac.uk>guidelines-for-the-provision-of-intensive-care-services.
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APPENDIX 1

Abbreviations

FG – French Gauge

kPa – Kilopascals

MAP - Mean Arterial

mmHg – Millimetres of Mercury

NIBP – Non Invasive Blood Pressure

O_2 – Oxygen

PPE – Personal Protective Equipment