Keep Pace With Step-Down Care

Wendy J. Berke, RN, BSN, MHA
Margaret M. Ecklund, RN, MS, CCRN, APRN-BC

Fifty-year-old Marvin Smith, an African American male with no significant history of heart disease, presented to the ED with 6/10 chest pain and diaphoresis. His heart monitor showed normal sinus rhythm, and ECG showed ST segment depression in the anterior leads. His troponin was positive, indicating an acute non-ST-segment elevation myocardial infarction (MI).

Five to 15 years ago, the ED nurse manager would have assigned Smith to a CCU bed. Today, as advanced technology supports higher-acuity stable patients in less-intensive environments, managers have other options. Since Smith is hemodynamically stable, he’s more likely to receive ongoing monitoring and therapy on the cardiac step-down unit.

Progressive care units (PCUs)—also called step-down, telemetry, intermediate care, and transitional care units—continue to grow in number as the patient acuity gap between critical care and medical/surgical care narrows. Optimally, patients should be transferred to where they can get the best care, without limiting their placement by traditional unit boundaries. Thus, patients’ care needs define acute and critical care, not the hospital’s geography.

Patients admitted to PCUs span a range of diagnoses and care demands. Typically, they need high-frequency monitoring interventions and are at risk for rapid status change. Examples include patients with acute coronary syndrome, atrial fibrillation, post-cardiac intervention, or those requiring mechanical ventilation. PCUs vary in name, management, and patient population, and their size typically ranges from two beds to 80 or more.¹

High-Performance Care Teams

The PCU care delivery team comprises a mixed level of caregivers. PCU nurse managers vary in background and expertise from critical to general care. Staff nurses may often be graduates with minimal experience. Licensed practical nurses (LPNs) or licensed vocational nurses (LVNs) can efficiently administer medications. Under nurse supervision, LPNs also can provide direct care, give treatments, and make observations, but not clinically assess patients. Unlicensed assistive personnel (UAPs) provide support services including direct care, technical procedures (phlebotomy, ECG, monitor set-up, and surveillance), and equipment and environmental maintenance. These team members also work under RN supervision.

Because of high acuity and changing patient conditions, it’s imperative to develop a high-performance team with a clear communication structure and appropriate delegation. RNs with minimal clinical experience may be challenged to learn assessment skills in addition to supervisory skills for LPNs/LVNs and UAPs. Unit leaders, such as nurse managers or advanced


Authors

Wendy J. Berke is Director of Professional Practice, American Association of Critical-Care Nurses, Aliso Viejo, Calif.

Margaret M. Ecklund is Advanced Practice Nurse, Clinician V, Pulmonary Medicine, Rochester General Hospital, Rochester, NY.
practice nurses (APNs), can best model and coach novice RNs.

In the Synergy Model, a practice model developed by AACN, patient needs drive nurse competencies. With predominantly novice-level nurses on the unit, a more experienced nurse on the unit ideally helps to model and coach their performance. Deliberate delegation to novice-level nurses ensures feedback and appropriate supervision. When a patient care issue arises, it’s important to know who’s best suited to perform assessment, intervention, and evaluation. The appropriate decision impacts effective patient care.6

At the core of excellent communication? Trust. Effective team building promotes developing relationships for trust. Communication exercises can help to model effective ways to deliver a message and ensure feedback. In a busy clinical environment with multiple levels of caregivers, efficient patient care depends on communication.

Written unit standards for each hospital’s PCU describe the environment and the usual care process. In these standards, it’s important to describe each team member’s responsibilities and what tasks can’t be delegated. The unit standard also describes a reporting mechanism to ensure consistent practice.4

Frequency of assessment—in the written standard—considers patient characteristics. In addition to physical parameters of vital signs and nursing assessment, also determine psychosocial, cultural, and learning needs to identify any barriers.

The unit standard describes the patient population targeted for a particular PCU. Multidisciplinary admission, discharge, and transfer criteria help to determine care needs and the appropriate acuity level of patients admitted from other units. Tools such as algorithms and flow charts can enhance decision making in such units. Pre-established care guidelines can help to move patients efficiently through the unit.5

As described by the Synergy Model, PCUs optimally provide care for patients with lower to middle levels of resiliency, vulnerability, stability, complexity, resource availability, participation in care, decision making, and predictability. Whether a pulmonary, cardiac, or neurological specialty care focus, patient acuity is usually less intense than in traditional ICUs or CCUs, but not as stable as in medical/surgical units or extra-hospital care.

Enhanced Education Needs

Providing care for higher-acuity patients often necessitates enhanced education for the staff. Topics for education may include, but are not limited to:

- critical care assessment skills
- ventilators
- vascular access
- chest tubes
- pacemakers
- automatic implantable cardiac defibrillators
- pharmacologic infusions
- advanced cardiac life support
- conscious sedation
- pulse oximetry
- cardiac monitoring
- hemodynamic monitoring.

If monitor technicians perform cardiac surveillance, they’ll require pretesting, training, competency assessment, and quality assurance monitoring. To ensure effective communication of arrhythmia information, all staff must have a thorough working knowledge of the technology, as well as the ability to recognize various arrhythmias, understand alarm priority, and be familiar with treatment protocols.

The PCU nurse manager and team must develop a system of defining personnel roles and the necessary education offerings to mesh with annual competency assessment and performance evaluation. Competency assessment includes:

- knowledge—does the individual know why and what to do?
- skill—is the individual skilled to complete the job?
- attitude—is the individual willing to do what it takes to complete the job?
- critical thinking—does the individual apply the knowledge and skill thoughtfully and appropriately?6

Understand Regulatory, Safety Standards

PCU nurse managers must know important regulatory and safety standards. Almost all acute care hospitals in the United States receive federal and state funding to pay for Medicare and Medicaid patients. To qualify for payment, various conditions of participation exist, including those on minimum guidelines for staffing and quality.

Managers should be familiar with regulations of the Department of Health, the Center for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration), and Joint Commission on Accreditation of Health-care Organizations. Be sure to identify resources to support
decisions and an ethical decision-making framework.  

Technology Versus Staff Education

When assessing technology, it’s critical to differentiate between staff education needs and technology. The needs of the patient will help to determine technology needs. Some caregivers will require training. Once managers establish PCU care limits, assessing technology based on institutional needs, staff qualifications, and unit resources can occur.

As part of technology assessment, consider the extent of invasive monitoring, mechanical ventilation, and the type of medications and therapies the PCU will provide. Telemetry monitoring designed for continuous ECG monitoring of patients, for example, is needed in step-down units or PCUs for patients who require cardiac care. In conjunction with technology needs, consider:

- centralized or decentralized configuration (remote monitoring)
- geographic location of the patients
- equipment needs
- networked system
- physiologic parameters
- patient care objectives
- cost objectives (fewer transfers, decreased lengths of stay)
- mobility needs of the patient to attain optimal functioning.

Databases such as acuity systems or patient classification systems can provide nurses with useful information by describing patient characteristics and needs. Many different acuity systems, severity of illness measurements, proprietary workload, and acuity measurement tools exist. The decision to use such a system and the selection of one should be a collaborative effort among nursing staff, physicians, administrators, and nurse managers to provide objectivity for staffing demands. Such a staffing tool must link cost implementation, competency, and staffing with patient outcomes to meet the comprehensive strategic plan of care. When considering an acuity system, ask the following:

- Is computer hardware needed?
- Is information system support needed?
- Does the vendor provide education support?
- Is there a need to generate new forms or modify charting?
- Is the retention of data required?
- What are the time and workload requirements for the nurse to enter data?
- How responsive is the system in providing feedback to the staff to project staffing needs?

Nurse managers must consider direct and indirect labor costs, productivity, cost allocation, budgets, and position control in planning for and maintaining the success of the PCU. Critical outcome measurements include risk management, staffing, tracking quality assurance/improvement indicators, notification reporting, and patient, staff, and physician satisfaction. Astute managers apply both business acumen and analytical skills to measure and evaluate outcomes. New PCU managers will benefit from an experienced manager who can provide mentoring and coaching for business acumen.

Quality Measures

The progressive care environment requires methods of risk management and involves structured monitoring mechanisms, preventive strategies or standards, and continuous surveillance of potential patient care incidents or quality indicators. Quality indicators may be clinical or financial, and may include the quantity of untoward incidents (such as falls, medication errors), census, readmission rates, budget variances, and length of stay. Quality care requires these five major components:

1. professional performance by physicians and other health care providers
2. efficient use of resources
3. minimal risk (of injury related to care) to the patient
4. patient satisfaction
5. compassionate care

Other measurements of success include staff, patient, and physician satisfaction. It’s not just the clinical care provided, but the customer service aspect of “how you care” as nurses meet progressive care patients’ needs in a safe, competent care environment.

References

5. Society of Critical Care Medicine Guidelines/Practice Parameters Committee: Guidelines on Admission and Discharge for Adult Intermediate Care Units. SCCM, Anaheim, Calif., 1999.
8. Ibid, 65.
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