Progressive Care

Progressive Care Units: Different but the Same

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Progressive care units are increasingly common in hospitals in the United States. These units are often used to bridge the gap between intensive care units and medical-surgical units, with the goal of providing cost-effective, high-quality, safe care. Although progressive care units today may seem to provide care for a wide variety of patients, these patients do share certain typical features: they require a high intensity of nursing care and/or a high level of surveillance. Nurses working in progressive care units all must have certain basic competencies. Those core competencies have been identified and should form the basis for education and training of progressive care nurses. (Critical Care Nurse. 2011;31[3]:77-83)

It has been 10 years since the American Association of Critical-Care Nurses (AACN) developed the Progressive Care Task Force and Advisory Panel to gather information to develop a better understanding of progressive care units and the needs of nurses working in those units.1 During this time, the number of progressive care units (PCUs) throughout the United States has increased significantly2 as many hospitals have adopted this model as a cost-effective way of providing quality health care to a distinct population of patients.1 Initially developed in the 1970s to care for patients with myocardial infarction who required cardiac monitoring,3 progressively today often provide care for a variety of patients.6 Many hospitals have espoused this level of care to bridge the gap between the intensive care unit (ICU) and the medical-surgical unit.6

On the surface, PCUs may appear to vary widely. Although some PCUs are designed to be specialized and focus on caring for a specific population of patients (eg, cardiac patients, respiratory patients, or stroke patients), other PCUs are designed to be eclectic and focus on caring for a wide assortment of patients.8 Another difference is the name of the unit. In one hospital, the progressive care area may be called the PCU, but in another hospital, it may be called a variety of different names, for example, intermediate care unit (Table 1).9 In addition, the units may vary in size from hospital to hospital, with anywhere from 12 beds or fewer to more than 30 beds.2

Upon closer examination, however, the units are much more similar than they may initially appear. PCUs are all designed to serve patients with the same level of acuity and/or intensity of nursing care and the nurses all require the same level of education and training. These units have the same goal of providing cost-effective, high-quality, safe patient care to progressive care patients. The AACN’s definition of progressive care is provided in Table 2. The purpose of this article is to discuss the typical profile of a patient being cared for in a PCU and to describe the basic competencies of the nurses required to provide care for these patients.

Profile of Progressive Care Patients

Whether the types of patients served by the PCU are very alike or very different, the characteristics of the patients cared for in PCUs are generally very similar. These patients generally fall into 2 categories; patients who require an increased intensity of nursing care and/or patients who require an increased

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level of surveillance. Generally, PCU patients do not require the more sophisticated technologies found in an ICU. Intensity of nursing care is the amount of nursing resources that a patient requires each shift and is a product of a number of factors, including the patient’s age, the length of stay, and the complexity of the patient’s care. Thus patients may be candidates for the PCU if the intensity of nursing care required exceeds the ability of the medical-surgical units.

Increased Intensity of Nursing Care

PCU patients can also be described in terms of the stability of their condition, their risk of a life-threatening event, their need for invasive monitoring, and their ability to participate in their care. When compared with patients in the medical-surgical unit, patients in the PCU are generally considered to have an increased risk of their condition becoming unstable or of experiencing a life-threatening event. When compared with patients in the ICU, PCU patients can generally be described as having greater stability, a lower risk of a life-threatening event, less need for invasive monitoring, and a greater ability to participate in their care. Thus PCU patients are on the less acute end of the continuum of critical care.

Patients who require a greater intensity of nursing care are often transferred to the PCU. Usually these are patients who have been transferred from the ICU as their condition has stabilized and they no longer require the ICU level of technology. The patient’s condition may be stable enough for the patient to go to a medical-surgical unit but either the number of hours of nursing care or the complexity of nursing care required exceeds that which is provided in the medical-surgical areas. These types of patients usually include those requiring extensive wound management, extensive pulmonary interventions, or other interventions that cannot be provided in the medical-surgical unit. Some of these interventions include weaning a patient off of mechanical ventilation and managing a patient with an arterial catheter, a temporary pacemaker, or a ventricular assist device. Interventions that cannot be provided in the medical-surgical unit will vary depending on the health care organization and the types of medical-surgical units available within the organization.

One population of patients that has grown in the past 10 years is chronically critically ill patients. Chronic critical illness is a syndrome that has been observed in patients with respiratory failure that requires prolonged mechanical ventilation.

Table 1 Alternative names for progressive care units

<table>
<thead>
<tr>
<th>Intermediate care unit</th>
<th>Transitional care unit</th>
<th>Telemetry unit</th>
<th>Step-down unit</th>
<th>Step-up unit</th>
<th>Definitive observation unit</th>
<th>Direct observation unit</th>
<th>Postinterventional unit</th>
<th>Cardiac interventional unit</th>
<th>Clinical decision unit</th>
<th>Intermediate intensive care unit</th>
<th>Intermediate coronary care unit</th>
<th>Subacute coronary care unit</th>
</tr>
</thead>
</table>

Table 2 The American Association of Critical-Care Nurses’ definition of progressive care

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

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It includes a host of features such as profound neuromuscular weakness, neuroendocrine changes, increased risk of infection and pressure ulcers, brain dysfunction, and malnutrition. Such patients experience a variety of symptoms, including pain, fatigue, thirst, dry mouth, dyspnea, and anxiety. These patients have complex needs for nursing care and require care on a long-term basis. To limit costs, these patients are often transferred to long-term acute care facilities. If such a facility is not feasible at the time of transfer out of the ICU, the PCU may become the appropriate alternative destination.

**Increased Level of Surveillance**

The other patients commonly seen in the PCU are patients who require a high level of surveillance. Surveillance is a critical element of patient safety. Patients are often admitted to the PCU because the level of surveillance needed exceeds that which can be provided in the medical-surgical area. In some cases, this situation arises because the nurses in the PCU possess specialty knowledge and skills that are not available in the medical-surgical unit, and in other cases it is related to the availability of monitoring equipment that is not found in the medical-surgical unit. Although the patient’s surveillance needs could be managed in the ICU, the higher level of care is not warranted because the patient’s condition is stable. Thus PCUs increase patient safety by providing enhanced surveillance of critically ill patients in stable condition.

Bulechek et al describe surveillance as the “purposeful and ongoing collection and analysis of information about the patient and the environment for use in promoting and maintaining patient safety.” Nursing actions inherent in the concept of surveillance include maintaining vigilance for potential problems, developing awareness of problems as they occur, and responding to problems when they occur. Surveillance is a complex concept that incorporates both behavioral and cognitive components. In this case, patients are admitted to the PCU because the nurses possess additional competencies (knowledge and skills) not available in the medical-surgical unit. Examples of such patients include patients who require frequent neurological assessments, patients experiencing cardiac dysrhythmias, and patients receiving continuous intravenous infusions of medications such as nitroglycerine or insulin.

Surveillance also incorporates the use of technology as a means of monitoring the patient. Patients are also often admitted to the PCU for monitoring that is not available in the medical-surgical units. Examples of these types of patients include patients who require electrocardiographic monitoring, continuous pulse oximetry, or continuous blood pressure monitoring via an arterial catheter. The type of monitoring equipment will vary depending on the purpose of the PCU and the demographics of the patients being served by the unit.

**Admission and Discharge Criteria**

PCU patients may be transferred from the ICU or admitted directly from the emergency department or a physician’s office or clinic. Appropriateness of patients for the PCU can be an issue if clear admission criteria have not been developed. In 1998, the American College of Critical Care Medicine of the Society of Critical Care Medicine (SCCM) published “Guidelines on Admission and Discharge for Adult Intermediate Care Units.” These guidelines have become the standard for the development of many hospitals’ PCU admission criteria. The guidelines provide a list of examples of patients by body system (eg, cardiac, pulmonary) that would and would not be appropriate for admission to the PCU. Discharge criteria are also provided. When the patient meets the discharge criteria for the PCU, the patient should be evaluated for transfer to the medical-surgical unit. The document can be viewed in the guidelines section of the SCCM Web site (www.sccm.org).

**Synergy Model**

Clear and comprehensive admission criteria help ensure that the right patient is placed in the right bed and is cared for by the right nurse. It is important to define as objectively as possible the characteristics of the patients who should be placed in the ICU, the PCU, and the medical-surgical unit. One such method of identifying characteristics of appropriate patients for each unit is through the AACN’s Synergy Model for Patient Care.

The Synergy Model describes patients’ characteristics and nurses’ competencies and notes that when the 2 are aligned, the result is optimal patient outcomes. In other words, synergy occurs when the needs of the patient are matched with the competencies of the nurse. The model lists 8 characteristics of patients: resiliency, vulnerability,
stability, complexity, resource availability, participation in care, participation in decision making, and predictability. Each characteristic is rated on a continuum of 1 (minimal) to 5 (high). A total of 8 nurse competencies are listed: clinical judgment, advocacy and moral agency, caring practices, collaboration, systems thinking, response to diversity, facilitation of learning, and clinical inquiry. Each competency is rated on a scale of 1 (competent) to 5 (expert). When the needs of the patient are evaluated by rating the patient’s characteristics and the strengths of the nurse are identified by rating the nurse’s competencies, the best possible assignment of patients can occur. The Synergy Model facilitates matching a patient with a nurse who is strong in the particular competencies that are required by the patient at that time, hence facilitating the achievement of optimal patient outcomes.

Several case studies on how to implement the Synergy Model in clinical practice are available on the AACN Certification Corporation’s Web site (www.certcorp.org).

Core Competencies of Progressive Care Nurses

The PCU is a place where specialty-educated and trained nurses combine the knowledge and skills of their practice. It was evident from the results that nursing practice differs distinctly between the PCU and the ICU, thus facilitating identification of the scope of progressive care nursing practice. Analysis of the data led to the identification of the knowledge and skills necessary for registered nurses to practice in progressive care settings. These became the core competencies for a PCU nurse (Table 3). In 2008, the AACN Certification Corporation completed a second study examining progressive care nursing practice. Conducted in the same fashion as the first study, the results led to a revised set of core competencies for progressive care nurses in 2009. Table 3 provides a comparison of the 2004 competencies with the 2009 competencies and highlights the differences between the 2 sets.

The expansion and revision of the core competencies provides an excellent illustration of the changes that have occurred in progressive care nursing practice. For example, the revised competency for dysrhythmia interpretation now includes ST-segment and QTc interpretation, reflecting the evolution of cardiac monitoring in the PCU. The initial competencies regarding continuous medication administration addressed nontitrated vasoactive agents, whereas the revised competencies address titration of vasoactive medications. The initial competencies addressed hemodynamic monitoring, whereas the revised version now specifies arterial pressure monitoring and non-invasive hemodynamic pressure monitoring. The refinement of these standards reflects the expansion and clarification of nursing practice that has occurred over time. The initial competencies addressed weaning and long-term mechanical ventilation, but this competency is no longer part of the revised 2009 competencies. Although some units may take patients who require long-term mechanical ventilation, this was

As PCUs continue to evolve and flourish, it is important to note that the units may have different names and may serve different groups of patients, but the characteristics of the patients in such units are very similar.
<table>
<thead>
<tr>
<th>Core competencies</th>
<th>2009</th>
<th>Changes from 2004 to 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysrhythmia monitoring techniques</td>
<td>Cardiac monitoring techniques and lead placement</td>
<td>Expanded to specify lead placement</td>
</tr>
<tr>
<td>Basic and advanced life support</td>
<td>Basic and advanced life support</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Basic dysrhythmia interpretation and treatment</td>
<td>Basic dysrhythmia interpretation and treatment, including ST-segment and QTc interpretation</td>
<td>Expanded to include ST-segment monitoring and QTc interpretation</td>
</tr>
<tr>
<td>Drug dosage calculation, continuous medication infusion administration, and monitoring patients for medication effects (eg, nontitrated vasoactive agents, platelet inhibitors, anti-arrhythmic agents, and insulin)</td>
<td>Drug dosage calculation, continuous medication infusion administration, and monitoring patients for medication effects</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Patient monitoring using standardized procedures for before, during, and after procedures (eg, cardioversion, transesophageal echocardiography, cardiac catheterization with percutaneous coronary intervention, bronchoscopy, esophagastroduodenoscopy, percutaneous endoscopic gastrostomy placement, chest tube insertion)</td>
<td>Monitoring patients using standardized procedures for before, during, and after procedures (eg, cardioversion, transesophageal echocardiography, cardiac catheterization with percutaneous coronary intervention, bronchoscopy, esophagastroduodenoscopy, percutaneous endoscopic gastrostomy placement, chest tube insertion)</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of instability in patient’s condition</td>
<td>Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of instability in patient’s condition</td>
<td>New competency</td>
</tr>
<tr>
<td>Hemodynamic monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of instability of patient’s condition</td>
<td>Noninvasive hemodynamic pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of instability of patient’s condition</td>
<td>Competency was changed to specify noninvasive hemodynamic monitoring only</td>
</tr>
<tr>
<td>Recognition of the signs and symptoms of cardiopulmonary emergencies and initiation of standardized interventions to stabilize the patient’s condition while the patient awaits transfer to critical care</td>
<td>Recognition of the signs and symptoms of cardiopulmonary emergencies and initiation of standardized interventions to stabilize the patient’s condition while the patient awaits transfer to critical care, including cardioversion, defibrillation, and transcutaneous pacing. Seek assistance as needed</td>
<td>Expanded to specify cardioversion, defibrillation, and transcutaneous pacing</td>
</tr>
<tr>
<td>Monitoring normal and abnormal results of diagnostic tests</td>
<td>Monitoring normal and abnormal results of diagnostic tests</td>
<td>New competency</td>
</tr>
<tr>
<td>Interpretation of results of arterial blood gas analysis and communication of findings</td>
<td>Interpretation of results of arterial blood gas analysis and communication of findings</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Recognition of indications for and management of patients requiring noninvasive oxygen delivery systems including oral airways, bilevel positive airway pressure, and nasal continuous positive airway pressure</td>
<td>Recognition of indications for and management of patients requiring noninvasive oxygen delivery systems including oral airways, bilevel positive airway pressure, and nasal continuous positive airway pressure</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Assessment of the ventilator-dependent patient to ensure delivery of the prescribed treatment and patient’s response</td>
<td>Assessment of the ventilator-dependent patient to ensure delivery of the prescribed treatment and patient’s response including tracheostomy care, and continuous and intermittent monitoring of oxygen saturation</td>
<td>Expanded to specify tracheostomy care and monitoring of oxygen saturation</td>
</tr>
</tbody>
</table>

Continued
not the norm when the 2008 practice survey was conducted and thus the competency was removed. However, managing patients with tracheostomy tubes and pulse oximetry is still part of the competencies. In addition, the revised competencies address management of chest tubes, insulin infusions, procedural sedation, stroke patients, behavioral emergencies, and complex wounds.7 These additions reflect the changes in the patients who are currently being cared for in the PCU and the increasing complexity of nursing practice.

Table 3  
Core competencies*  
<table>
<thead>
<tr>
<th>2004</th>
<th>2009</th>
<th>Changes from 2004 to 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing and understanding of long-term mechanical ventilation and weaning</td>
<td>Managing patients with chest tubes</td>
<td>Competency was deleted</td>
</tr>
<tr>
<td></td>
<td>Assisting with thoracentesis and chest tube insertion</td>
<td>New competency</td>
</tr>
<tr>
<td></td>
<td>Administering medications for procedural sedation and monitoring of patient’s response</td>
<td>New competency</td>
</tr>
<tr>
<td></td>
<td>Assessing, monitoring, and managing patients with stroke, seizure disorders, and intracranial hemorrhage</td>
<td>New competency</td>
</tr>
<tr>
<td>Recognition of indications for and complications of enteral and parenteral nutrition</td>
<td>Recognition of indications for and complications of enteral and parenteral nutrition</td>
<td>Unchanged</td>
</tr>
<tr>
<td></td>
<td>Assessing, monitoring, and managing patients requiring renal therapeutic interventions (eg, hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies)</td>
<td>Unchanged</td>
</tr>
<tr>
<td></td>
<td>Management of patients with complex wounds with fistulas, drains, and vacuum-assisted closure devices</td>
<td>New competency</td>
</tr>
<tr>
<td></td>
<td>Recognition of signs and symptoms of behavioral emergencies (eg, delirium and dementia, mood disorders, and substance abuse)</td>
<td>New competency</td>
</tr>
<tr>
<td>Recognition of and evaluation of the family’s need for enhanced involvement in care to facilitate the transition from hospital to home</td>
<td>Evaluating the family’s need for enhanced involvement in care to facilitate the transition from hospital to home</td>
<td>Unchanged</td>
</tr>
</tbody>
</table>

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To learn more about progressive care, read “Bold Voices in Progressive Care: Using Shared Decision Making to Implement Evidence-Based Practice in Progressive Care” in Critical Care Nurse, 2005;25(2):76-87. Available at www.ccnonline.org.

These additions reflect the changes in the patients who are currently being cared for in the PCU and the increasing complexity of nursing practice.

These competencies should form the basis for education and training for a PCU nurse. If the unit manages patients or equipment not covered by the core competencies, additional competencies should be developed and incorporated into the unit’s education plan. For example, if the unit manages patients who require long-term mechanical ventilation, then competencies regarding ventilators and weaning should be delineated and all staff should receive education and training to manage such patients.

Conclusion

During the past 10 years, PCUs and progressive care nursing have become a recognized specialty. In 2004, the AACN Certification Corporation introduced a specialty certification examination for progressive care nurses known as the PCCN. In 2008, for the first time, a PCU was recognized through the Beacon award for the high-quality patient care it provided. As PCUs continue to evolve and flourish, it is important to note that the units may have
different names and may serve different groups of patients, but the characteristics of the patients in such units are very similar. A distinct set of nursing practice core competencies have been identified to meet the needs of these patients. All progressive care nurses should receive education and training to meet these core competencies.

References

None reported.


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