INTRODUCTION

Let us look at Figure 1.1. Where do you think this set up can be seen?

Figure 1.1: Intensive Care Unit (ICU) room
Source: http://zeroscope.net/
The Intensive Care Unit (ICU) or Critical Care Unit can be viewed as one of the most stressful areas in hospitals for patients and family members, causing them great anxieties. It can be very challenging for nurses who have never worked in an ICU previously as demands from medical personnel, patients and patients’ family members are extremely high. The nurses have to learn to manage the various machinery and electronic gadgets used for patients. This alone is stressful and daunting for uninitiated nurses. Furthermore, caring for severely ill patients is also time-consuming and requires patience.

For patients and their family members, the ICU is the most fearful place to be as it is associated with high mortality and morbidity rates. The number of highly technological gadgets a patient is attached to implies the gravity of his/her illness. The situation becomes worse when a doctor informs a patient’s relatives that he/she is gravely ill and tells them to expect the worst. The relatives are then asked to sign a declaration form from the “dangerously ill list” (DIL) as issued in accordance to unit protocol. Knowing all the above, would you still be able to perform professionally as a nurse in an ICU?

1.1 DESCRIPTION OF AN INTENSIVE CARE UNIT (ICU)

What do you know about the ICU? Are the following some of your answers?

(a) A specialised unit that attends to all critically ill patients.
(b) Nurses need to be specially trained to work effectively in this unit.
(c) A unique place to work – patients from different disciplines.
(d) A working unit where patients are attached to many technological gadgets.
(e) An isolated place and restricted to a few visitors.
(f) A very stressful place to work, sometimes also called the critical care unit.

If you mentioned any three of these responses, then you have an acceptable level of understanding of the ICU.
1.1.1 Definition of ICU

There are many definitions of ICU, such as the following:

(a) “A unit catering for the needs of patients who require constant individual nursing attention throughout 24 hours and the immediate availability of medical help” (Intensive Care Society, 1982).

(b) The comprehensive care of a critically ill patient, who is deemed recoverable (Barrie-Shevlin, 1985).

The most acceptable definition and which is currently being practiced by many organisations in accepting admission to the ICU is that the unit “delivers comprehensive care of a critically ill patient who is deemed recoverable.”

ACTIVITY 1.1

Look up some definitions of ICU on the Internet. Choose one that you think fits the description of the ICU at your workplace and discuss it with your tutor.

1.1.2 History of ICU

The historical perspective of the ICU is very important for nurses to appreciate as it will greatly impact their medical and nursing care. New innovations to nursing care in recent years from research findings have provided improvement to the outcome of ICU patients.

ACTIVITY 1.2

Do you know how the ICU was first established? Discuss this with your coursemates.

The ICU was first set up in the 1950s during a polio epidemic outbreak in Denmark (see Figure 1.2). Polio patients were grouped together in different hospitals for simultaneous close observation and mechanical ventilation. Soon, this method of grouping ill patients together was accepted as a way for effective staff management. At the same time, it was noted that the patients’ mortality rate fell significantly, thus beginning a new era in caring for critically ill patients.
ICUs can be very specific in nature like medical ICU, surgical ICU, neurological ICU or a general ICU. Most hospitals with fewer than 10 ICU beds are general in nature and may cater to both adult and paediatric patients. Special cases including cardiothoracic and neurosurgery should be catered to separately if possible.

### 1.1.3 Features of the ICU

In general, ICUs vary in size and design. However, certain ideal ICU requirements need to be followed to create a suitable environment for patients. The following are some of these ideal requirements:

(a) Floor plans that minimise traffic but are accessible to diagnostic, monitoring and therapeutic facilities.

(b) Adequate supply and distribution of oxygen and medical air, a suction apparatus and electricity. Backup services in case of power failure. Air-conditioning.

(c) Adequate space between each bed with easy access to the patient’s head.

(d) Separate “clean” and “dirty” work areas.

(e) Ability to separate or isolate an infected patient or patients at particular risk of infection.

(f) Facilities for hand washing in each room.

(g) Facilities for staff offices, call rooms, restrooms, washrooms and conference rooms.

(h) Provision for the waiting area of relatives.

(i) Mini laboratory areas and storage (arterial blood gases).
1.1.4 ICU Design

The design of an ICU can vary from an open plan to cubicles and single rooms. Many newer designs have a mixture of both. Windows or views to the outside world are encouraged, to allow conscious patients an outside view. Clocks should be strategically placed to allow patients to keep track of time. Individual bed unit lighting and special night lights should be provided.

Table 1.1 outlines the advantages and disadvantages of single room units in an ICU.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced noise levels.</td>
<td>• Ratio of nurse to patient is 1:1, need additional staff for relief during meal times.</td>
</tr>
<tr>
<td>• Isolation of infectious patients or immuno-compromised patients.</td>
<td>• Nurses feel isolated when left for long periods with unconscious patients.</td>
</tr>
<tr>
<td>• Prevents unpleasant viewing of other ill patients.</td>
<td></td>
</tr>
<tr>
<td>• Provides privacy to terminally ill patients, their children and family.</td>
<td></td>
</tr>
</tbody>
</table>

Self-Check 1.1

In your opinion, what are the requirements for setting up an ICU? Take five minutes to write your answer on a piece of paper. Compare your answer to the requirements provided in subtopic 1.1.3.

Activity 1.3

Can you identify the supporting members of staff who contribute to the care of patients in the ICU? Discuss this in myVLE.
1.1.5 Staffing in ICU

All the staff members of listed in Table 1.2 work as a team; however, not all ICUs have all the categories of staff listed.

<table>
<thead>
<tr>
<th>No</th>
<th>Staff Category</th>
<th>Function or Role(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Intensivist / Consultant Anaesthetist / Surgeon / Physician</td>
<td>Person-in-charge of the unit. Decides who should be admitted and allocates beds according to specialty / discipline.</td>
</tr>
<tr>
<td>2.</td>
<td>Anaesthetist / Medical Officer</td>
<td>Attends to patients at all times. Roster of duties depends on availability of staff. May need on call duties.</td>
</tr>
<tr>
<td>3.</td>
<td>Nurse Manager with ICU qualification – depending on unit size, may have more than one nurse manager.</td>
<td>Involved with unit administration, liaison personnel with consultants, staff supervision and staff training.</td>
</tr>
<tr>
<td>4.</td>
<td>Registered Nurses (RN) – at least 50% of the RNs must have ICU qualification and valid certification of Advanced Cardiac Life Support (ACLS)</td>
<td>Total patient care (1:1 nurse to patient ratio), 1:2 is acceptable.</td>
</tr>
<tr>
<td>5.</td>
<td>Auxiliary Nurses</td>
<td>Perform hygienic care of patients.</td>
</tr>
<tr>
<td>6.</td>
<td>Respiratory Therapists</td>
<td>Responsible for the maintenance of respiratory and electronic equipment.</td>
</tr>
<tr>
<td>7.</td>
<td>Physiotherapist</td>
<td>Performs specific and general physiotherapy for patients.</td>
</tr>
<tr>
<td>9.</td>
<td>Pharmacist</td>
<td>Pharmacological dispensing and monitoring.</td>
</tr>
<tr>
<td>10.</td>
<td>Administrative Personnel</td>
<td>Clerical and administrative duties.</td>
</tr>
<tr>
<td>11.</td>
<td>Hospital Assistants / Attendants</td>
<td>Focuses on environmental hygiene and despatching and accompanying patients.</td>
</tr>
</tbody>
</table>

1.1.6 Criteria of Admission to ICU

The ICU serves as a place for caring and monitoring critically ill patients with potentially severe physiological instability who require technical and/or artificial life support. The ICU’s admission criteria are used to select the most suitable patient who is likely to benefit from the ICU management. This decision may be based on prioritisation. This system categorises those that will benefit most from the ICU (Priority 1) to those that will not benefit at all (Priority 4) from ICU admission (refer to Table 1.3).
Table 1.3: ICU Admission Criteria using the Prioritisation System

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| Priority 1 | Critically ill and unstable patients with a single system disorder and/or good reversibility of conditions and who require ventilatory support that cannot be provided outside the ICU. These patients need ventilatory support, invasive monitoring and/or vasoactive drugs. Examples of these patients may include the following:  
• Post-operative patients for stabilisation and ventilation.  
• Acute respiratory failure from a reversible cause e.g. Guillain-Barre syndrome, myasthenia gravis, bronchial asthma or drug overdose.  
• Multiple trauma.  
• Acute obstetric complication e.g. post-partum haemorrhage or eclampsia. |
| Priority 2 | These patients require intensive monitoring and may potentially need immediate intervention although they were not critically ill at the time of admission. This includes patients with chronic comorbid conditions who develop acute severe medical or surgical illnesses. Examples of these patients may include the following:  
• Patients with underlying heart, lung or renal disease, with acute exacerbation of the illness or who have undergone major surgery.  
• Progressive paralysis of neuromuscular origin. |
| Priority 3 | Critically ill, but have a reduced likelihood of recovery because of underlying diseases or the nature of their acute illness. Patients may receive intensive treatment to relieve acute illnesses but limits on therapeutic efforts may be set, such as no intubation or cardiopulmonary resuscitation. For example:  
• Patients with metastatic malignancy complicated by infection.  
• Patients with end-stage heart or lung disease complicated by severe acute illnesses. |
| Priority 4 | These are patients who are generally NOT appropriate for ICU admission. Admission of these patients should be on an individual basis, under unusual circumstances and at the discretion of the ICU Director. These patients can be in the following conditions:  
• Irreversible brain death.  
• End-stage cardiac, respiratory and liver disease with no options for a transplant.  
• Metastatic cancer unresponsive to chemotherapy and/or radiotherapy.  
• Patients in anon-traumatic coma who are in a permanent vegetative state. |
1.1.7 Criteria of Discharge

The status of patients admitted to the ICU should be reviewed continuously to identify patients who may no longer need ICU care (Program Anesthesiologi dan Cawangan Kualiti Penjagaan Kesihatan, KKM, 2012). This includes assessing the following conditions:

(a) When a patient’s physiologic status has stabilised and the need for ICU monitoring and care is no longer necessary.

(b) When a patient’s physiological status has deteriorated and/or become irreversible and active interventions are no longer beneficial, withdrawal of therapy should be carried out in the ICU. The patient should only be discharged to a normal ward if a bed is required for other patients.

Discharge of patients from ICU care will be based on the following criteria listed in Table 1.4.

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stable haemodynamic parameters.</td>
</tr>
<tr>
<td>2</td>
<td>Stable respiratory status (patient extubated with stable arterial blood gases) and airway patency.</td>
</tr>
<tr>
<td>3</td>
<td>Oxygen requirements not more than 60%.</td>
</tr>
<tr>
<td>4</td>
<td>Intravenous inotropic/vasopressor support and vasodilators are no longer necessary. Patients on low dose inotropic support may be discharged earlier if an ICU bed is required.</td>
</tr>
<tr>
<td>5</td>
<td>Cardiac dysrhythmias are controlled.</td>
</tr>
<tr>
<td>6</td>
<td>Neurologic stability with control of seizures.</td>
</tr>
<tr>
<td>7</td>
<td>Patients who require chronic mechanical ventilation (e.g. motor neuron disease or cervical spine injuries) with any of the acute critical problems reversed or resolved.</td>
</tr>
<tr>
<td>8</td>
<td>Patients with tracheostomies who no longer require frequent suctioning.</td>
</tr>
</tbody>
</table>

1.2 ROLES AND RESPONSIBILITIES OF CRITICAL CARE NURSES

Nursing in the ICU is unique as the nurses are expected to initiate and control the care given to their patients. It also has collaborative elements in that the patients themselves and their family members are involved and will participate in the care given.
Nurses in the ICU adhere to certain conditions of care when handling their patients, such as delivery of comfort and care, communication skills and technological competencies. These patients will have physical and psychosocial needs due to the severity of their illnesses.

CCN is a field of nursing which focuses on providing the utmost care for critically ill patients. Critical care nurses can be found working in a wide variety of environments and specialties, such as in emergency departments and ICUs.

The following are the roles of critical care nurses in fulfilling goals of care in the ICU:

(a) Nurses play an essential role in facilitating communication between critically ill patients and their families.

(b) Nurses must be proficient in communication skills in addition to clinical skills.

(c) Nurses can use evidence-based knowledge related to disease processes and prognosis to advocate effectively for patients and families.

(d) Nurses have an essential role as team members in establishing the goals of care in the ICU.

1.3 PSYCHOSOCIAL CARE AND COMMUNICATION IN THE ICU

In the ICU, nurses will need to deliver physiological and psychosocial care. The psychosocial aspect is developed over time as one interacts with others and the environment. Some of the psychosocial development experienced is universal in that it is experienced by all humans. Understanding basic concepts of psychosocial care will help nurses to understand their patients better and plan their care in a more holistic manner.

Experiencing illnesses which require intensive care can be a very frightening and stressful experience for patients. They have to cope with many highly technological invasive and non-invasive procedures and be in a very unfamiliar environment. For most patients, they are totally dependent on nurses to care for them and prevent them from any danger and this often makes them feel dehumanised.
In order for nurses to preserve the patient’s humanity in this respect, assessment of the psychosocial impact of ICU admission is done through comprehensive evaluation of behavioural, emotional, environmental and physiological factors. Each one of these factors is explained in greater detail in the following sections.

### 1.3.1 Behavioural Assessment

A patient’s behaviour can be affected by rapid physiological and psychological changes associated with their critical illnesses and pharmacological and biological treatments. If the psychological responses are not treated, it may threaten the patient’s recovery process.

Therefore, a behavioural assessment needs to be done focusing on the following:

(a) Data on the patient’s background relating to medical and social history; marital status, profession and financial status and education.

(b) Behaviour for consistency and appropriateness.

(c) Conscious level, orientation and responsiveness.

(d) Movement control for paralysis or hypertonicity – especially post-neurosurgery or post-traumatic injury.

### 1.3.2 Emotional Assessment

Emotional assessment is aimed at recognising patients’ response to the ICU from their expression and feelings as listed in Figure 1.3.

![Figure 1.3: Feelings involved in an emotional assessment of patients in the ICU](image)
1.3.3 Environmental Assessment

Environmental assessment includes determining the following conditions listed in Figure 1.4.

![Figure 1.4: Conditions related to Environmental Assessment](#)

1.3.4 Physiological Assessment

Physiological assessments include the following:

(a) A thorough physical examination; and

(b) Laboratory assessments such as blood tests, blood pressure, heart rate and respiration monitoring.

1.3.5 Nursing Interventions

The findings from the four assessments (behavioural, emotional, environmental and physiological) will guide nurses in administering appropriate nursing interventions. The aim of interventions is to minimise the effect of the four assessment factors. This aim can be achieved by taking the following steps:

(a) Promote self-esteem
   The patient is addressed by his/her proper name or title, his/her dignity is preserved by not exposing his/her body unnecessarily, he/she is given privacy and is informed of all procedures. The staff should not discuss private matters or those concerning the patient even if he/she is unconscious as he/she can still hear. If the patient is conscious, all conversation held at his/her bedside must include him/her. Establishing rapport with the patient during assessment shows concern and a caring attitude.

(b) Prevent powerlessness
   This can be initiated by including the patient in planning his/her care and allowing him/her to participate in his/her care; encouraging his/her family members to visit him/her frequently; and allowing them to practise
their religion or complementary medicine if it does not interfere with the medical care being provided.

(c) **Minimise environmental stress**
Eliminate or reduce noise to the level proposed internationally, which is 45 decibels. Attend to alarms immediately. Monitor emitting sounds to ensure that they are kept to a minimum level. Inform conscious patients of the machines and monitors being used. Remove any unnecessary equipment from the bed unit.

(d) **Control and accommodate emotional stress**
One method proposed for this is using touch as a means of communication and expression of comfort and assurance whenever attending to the patient. Encourage the patient’s family members to touch the patient and to not be fearful of the many types of equipment attached to him/her. Anxious family members can transfer their anxiety to the patient, so give them adequate information of the patient’s condition to prevent them from expressing worry. The presence of family members have been described as having a therapeutic effect on the patient, therefore allow frequent visits. The ICU should practise open visiting to facilitate this.

Patients used to the constant care in the ICU will express fear and stress when they are due for transfer to a normal ward. Adequate information that they have recovered will alleviate this fear and stress. Good communication is essential to minimise stress. This will be further discussed in the next section, on communication in the ICU.

### 1.3.6 Psychosocial Impact on Paediatric Patients and Their Families

When a child is admitted to the ICU, his/her parents and other family members will be stressed and feel helpless. The following are some responsibilities of nurses dealing with child patients in the ICU and their family members:

(a) **Part of the nurse’s assessment of the child’s behaviour during the ICU stay includes determining the developmental stage of the child based on age.**

(b) **The aim of ICU care is also to give support to the child, parents and other family members.** For the child, the nurse may allow favourite toys or belongings to accompany the child during his/her ICU stay.

(c) **Plan procedures so as to not interrupt the child’s sleep patterns and where possible accommodate his/her preferences when a procedure is expected.**

(d) **For an older child, adequate explanation using simple terms about the equipment used may result in better acceptance and compliance.**
Parents are encouraged to be with the child as much as possible to provide him/her with comfort and minimise stress if within nursing and medical constraints. If there are other children needing care at home, parents are advised to plan time to be with them too. Promise of contact if anything occurs will ease their anxiety of leaving their child in the ICU.

Stressful and anxious parents may be referred to counsellors. Adequate explanation of the child’s condition may reduce their stress.

Providing family members with psychological, informational and social support can help them cope better with the patient’s state of critical illness.

**1.4 COMMUNICATION IN ICU**

Communication is a reciprocal process of sending and receiving messages using a mixture of verbal and non-verbal communication skills. This includes words spoken, movements, facial expressions and body postures which convey information. Communication is the most fundamental part of nursing and assists nurses in developing a positive nurse-patient relationship in order to deliver quality nursing care.

Any alteration to health will invoke stress. Patients who are seriously ill and admitted to the ICU experience higher levels of stress from the highly technical care and equipment in the unit. The patient and family members face difficulty in coping with the patient’s serious illness. One of the difficulties is in trying to communicate effectively with each other and health care workers like nurses.

For the patient and family, the ability to communicate before the occurrence of the illness is disrupted after the illness presents itself, due to changes in the role of the patient from independent to dependent and changes in the routine of the family. More so if the patient is the breadwinner or head of the family or the mother of several young children.

Adding on to that is the severity of the illness which may have poor prognosis, the environment of the ICU and the need for information. All these are intimidating for the patient and his/her family, resulting in high anxiety and helplessness and it is difficult for them to communicate these feelings to the nurses.

Nurses need to recognise and identify patients’ coping difficulties and that of their families through effective communication. What is effective communication? Nurses have to identify the communication needs of the patients and their families.
1.4.1 Communication Barriers for ICU Patients

The following factors contribute to communication barriers among ICU patients:

(a) Impairments such as paralysis and conscious level, physical weakness and fatigue.
(b) Medications used such as sedatives, narcotics and muscle relaxant agents.
(c) Presence of an endotracheal or tracheostomy tube.
(d) Surgery that affects speech such as glossectomy or oromaxillary injury.
(e) Linguistic, cultural, behavioural and physical barriers (e.g. patient with glasses or hearing aids).

1.4.2 Patient Assessment

Determining the appropriate type of communication methods is based on the following factors:

(a) Level of consciousness and orientation;
(b) Language preference;
(c) Ability to grasp and write;
(d) Influence of sedatives or narcotics; and
(e) Paralysis – chemically induced or physiological.

1.4.3 Communication Intervention for Nursing

Nursing intervention includes identifying appropriate communication methods following patient assessment. These are some of the communication methods that can be used:

(a) Use of pen and paper communication aids;
(b) Use of other communication aids such as pictures and letters of the alphabet;
(c) Use of computer-aided methods, as available in developed nations;
(d) Provide an access of hearing aid devices and glasses as soon as the procedure or test that restricted access is completed; and
(e) Provide the services of a qualified health care interpreter.
1.4.4 Family Assessment

Family assessment is aimed at fulfilling the following purposes:

(a) Improving the relationship between the patient and his/her spouse, parent and significant other.

(b) Catering to information needs – giving basic to detailed information on the patient’s condition.

(c) Identifying a spokesperson for the family for passing on information and relaying health education.

1.5 ETHICAL AND LEGAL CONSIDERATIONS IN AN ICU

Ethical and legal considerations in an ICU are essential aspects in the nursing care of patients in the ICU. Critical care nurses need to develop their ethical decision-making skills. This includes cases with ethical dilemma which occurs when two (or more) ethically challenged issues arise.

1.5.1 Code of Professional Conduct, Principles of Ethics and Ethical Decision-making in the ICU

Critical care nurses are responsible for their patients and to perform their duties in a way that provides high quality nursing care. Critical care nurses must be able to do the following:

(a) Demonstrate the appropriate application of knowledge in nursing practices which comply with the code of professional conduct, principles of autonomy, non-maleficence, beneficence, justice, privacy and confidentiality.

(b) Accept personal responsibility for one’s own professional judgements and actions as well as the consequences of one’s behaviour in carrying out their practices.

(c) Respect for patient/family rights including confidentiality.

(d) Conduct intensive care nursing practice and make sound independent clinical judgement in ways that can be ethically justified.
(e) Be aware of the importance of open discussions with others about her/his own views on ethical dilemmas.

(f) Report all unethical incidents to the person in charge.

(g) Maintain professional behaviour when dealing with patients, family members and co-workers.

1.5.2 Legal Issues in an ICU

Critical care nurses are often confronted with legal issues in the ICU such as those in Figure 1.5.

![Legal Issues in ICU](image)

Figure 1.5: Legal issues in ICU

1.5.3 Nursing Interventions in Building an Ethical Environment in the ICU

ICU nurses need to create an ethical working environment as this is a necessary pre-condition for dealing with ethical issues raised by specific factors. The nursing interventions for building an ethical environment include:

(a) **Values clarification**
Assist patients and family members in values of clarification. This process helps families to weigh the burdens and benefits of medical interventions and provides them with a framework of the patient’s preferences and interests.

(b) **Provide information and clarify issues**
Develop a trusting environment between patients and their families with nurses. ICU nurses play a key role in facilitating communication and translating discrepancies. The information provided to patients and families must be more than just disclosing facts.
(c) **Recognise moral distress**
Nurses are often trapped between institutional constraints, medical personnel, patient and family wishes and personal beliefs, duties and values.

(d) **Engage in collaborative decision-making**
Every critical care nurse must be able to work together with one another, remain involved, attached and committed to the process of shared decision-making and collaborative interaction.

### 1.6 A PROFESSIONAL PRACTICE MODEL FOR CCN: AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES (AACN) SYNERGY MODEL

The American Association of Critical Care Nurses (AACN) introduced the AACN Synergy Model for Patient Care to provide a conceptual framework as a guide in linking critical care practices to the competencies of critical care nurses.

This model suggests that the level of care must be determined by the needs of the patient, which includes the patient’s characteristics as in Figure 1.6.

![Figure 1.6: Patient characteristics as defined in the AACN Synergy Model for Patient Care](image)

According to AACN, synergy occurs when the needs of patients, their families and the clinical unit are matched with the nurse’s competencies.
An intensive care unit (ICU) is a specialised unit that attends to all critically ill patients. It can be defined as a unit that caters to the needs of patients who require constant individual nursing attention throughout the whole 24 hours and the immediate availability of medical help.

The design of an ICU can vary from an open plan to cubicles and single rooms.

ICU’s admission criteria can be based on the prioritisation system. It assesses those that will benefit most from the ICU (Priority 1) to those that will not benefit at all (Priority 4) from ICU admission.

Nurses play an essential role in facilitating communication with critically ill patients and their families.

In order for the nurse to preserve a patient’s humanity, assessment of the psychosocial impact of ICU admission is done through comprehensive evaluation of behavioural, emotional, environmental and physiological factors.
Nursing interventions for patients in the ICU are as follows:
- Promote self-esteem;
- Prevent powerlessness;
- Minimise environmental stress; and
- Control and accommodate emotional stress.

Nurses need to recognise and identify the difficulties of coping experienced by patients and their families through effective communication.

### KEY TERMS

<table>
<thead>
<tr>
<th>Behavioural assessment</th>
<th>Intensive care unit (ICU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care unit (CCU)</td>
<td>Patient assessment</td>
</tr>
<tr>
<td>Environmental assessment</td>
<td>Physiological assessment</td>
</tr>
<tr>
<td>Emotional assessment</td>
<td>Prioritisation system</td>
</tr>
<tr>
<td>Family assessment</td>
<td>Psychosocial care</td>
</tr>
</tbody>
</table>

### REFERENCES


