

Current practice in critical care

Volume One

**Mosby's Current
Practice and
Perspectives in
Nursing Series**

VOLUME ONE

Current practice in critical care

with 66 illustrations

The C. V. Mosby Company

ST. LOUIS • TORONTO • LONDON 1979

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Printed in the United States of America

The C. V. Mosby Company
11830 Westline Industrial Drive, St. Louis, Missouri 63141

Library of Congress Cataloging in Publication Data

Main entry under title:

Current practice in critical care.

1. Intensive care nursing.
RT120.I5C82 610.73'6 79-15997
ISBN 0-8016-3522-5 (Paperback) 01/D/017
ISBN 0-8016-3521-7 (Hardbound) 01/B/002

C/CB/B 9 8 7 6 5 4 3 2 1

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Foreword

Although the impact of new techniques and technology has been felt in all of health care, critical care facilities have probably been the most directly affected. Two of the developments that greatly altered the delivery of critical care took place in the early 1960s. First, scientists and clinicians at the Johns Hopkins Hospital in Baltimore, Maryland, published a resuscitation technique utilizing mouth-to-mouth ventilation and closed-chest cardiac compression. The advent of cardiopulmonary resuscitation (CPR) put a life-saving technique into the hands of doctors and nurses. Some years later, CPR was used in the prehospital phase of care, and today there are many programs that teach the technique to various groups of citizens. The second development was the United States space program. Technological spin-off from the program resulted in intensive care units being invaded by large, complex pieces of equipment that not infrequently totally encompassed the bed area. One could reach the patient only after successfully passing through an obstacle course of electrical wires, monitoring and intravenous lines, and bulky, noisy machinery.

In 1974 the American Association of Critical Care Nurses published a definition of critical care nursing practice based upon total patient needs. It was recognized that patients and their loved ones are unique individuals with significant social and environmental relationships and that they find the intensive care unit unfamiliar and often threatening and hostile. The Association stressed that critical care nurses are expected to develop a thorough knowledge of the interrelatedness of body systems and the dynamic nature of the life process in order to be able to intervene in life-threatening situations and—more importantly—to prevent them from occurring. It was also recognized that, since the nurse is the health care professional most consistently in contact with patients and their loved ones, it is the responsibility of the critical care nurse to facilitate the transition required in the intensive care unit.

Fortunately, we have left the era when machines and equipment competed with critically ill patients for nurses' time. The intervening years have restored perspective and brought back patient-centered care.

This book carries out the Association's critical care philosophy by including not only the pathophysiologic causes of critical illness but also the behavioral responses of critically ill patients.

You have a unique and rewarding experience ahead of you. It has been my privilege to make even this very small contribution to such a book.

Diane C. Adler

Preface

Volume One of *Current Practice in Critical Care* has been prepared to reflect the advances in knowledge, skills, and professional identity of the critical care practitioner. Original contributions have been gathered to present viewpoints and information on pertinent topics that concern today's critical care nurse. These topics include the necessity for, and methods of, continuing education in critical care, the complexities of administering resources and personnel in an intensive care unit, the constant flow of new data and refined skills that must be mastered in the critical care specialties, and the commitment to care of the whole person who is critically ill.

This volume does not purport to be a textbook of critical care or to provide a consistent approach. The approach is by design eclectic, providing alternatives for practice and food for thought.

We wish to thank the contributors whose chapters appear herein for their co-operative participation in the endeavor as well as the many reviewers, whose comments have been most helpful.

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