

I. DESCRIPTION AND MISSION

A. DESCRIPTION

1. Type of unit

The Intensive Care Unit (ICU) is located on the second floor of the hospital building. It is a multidisciplinary ICU for medical, surgical or cardiac intensive care.

2. Size

a. Patient Rooms

The ICU is a 15-bed unit consisting of 5 private rooms and 5 2-bed rooms.

b. Central Module

(1) The unit is designed in a semi-circle, organized around a central work-area for staff and a central monitoring station.

(2) Kitchen facilities are maintained by Dietary and Housekeeping personnel.

(a) The refrigerator is to be emptied and stocked daily by Dietary staff. It is cleaned on a weekly basis by Dietary staff. There is a thermometer in each refrigerator and the temperature range should be 38 to 44 degrees F. A sign reading: "Food Only" is on the door.

(b) The freezer is emptied and cleaned monthly by Dietary staff.

(c) The ice machine is disinfected every three months by the Maintenance Department. Only hospital personnel may use the machine.

(d) The refrigerator in the Pharmacy area has a sign on the door, reading: "No Food".

(e) Juices must be kept on the unit for use with Diabetics.

(f) Electrical equipment is checked by Maintenance on a scheduled basis and PRN via the communication book.

c. On-Call Room

The on-call room for ICU House Staff is located on the second floor in close proximity to the ICU. Daily cleaning is the responsibility of the Housekeeping Department.

d. Utility Rooms

(1) Cleanliness is the responsibility of Housekeeping.

- (2) Central Sterile supply technicians are responsible for removing soiled equipment, which has been properly bagged for re-sterilization.

e. Offices

1. The Nurse Director's office is located on the 2nd floor in close proximity to the ICU.
2. The Assistant Nursing Manager(s) office is located on the second floor in close proximity to the ICU.

3. Scope of Nursing Services

a. Clinical:

Nursing care is provided to all adult patients. Standards of care are consistent for all services unless otherwise specified. Practice concerns are addressed through the ICU Coordinating Committee, ICU Standards Committee, and Unit staff meetings.

b. Professional:

There is a comprehensive focus on the professional needs of ICU staff including unit and hospital inservices, unit standards including practice and guidance for advancement through the Clinical Advancement System.

c. Administration:

The structure and organization of the ICU is written in these standards for the purposes of planning, organizing, implementing, controlling and evaluating the conduct of the ICU. The Nursing Manager is responsible for administrative concerns with guidance from the Director of Nursing/Associate Hospital Director, as needed.

B. MISSION

The mission statement of the ICU is consistent with that of the Department of Nursing and that of John Dempsey Hospital. Refer to Department of Nursing Structure Appendices.

II. PHILOSOPHY AND GOALS

A. PHILOSOPHY

The philosophy of the ICU coincides with that of the Department of Nursing and that of John Dempsey Hospital. Refer to the Department of Nursing Structure Standards & Appendix 3.

B. Work Plan

1. The purpose of the work plan is to establish the major activities believed to be important for the ongoing operations, continued development and success of the ICU. Refer to Appendix 1.

2. The plan is developed from the Department of Nursing work plan and framed in reference to the Nurse Practice Act in the state, the ANA Standards of Practice, and the American Association of Critical Care Standards.
3. The work plan is developed and approved by the ICU Coordinating Committee in consultation with the nursing staff.
4. Many individuals are involved in the implementation of the goals during the year, therefore, participation by all levels of staff is important and is reflected in the annual work plan for the unit. Refer to Appendix 2.

III. ADMINISTRATIVE POLICIES

A. ORGANIZATION

1. Relationships

a. Administrative

The ICU is organized as a unit within the Department of Nursing. Refer to Department of Nursing Structure Standards Appendix 4.

b. Interdepartmental

The ICU is an integral part of the Department of Nursing under the direction of the Nursing Manager who reports to the Director of Nursing /Associate Hospital Director, who in turn reports to the Hospital Director.

c. Intra-unit

The overall nursing direction of the unit is the responsibility of the Nursing Manager with supervision, direction and support from the Director of Nursing. The medical direction is the responsibility of the Medical Director of the ICU, appointed by the Chief of Staff. Collaboration with nurses, physicians and appropriate department heads takes place monthly through the ICU Coordinating Committee. The organization of the ICU is consistent with the scope, variety and complexity of patient care services provided. ICU organizational chart is in Appendix 3. Performance descriptions exist for each position on the organizational chart and can be found in Human Resources, with the exception of the Medical Director which is located in the Chief of Staff office.

2. Communication Mechanisms

a. Administrative

Verbal and written information to and from the ICU, Hospital and Health Center Administration is delivered, received and transmitted through the ANM/Nursing Manager and/or Medical Director.

b. Interdepartmental

Communication channels to and from the ICU and the Department of Nursing are based on the Departmental Organizational chart (Department of Nursing Structure Standards, Appendix 5).

c. Intra-unit

Communication channels in the ICU are based on the unit organizational chart (Appendix 3).

d. Mechanisms

A variety of communication mechanisms are available: (1) shift/transfer report, (2) telephone/paging system throughout the Hospital, (3) bulletin boards/mailboxes on the unit, (4) unit staff meetings, (5) meeting minutes and memos, (6) ICU committees, (7) TTY phones, (8) sign and foreign language interpreters (HAM, #08-007).

3. Unity/Extent of Command

- a. The authority, final responsibility for, and control of all actions directed toward the nursing goals of the ICU are vested in the Nursing Manager.
- b. The Nursing Manager is also responsible for the nursing staff, health unit clerks, and unit aides.
- c. In the absence of the Nursing Manager coverage is provided by the Assistant Nursing Manager(s) or designee. Administrative Managers are qualified to act in the absence of the Nursing Manager on the off-shifts, weekends and holidays.
- d. The Director of Nursing appoints an Interim Nursing Manager when necessary.
- e. The authority, final responsibility for, and control of all actions directed toward the medical goals of the ICU are vested in the Medical Director. The Medical Director is also responsible for the ICU house staff team. The Medical Director appoints a qualified alternate in his absence. The Chief of Staff appoints an Interim Medical Director when necessary.

4. Evaluation of Organizational Structure

- a. The organizational structure reflecting the philosophy of the ICU is reviewed every year by the ICU Coordinating Committee. b. The organizational structure is approved by the Nursing Administrative Council and the Medical Board.

B. GOVERNANCE

1. Functions of the Unit

a. Institutional and Interdepartmental

Qualified nurses and physicians are selected to represent the ICU on Hospital and Health Center standing committees based on the recommendation of the Nursing Manager and/or appropriate Director. These recommendations are processed through the appropriate council for confirmation of committee appointments. Nurses may volunteer or be appointed by the Nursing Manager to unit committees. Refer to Department of Nursing Structure Standards

for the role and responsibilities on the stated Hospital/Health Center Committees. Refer to Administrative Protocol: Committee/Council Membership for Department of Nursing.

b. Intradepartmental

The functions listed in the Department of Nursing Structure Standards are performed by the appropriate members of the nursing leadership group in the ICU.

2. Nursing Direction

a. Type of Governance

The ICU is decentralized and organized under the Department of Nursing and conforms with the Philosophy of the Department of Nursing (refer to Department of Nursing Structure Standards).

b. Unit Control

(1) The authority, responsibility, and accountability for assisting the Nursing Manager in directing operations of the ICU to fulfill unit function is vested in the ICU Coordinating Committee.

(2) ICU Committees

(a) ICU Coordinating Committee

CHAIRPERSON: Medical Director of ICU

MEMBERSHIP: A multi-disciplinary Committee designated by position or appointed by the appropriate medical department.

1- Chairman/Director ICU

1- Director of Nursing

1- Physician Representation from the following Departments:

Anesthesia

Cardiology

Emergency Department

1- Nursing Manager

1- Clinical Nurse Specialist

1- ANM

1- Acute Care Nurse Practitioner

ICU Attending Staff

PURPOSE: To provide approval/advice on policies concerning admission and discharge, area of responsibility, nursing and medical procedures, annual budget for capital items, efficient utilization of personnel and space, and monitor Quality Improvement.

* review and evaluate the quality, safety and propriety of patient care within the unit.

* recommend corrective action when necessary.

* review and approve recommended policies for operation of the unit.

* develop and promote long-range goals for the unit.

- * accept and approve requests from medical staff for special program development on the unit.

MEETING

FREQUENCY: Once per month

AGENDA/

MINUTES: The agenda is developed by the chairman with input from committee members. Meeting minutes are kept on disk, and circulated to the members of the Committee, Utilization Review Department, and AHD/DON.

(b) ICU Staff Meetings

CHAIRPERSON: Nursing Manager/designee

MEMBERSHIP: ICU staff

PURPOSE: To enhance the flow of information to and from staff as noted in the Department of Nursing Structure Standards (refer to Department of Nursing Structure Standards.)

MEETING

FREQUENCY: Once per month

AGENDA/

MINUTES: Agendas are developed by the Chair with input from staff. Minutes are in ink and filed on the unit. Minutes are kept and circulated for signature by all staff who are unable to attend the meeting. Copies are circulated to the Divisional Director and Assistant Hospital Director/Director of Nursing Director.

c. Day-to-Day Operations

(1) Authority, responsibility and accountability for the day-to-day, shift-to-shift provision of nursing services is vested in the unit hierarchy.

(2) Unit Hierarchy

(a) Staff Nurses

*are responsible for providing nursing care to a specific patient assignment for a 12-hour shift. Primary nursing is incorporated when possible. Each staff nurse is accountable to the charge nurse.

(b) Assistant Nurse Managers/Charge Nurses

*are assigned by the Nursing Manager each shift for the purpose of decision-making and facilitating unit communication, coordination and delivery of patient care.

* ANM's develop work schedules in consultation with the Nurse Manager.

(c) Nursing Manager

*is responsible for the effective organization and management of the ICU. Has 24 hour accountability for the effective functioning of the staff including their development and evaluation, the efficient functioning of the unit subsystem, and the quality of patient care provided in the setting.

(d) Director of Nursing/ Associate Hospital Director

Refer to Department of Nursing Structure Standards.

d. Support Services within the ICU

(1) Nurse Manager/Clinical Nurse Specialist

*is responsible for clinical practice, consultation, education and research within the ICU, and reports to the Director of Nursing/Associate Hospital Director.

(2) ACNP

Responsible to the Nurse Manager, in collaboration with the Medical Director.

(3) Preceptor

*refer to Orientation Protocol.

(4) Non-Nursing Support

(a) Health Unit Clerks/Monitor technicians

*are available on all shifts, to carry out all aspects of job description. Responsible to the Nursing Manager or designee.

(b) Certified Nurse Aides

*are available on all shifts, to carry out all aspects of job description. Responsible to the Nursing Manager or designee.

e. Support Services within the Department of Nursing

(1) Administrative Managers

*are resources to the Assistant Nursing Manager or charge nurse (in the absence of the Nursing Manager) providing direction and support in the decision-making process during weekends, holidays and off-shifts. Refer to Department of Nursing Structure Standards.

3. Medical Direction of Patient Care

a. Medical Director's Role

Responsible for the medical administrative control of the unit and with advice from Clinical Department Heads, sets medical standards of care. In the absence of the Medical Director a qualified alternate is chosen. Responsible to the Chief of Staff.

b. ICU/ Cardiology Attending Physician's Role

All ICU/Cardiology patients will receive a clinical appraisal by a qualified attending. Refer to the Department of Nursing Structure Standard.

c. Physician Consultant

Refer to the Department of Nursing Structure Standards.

d. Teaching Staff

Refer to the Department of Nursing Structure Standards. Daily teaching rounds conducted by the ICU Attending incorporate input from the nursing staff.

C. RESOURCE DEVELOPMENT/ALLOCATION/UTILIZATION

1. Financial

Refer to the Department of Nursing Structure Standards.

2. Facilities

a. Patient Care Areas

The ICU unit provides twenty-four hour care.

(1) Admission

(a) Admission Criteria

Refer to HAM, #09-007, "Admissions Guidelines". Patients are admitted to the unit based on their need for the medical and nursing care beyond the realm of medical/surgical scope of services, and on a need for selected acute and/or complex medical diagnostic or treatment regimens such as:

*Acute Myocardial Infarction

*Mechanical Ventilation

*Invasive Hemodynamic Monitoring

*Monitoring of Intracranial Pressure/Neuro Assessment

*Intra-aortic Balloon Pump

*Continuous Venous-Venous Hemofiltration

*Continuous drug infusion for anti-arrhythmic and/or vasopressor intervention

*Acute Peritoneal Dialysis/Hemodialysis, CRRT and/or Plasmapheresis

*Acute/Potential System Failure

*In emergency situations, pediatric patients age 14 or above

*Immediate neurosurgical post-op open heart surgery

(b) Modes of Admission

Patients are admitted to the ICU via any of the following modes:

- *Emergency: patients are admitted through the Emergency Department.
- *Direct: Patients are admitted directly from MD office (UCONN Health Center Clinics or outside).
- *Elective: Patients are pre-scheduled for admission and are placed in the ICU according to research study protocol, diagnostic tests, medical therapies only provided in the ICU or via Admit Day Surgery.
- *Transfers: Patients are admitted to the ICU from in-patient care areas or from outside referring agencies. Refer to protocol for: Transfer of IN-House Patients to the Intensive Care Unit.
- *Admission for Post-Anesthesia Care: Patients may be admitted to the ICU from PACU.
- *Boarders: When there are no other beds available in the hospital and staffing permits, boarders may be admitted to the ICU. The admitting office will collaborate with the nursing manager/designee to move them as soon as possible.

(c) Relationship between charge nurse, ICU House Staff, Medical Director and Admitting:

The responsible physician notifies the ICU attending/designee and Admitting about the candidate for admission. The attending/designee, acting as the designate of the Medical Director for admissions and transfers, confers with the Charge Nurse. Criteria for admission, adequate staffing for patient classification, and triage are considered. The attending/designee may confer with the Medical Director in cases where admission is to be denied. If the denial involves an ED patient, the transfer of the patient to another facility is arranged by the ED staff. The final decision for denial of admission is made by the Medical Director, with consultation with the nursing manager, charge nurse, Director of Nursing and/or administrative assistants. They notify the Hospital Administrator on-call only if there are extenuating circumstances involved in admission/transfer.

(d) Attending MD Responsibilities:

Patients are admitted to either the Critical Care Service or Cardiology Service. It is the Attending's responsibility to see and evaluate the patient promptly after admission, provide indicated patient care or consult other physicians as needed, and collaborate with the house staff to keep family informed. In addition, they must continue to see the patient on at least a daily basis, as evidenced by a progress note.

(e) ICU House Staff Responsibilities:

The responsibilities of the ICU house staff/ACNP's include, but are not limited to, the following:

- *Informing the patient/family about admission to the ICU.
- *Evaluating patient and write orders for admission.
- *Obtaining consent for special procedures.
- *Providing around-the-clock coverage for in-house patients.
- *Retaining responsibility for specific diagnostic procedures and medical therapy.
- *Writing, at a minimum, a daily note on each patient in order to justify occupancy in the ICU.
- *Notify the attending MD and MOD of patient's admission/transfer.

(f) Admitting Nurse's Responsibilities:

It is the responsibility of the admitting nurse to provide and maintain the following:

- *Initiation of the ICU Admission Protocol, including initial assessment within 30 minutes of admission, and reassessment every 2-4 hours, per RN discretion and patient condition.
- *Completion of admission documentation as per Dept. of Nursing policies.

(2) Transfers

(a) In-House

The attending/designee and charge nurse make the assessment that the patient no longer meets criteria. The responsible house officer must write transfer orders and identifies the attending physician who will accept the patient. All previous physician's orders are automatically canceled at this time. Bed control is notified by the ICU charge nurse or designee of all potential or actual transfers according to priority. A transfer note and up-dated care plan are written by the patient's nurse. Telephone nursing report is made to the receiving unit prior to transfer. Upon transfer the patient is accompanied by appropriate care providers.

(b) Other facilities

The physician of record makes arrangements with the receiving physician. The ambulance transfer is coordinated by the admitting department. The patient is accompanied by the appropriate care providers. Prior to transfer a W-10 form, a clinical resume, and a nursing discharge summary are completed. Telephone nursing report is made to the receiving facility. Photocopy of portions of the patient's record is provided upon request of the accepting physician.

(3) Discharge

(a) Criteria

Patient no longer requires the scope of services provided in the ICU - for example:

- *Myocardial Infarction is ruled out
- *ECG and enzymes stable, vital signs stable, significant arrhythmias controlled
- *Extubated. ABG's within normal limits for patient with or without supplemental oxygen
- *No invasive hemodynamic monitoring required for assessment/diagnostic parameters
- *Neurologic status stable. Assessment complete without intracranial monitoring device
- *IABP discontinued. No evidence of complications after removal
- *Angina, CHF, arrhythmias and /or other parameters are stable
- *Renal function improved no longer requiring acute interventions
- *System Failure resolved
- *Patient/Family requesting no further acute interventions
- * Service required not available in JDH

(b) Modes of discharge

Duration of stay in the ICU is determined by the patients physiologic status and patient care needs. Planning for discharge is combined decision made by the ICU house staff, Nursing staff and Attending MD. The attending is responsible for making decisions, in consultation with the physician responsible for the patient, for the disposition of a patient when patient load exceeds optimal operational capacity. Modes include Home, AMA, or Transfers (refer to above section 3). Refer to Department of Nursing Structure Standards.

(4) Utilization Crises

Refer to Department of Nursing Structure Standards.

(a) Files

Tools for verification of skills/competencies are maintained in individual staff files located in the Human Resources Department. Refer to Department of Nursing Structure Standards.

3. Human Resource Development

a. Orientation

(1) Health Center/Hospital

Permanent new employees attend a three hour orientation session coordinated by the UCHC Human Resource Department. A general overview of the Health Center, including a brief history and current organizational structure, is provided followed by a review of pertinent safety services, (fire,

infection control, police, environmental hazards), employee benefits information and other general information.

(2) Department of Nursing

(a) General Nursing Orientation

General Nursing Orientation is a program, which is scheduled on at least a monthly basis and conducted by the Educational Services Department (ESD). All newly hired Department of Nursing Staff attend a portion(s) of General Orientation. Specific orientation plans for each category of personnel are determined by ESD in consultation with the appropriate managers of those personnel.

The General Nursing Orientation program is organized to provide general, hospital wide information first, then focuses on more specific nursing related areas. A combination of competency-based techniques and more traditional educational methods, (e.g. lecture/discussion and exercises) are used, as appropriate, to the various content areas. Evaluation of learning is accomplished through verbal feedback, review of written assignments, and paper and pencil tests. Documentation of completion of orientation activities is recorded on the orientation checklist. The completed orientation checklist is reviewed by the appropriate manager and placed in the employee's file in the Nursing Manager's Office, with a copy to Human Resources Dept.

(b) ICU Orientation

All new ICU personnel shall have a 5 day didactic orientation followed by a 4-8 week clinical orientation with a preceptor. The specific content is outlined in the ICU orientation plan, which is comprised of self-learning packets, lectures, and competency skill checklists. At the completion of didactic orientation, the orientee completes an evaluation based on that portion. At the completion of the clinical orientation, the preceptor and orientee jointly complete a CNI evaluation form, which is placed in a file in the Human Resources Department, with a copy in a file in the Nurse Manager's office.

b. Staff Development

Unit decentralized development is the responsibility of the Nurse Manager/Clinical Nurse Specialist. The purpose is to facilitate clinical educational needs, based on input from the staff, and the NM/CNS. Educational programs will be held for each shift geared to maintaining and improving skills and learning new techniques. Health team members are utilized to instruct inservices as appropriate. All educational programs are documented, reviewed, and a record maintained by the Nursing Manager or designee. An educational activity record for each staff member is maintained as part of the annual evaluation process. All Department of Nursing

programs, which include mandatory inservices, are coordinated through the Department of Education and Staff Development.

c. Continuing Education

Refer to Dept. of Nursing Structure Standards.

Support for staff nurses to attend outside programs is provided through the UHP contract.

d. Support Services

Refer to Dept. of Nursing Structure Standards.

e. Consultants

(1) Medical

In the provision of patient care, nursing consults with physicians on formal (e.g. rounds and conferences) and informal bases. Refer to Dept. of Nursing Structure Standards.

(2) Nursing

Additional nursing resources can be found in the Advanced Practitioners and Clinical Nurse Specialists. The Clinical Nurse Specialists and Advanced Practitioners are Master's prepared in a clinical specialty.

(3) Management

Consultation about management can be obtained from appropriated Administrative officers, members of the NAC, and ESD. Networks have been established with peer groups outside the hospital.

4. Materials Management

a. Equipment

Refer to Dept. of Nursing Structure Standards, p. 49-50.

The following are specific equipment for the ICU:

- *2-Defibrillator, 1 with transcutaneous pacing capability - monitors, with synchronization
- *Crash Cart
- *Hewlett Packard central monitoring stations
- *15-Hewlett Packard Merlin monitoring equipment with modules for pressures and plethmography
- *9-Hewlett Packard non-invasive B/P modules
- *2-Nellcor Pulse oximeters
- *6-Hewlett Packard Cardiac Output modules
- *Hewlett Packard portable transport monitor
- *3-Intubation trays
- *3-Ambu Bag Resuscitators
- *2-single chamber pacemakers and 3-dual chamber pacemaker
- *3-Dopplers
- *1-Datascope Intra-aortic Balloon pump

- *2-Oxygen Tanks
- *1-Head lamp
- *1-Over-bed lamp
- *1-Open chest cart
- *1-CVVH machine
- *1-Blood warmer
- *1-Sling scale
- *1-Patient lift device

Refer to Emergency Equipment Protocol in ICU Administrative Protocol Section and HAM, "Emergency Resuscitation Equipment Check #11-024.

b. Supplies

Refer to Dept. of Nursing Structure Standards. Refer to ICU Administrative policy on Bedside Supplies.

c. Linen

Refer to Dept. of Nursing Structure Standards.

d. Product Safety Evaluation

Refer to Dept. of Nursing Structure Standards.

5. Evaluation of Resources

Refer to Dept. of Nursing Structure Standards.

6. Staff

a. Professional

Refer to Dept. of Nursing Structure Standards.

b. Non-Professional

Refer to Dept. of Nursing Structure Standards. Depending on patient status, a Certified Nurse aide may be utilized as a 1:1 sitter for a patient. Only professional staff provides patient care in the ICU.

c. Status

Professional staff may be hired full or part-time, as determined by the Nursing Manager and based on unit needs. The positions available range from 30% (4-twelve hour shifts per schedule) - 100% (13 twelve hour shifts per schedule).

Non-professionals may be hired as full-time or part-time. Refer to Dept. of Nursing Structure Standards for change of status.

d. Temporary Staff

(1) Agency Personnel

Refer to Dept. of Nursing Structure Standards.

(2) Private Duty Nurses

Private duty nurses are not utilized by the ICU, as per Nursing Practice Manual.

(3) Student Nurses

Refer to Dept. of Nursing Structure Standards.

(4) Nurse Pros

Refer to Dept. of Nursing Structure Standards.

e. Non-Nursing Staff

Refer to Dept. of Nursing Structure Standards.

D. STAFFING

1. Responsibility for Providing Adequate Staffing

Refer to Department of Nursing Structure Standards.

2. Administrative Staffing

Refer to Department of Nursing Structure Standards.

3. Master Staffing

Refer to Department of Nursing Structure Standards.

4. Unit Staffing

Refer to Dept. of Nursing Structure Standards.

5. Delivery of Care Methodology

Refer to Dept. of Nursing Structure Standards.

6. Shift Assignments

Refer to Dept. of Nursing Structure Standards.

a. Patient Acuity System

Patients in the ICU are assigned according to the following acuity levels:

(1) Level V (G in IDX) is 1:1 nurse to patient ratio

Patients at this level require hourly or more vital signs and system assessments (i.e., immediate post-op cardio thoracic, unstable post-cardiac/respiratory arrest or hemodynamically unstable patients, frequent titration of meds, CRRT).

(2) Level IV (F in IDX) is 1:2 nurse to patient ratio

Patients at this level require at least every 2 hour vital signs and minimal every 4 hour system assessment (i.e., stable vented patients, patients on titratable meds and/or require hemodynamic monitoring to include IABP/ventriculostomy monitoring, IV narcotic or sedative infusions).

(3) Level III (E in IDX) is 1:3 nurse patient ratio

Patients at this level require every 2-4 hour vital signs and minimal of every 4 hour system assessment. Vital signs can be less frequent than every 2-4 hours depending on MD order/patient code status (i.e., newly extubated patients, chronic stable vented patients, patients preparing for transfer out of the ICU; does not include patients requiring active titration of IV medication).

(4) Boarder status (SP or CS in IDX)

Patients at this level require every 4 hour vital signs and up to every 8 hour system assessments. Typically, beds are not available on other monitored or non-monitored units. These patients require an order pending transfer.

It is the responsibility of the charge nurse/primary nurse to review patient acuity status every 4 hours and to update the nursing director/ANM and nursing supervisor of changes.

7. Scheduling

a. Responsibility

Refer to Department of Nursing Structure Standards.

b. General Scheduling Practice

Refer to Dept. of Nursing Structure Standards.

E. EMPLOYMENT

Refer to Dept. of Nursing Structure Standards.

IV. NURSING PROFESSIONAL PRACTICE

A. Standards of Care - refer to Department of Nursing Structures Standards

NURSING RESPONSIBILITIES

The role of the professional nurse at JDH is consistent with the scope of practice outlined in the State of Connecticut Nurse Practice Act (1975).

Registered Nurse are authorized to perform all JDH protocols and procedures contained in the Department and Unit specific manuals, along with identified procedures from the Lippincott Manual (1986) and the AACN Procedure Manual. Orientation programs, ongoing educational activities

and completed annual evaluations which include competency checklists ensure individual nurses are competent.

The specialized, tertiary care setting demands assessment of specific nursing responsibilities in each clinical area. Therefore, Unit Structure Standards and Practice Manuals further define the professional nurse role in each area of nursing practice.

1. ICU nursing staff may perform the following bedside testing:

- a. Glucose meter
- b. Hemocult slides

Bedside and cognitive testing skills are validated annually.

2. Nursing staff at the change of each shift are responsible for performing a 12 hour audit on their assigned patients. The audit will include:

- a. Review all physician orders written during previous 12 hours.
- b. Check documentation of transcription of all orders on the MAR.
- c. Document completion of the 12 hour audit with designated electronic signatures, after the last POE order.

Refer to Department of Nursing Structure Standards.

B. Documentation/Retention of Records

Refer to Dept. of Nursing Structure Standards. All patients in the ICU will receive a systems assessment at the beginning of each shift, and reassessment may then be performed every 2 to 4 hours, at the RN's discretion. Variances will be documented in the progress note as they occur, on each shift, per Nursing Standards Practice Manual. Discharge planning will be addressed every 3 days.

C. Scope of Practice

An initial head to toe assessment will be performed on each patient on admission, within 30 minutes. Otherwise, refer to Dept. of Nursing Structure Standards.

D. PROFESSIONAL BEHAVIORS

Refer to Dept. of Nursing Structure Standards.

E. CREDENTIALING

Refer to Dept. of Nursing Structure Standards.

F. RESEARCH

Refer to Dept. of Nursing Structure Standards.

G. STANDARDS

Refer to Dept. of Nursing Structure Standards. ICU Standards are reviewed yearly by the ICU Standards Committee and the ICU Coordinating Committee.

V. CLINICAL POLICIES

Refer to Dept. of Nursing Structure Standards.

APPENDIX 1

ICU STRATEGIC PLAN

1. To provide close observation, intensive and continuous care and immediate recognition of potentially life-threatening complications.
2. To institute prompt treatment for identified problems.
3. To provide optimal nursing care utilizing the nursing process.
4. To develop and maintain standards of care for the seriously ill adult patient utilizing primary nursing concept.
5. To develop and maintain inservice and continuing education programs to meet the needs of patients and staff.
6. To evaluate patient care through participation in Quality Improvement programs.
7. To support efforts congruent with the University Medical Center.
8. To communicate with other services and departments.
9. To maintain an interdisciplinary team in order to provide a mechanism for participation in the decision-making process regarding issues and problems.

APPENDIX 2

ANNUAL WORK PLAN 2003

Short Term:

1. Clinical orientation for additional RNs for open heart by April 2004.
2. Open Heart nurses complete orientation to BIVAD by April 2004.

Annual:

1. All ICU staff will attend mandatory inservices.
2. Nursing staff will complete decentralized lab test per Dept. of Nursing Standards.
3. All HUC will complete EKG review annually.
4. Educational calendar developed with one educational program per month.
5. Nursing staff will complete annual Competency Review.
6. Nursing staff, as appropriate, will complete a review of:
7.
 - BIVAD
 - Open chest procedure

APPENDIX 3

ORGANIZATIONAL CHART

