

I. DESCRIPTION AND MISSION

A. DESCRIPTION

1. Neonatal Intensive Care Unit

- a. The Neonatal Intensive Care Unit (including the Special Care Nursery) is the designated Level III Regional Referral unit for newborn intensive care in Northern Connecticut. The Neonatal Intensive Care Unit is a primary care unit designed to care for those infants who are born prematurely, born to high-risk mothers, or born with a problem that is not conducive to normal growth and development, which requires complex medical and/or surgical intensive care. As the regional perinatal/neonatal referral center for Northern Connecticut, outreach education and transport services are provided
- b. The Newborn Nursery cares for those infants who do not require acute intensive care. It is a primary care unit designed to care for healthy infants born to both low and high-risk mothers and infants who no longer require intensive care, but are not ready for discharge.

2. The Neonatal Intensive Care Unit, Special Care Nursery and Newborn Nursery (NICU/SCN/NBN Nurseries) are located on the ground floor of the hospital building.

3. Size

- a. The NICU is a 40-bed unit.
- b. The Newborn Nursery is a 20-bed unit.
- c. The Neonatal ICU ambulance(s) provide transportation for sick and convalescing infants.

4. Scope of Nursing Services

- a. Clinical: The nursing staff provides for the nursing care needs of acute, chronic and convalescing, premature or term infants. Standards of care are established and maintained as outlined in the Nursing Department Structure Standards. Practice concerns are addressed through the Nursery Standards Committee, Administrative Council, Clinical Practice Council, the Advisory Committee, Nursing Leadership Committee, unit staff meetings and other identified work groups.
- b. Professional: There is a comprehensive focus on professional needs of the NICU/NBN staff through the providing of unit and hospital inservices, reviewing of educational standards in the yearly performance appraisal, and providing opportunity and guidance for advancement through the Clinical Advancement system. The professional practice council and nursing leadership committee address relevant issues.
- c. Administration: The structure and organization of the NICU/NBN is written in Standards for the purpose of planning, organizing, implementing, controlling and evaluating the conduct of the nurseries. Administrative concerns are addressed through the Nursing Manager and the Administrative Council.

B. MISSION

1. See Appendix A (Mission Statement)
2. See Appendix B (Nursery Conceptual Model)
3. Consistency is maintained with the mission, vision and values of the Department of Nursing and John Dempsey Hospital. Refer to Department of Nursing Structure Standards, Mission Statement.

II. PHILOSOPHY AND GOALS

A. PHILOSOPHY

1. All newborn infants in the referral area will have access to specialized care. These infants deserve quality care provided by skilled nursing, medical staff and other disciplines. This care, organized in a regional system, provides efficient bed utilization, cost effectiveness, and avoids duplication of service. Service, education, and research will be balanced so that the care continuously improves through expansion of professional knowledge and skills, proper allocation of resources, and an outcome evaluation.
2. The philosophy of the Nurseries is in accordance with the philosophy of the Department of Nursing and John Dempsey Hospital. Refer to Department of Nursing Structure Standards.
3. Philosophic and Ethical Approach to Care of the Newborn.
  - a. The goal of neonatal care is to apply advanced, efficacious technology in a humane, compassionate and thoughtful manner to attain the best possible outcome of the infant and family with the ultimate goal of returning them as a whole unit to their own community to live fulfilling, functional, growth-promoting and contributing lives.
  - b. Ethical decisions regarding the management of the infant must involve the parents as informed parties. The physician is responsible for relaying to the parents an accurate and unbiased assessment of the infant's condition and prognosis. The physician formulates an ethical approach for management of the infant that is consistent with current standards of medical care and is morally acceptable to both parent and physician.
  - c. The nursery views the family as part of the infant by promoting and encouraging involvement and attachment, providing accurate information, education and necessary support, and preparing them to care for the infant in a loving, supportive manner which is an extension of the holistic care provided by the nursery. The family-centered care philosophy that guides nursery staff recognizes that the family has the greatest influence on the infant's health and well being.
  - d. In situations where further medical or surgical intervention will only delay inevitable death or where death is being delayed by the use of life

support technology, measures such as those deemed drastic or heroic by current medical practice standards may be withheld or withdrawn with the consent of parents. Careful documentation of this consent should be recorded in the patient's chart.

- e. Infants with disorders that are not compatible with prolonged life, but yet who do not require intensive care measures to sustain life, will receive all components of standard nursery care. The goal of care in these circumstances is to make the infant as comfortable as possible as well as to comfort and support the family.
- f. It is the policy of this hospital, consistent with Federal Law, that nourishment and medically beneficial treatment (as determined with respect to reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

### III. ADMINISTRATIVE POLICIES

#### A. ORGANIZATION

##### 1. Relationships

###### a. Administrative

- (1) The NICU/SCN/NBN are units within the Department of Nursing. The relationships of the members of the Nursery staffs to other nursing units is outlined in the Nursing Department Structure Standards organizational chart.

###### b. Interdepartmental

- (1) The NICU/SCN/NBN are units under the direction of a Nursing Manager who reports to the Associate Hospital Director/Director of Nursing.

###### c. Intra-Unit

- (1) The overall nursing direction of the unit is the responsibility of the Nursing Manager with supervision, direction and support from the Associate Hospital Director/Director of Nursing. The medical direction of the NICU/SCN/NBN is the responsibility of the Medical Director of Neonatology who is appointed by the hospital director. The NICU/SCN/NBN Advisory Committee, Administrative Council, Professional Practice Council, and Clinical Practice Council provide a forum for collaboration among nursing, physicians and other disciplines.
- (2) The organization of the NICU/SCN/NBN is consistent with the variety; scope and complexity of patient care services offered
- (3) Performance descriptions for each position on the organizational chart can be found in Human Resources.

##### 2. Communication Mechanisms

a. Administrative

- (1) Verbal and written information to and from the NICU/SCN/NBN, Hospital, and Health Center Administration is delivered, received and transmitted through the Nursing Manager, Nursing Department committees, and/or Medical Director.

b. Interdepartmental

- (1) Information is delivered, received, and disseminated to and from the NICU/SCN/NBN and other departments according to the Nursing Department Organizational Chart.

c. Communication Mechanisms: A variety of communication mechanisms are available:

- (1) Shift/Transfer report
- (2) Telephone/Paging System
- (3) Bulletin board/Mailboxes/Communication Book/E-mail/Newsletter
- (4) Assistant Nurse Managers (all perinatal units) meetings
- (5) Unit level staff meetings
- (6) Charge Nurse Meetings
- (7) Meeting minutes, memos, and book maintained of staff meeting minutes
- (8) Weekly interdisciplinary care plan rounds and patient care conferences
- (9) Availability of (foreign language and deaf and hard of hearing) interpreters (Hospital Administration Manual).

3. Unit/Extent of Command

- a. The authority, final responsibility for and control of all actions directed toward the nursing goals of the NICU/SCN/NBN are vested in the Nursing Manager. Refer to Appendix C (organizational chart). In the absence of the Nursing Manager, the Assistant Nursing Managers or their designees provide coverage. Administrative Managers are qualified to act in the absence of the Nursing Manager on the off shifts, weekends and holidays. The Associate Hospital Director/Director of Nursing appoints an interim Nursing Manager when necessary.
- b. The authority, final responsibility for, and control of all actions directed toward the Neonatal Advanced Practitioner program are vested in the nursing manager.
- c. The Coordinator of Nursing Outreach and Transport oversees outreach activities and the functioning of the neonatal transport system.

B. GOVERNANCE

1. Functions of Department

a. Institutional and Interdepartmental

(1) Qualified nurses are selected to represent NICU/SCN/NBN on institutional and nursing department standing committees based on the recommendation of the Nursing Manager, application to the appropriate nursing councilor committee, and/or by the request of the Committee chairperson.

(2) The role of the nursing representatives on the committees is:

(a) To provide information to the members of the committee about the position of the NICU/SCN/NBN nursing on various issues.

(b) To vote as a full-fledged member of the committee.

To provide information concerning the functions and decisions of these committees to the appropriate individual and/or committees in the Neonatal department.

[1] Institutional Committees

[a] Child Protection Team

[b] Hospital Safety Committee

[c] C4I Subgroups

[d] Task forces convened for special purposes

[2] Nursing Department

[a] Clinical Recognition Review Board (CRRB)

[b] Clinical Advancement Advisory Committee (CAAC)

[c] Nursing Administrative Council

[d] Nursing Research Committee

[e] Regulatory Compliance Committee

[f] Clinical Nurse Specialist forum

[g] Task forces convened for special purposes

b. Intradepartmental

- (1) The functions listed in the Department of Nursing Structure Standards are performed by the appropriate members of the nursing leadership group in the NICU/SCN/NBN.
- (2) Provide coordination of regional outreach program.
- (3) Provide coordination of incoming and outgoing transport.

## 2. Nursing Direction

### a. Type of Governance

- (1) The NICU/SCN/NBN is decentralized and conforms with the philosophy of the Department of Nursing.

### b. Relationships of Governance and Organizational Structure

- (1) The NICU/SCN/NBN staff may be appointed to Hospital Nursing Committees or Councils.

### c. Unit Control

- (1) The NICU/SCN/NBN staff participates in Unit committees as directed in the Nursing Department Structure Standards and Administrative Protocol (NPM): Committee/Council Membership for Department of Nursing. Adhoc committees or task forces will be convened as needed and as directed by the Nursing Manager.
- (2) Decision-making occurs on the unit level.

#### (a) Nursing Leadership Group

[1] Chairperson: Nurse Manager

[2] Membership: Assistant Nurse Managers, CNS's, Coordinator of Nursing Outreach and Transport, and Clinical Nurse IV. Director of NIDCAP® Training Center, and Developmental Nurse Educator.

[3] Purpose: To provide a forum for productive creativity in the development, implementation, and evaluation of unit programs.

[4] Frequency: Monthly.

[5] Agenda/Minutes: Developed by and distributed to members.

#### (b) Advisory Committee

[1] Chairperson: Director of Neonatology

[2] Membership: Neonatal faculty, Nursing Manager, Assistant Nursing Managers, Clinical Nurse Specialists, Coordinator of

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Nursing Outreach and Transport, Nurse Analyst (Neonatal Health Information Management) Director of NIDCAP® Training Center, Developmental Nurse Educator, Case Manager, Social Worker, Respiratory Therapist, Pharmacist, Dietitian and representatives of other disciplines as needed.

- [3] Purpose: To provide a forum to address unit specific or interdepartmental/intradepartmental plans/progress/ problems.
- [4] Meeting Frequency: Monthly.
- [5] Agenda/Minutes: Agenda is developed by the chairperson with input from committee members. Minutes are circulated to membership and Associate Hospital Director/Director of Nursing.

(c) Administrative Council

- [1] Chairpersons: Medical Director and Nursing Manager
- [2] Membership: Coordinator of Nursing Outreach and Transport, NIDCAP® Developmental Program Manager, Nurse Analyst (Neonatal HIM), Chairperson of Clinical Practice Council, Chairperson of Professional Practice Council, Chairperson of Communication Committee, Case Manager, Social Worker
- [3] Purpose: Oversight and support of council structure and function, facilitate the work of the councils within a defined vision and direction, define goals and priorities for the nurseries, assure that all initiatives and proposed practices are in alignment with the nurseries' conceptual model and mission, oversight of process improvement, and ensure compliance with regulatory agency mandates.
- [4] Meeting Frequency: Weekly at outset, then monthly
- [5] Agenda/Minutes: Agenda is developed by chairpersons with input from committee members.

(d) Clinical Practice Council

- [1] Chairperson: Advanced Practitioner, Clinical Nurse Specialist, or Neonatologist
- [2] Membership: Neonatologist, Clinical Nurse Specialist, Assistant Nurse Manager, Advanced Practitioner, RN representative of NICU, NBN, SCN, Developmental Program staff, clinical support staff (Nutrition, Pharmacy, Respiratory Therapy)
- [3] Purpose: Develops clinical standards that are evidenced based. Examines clinical issues from an interdisciplinary perspective. Responds to clinical concerns and questions

from staff. Utilizes PI process when changing clinical practice.

[4] Meeting frequency: Monthly

[5] Agenda/minutes: Agenda is developed by chairperson with input from committee members.

(e) Professional Practice Council

[1] Chairperson: Advanced practitioner, Clinical Nurse Specialist, or Neonatologist

[2] Membership: Neonatologist, Clinical Nurse Specialist, Advanced Practitioner, Assistant Nurse Manager, RN representative of NICU, NBN, SCN, Developmental Program staff, Office Assistant, Nursing Care Associate

[3] Purpose: Areas of responsibility are scope of practice, professional competencies, continuing education and staff development, communication and teamwork, ethical principles, and environment of care.

[4] Meeting frequency: Monthly

[5] Agenda/Minutes: Agenda is developed by the chairperson with input from committee members.

(f) Infant care review committee

[1] Chairperson: Director of Neonatology or designee.

[2] Membership: Neonatal Faculty, Neonatal fellows, Perinatal Director, Legal Representative, Genetics Director, Neurologist, Nursing Manager, Clinical Nurse Specialist, Staff Nurses, lay persons (parents), member of the Clergy, Nurse Practitioners, NICU Social Worker, and other disciplines as indicated.

[3] Purpose: To provide a forum in which to discuss ethical issues related to neonatal care and specific cases involving ethical dilemmas.

[4] Meeting frequency: Monthly

[5] Agenda/Minutes: Agenda is developed by chairperson with input from committee members.

[6] Reports to Professional Practice Council

(g) Nursery Standards Committee

[1] Chairperson: Nursing Standards Committee Representative.

[2] Membership: Comprised of at least 5 and no more than 12 members obligated to a term of 2 to 3 years. Staff nurses

apply to Nursing Leadership Group for membership as vacancies arise. The Clinical Nurse Specialist and an Advanced Practitioner are members.

- [3] Purpose: To develop, review and establish standards of care in the NICU/SCN/NBN. To formulate and update procedures and protocols specific to NICU/SCN/NBN. To discuss issues that affect standards or quality of care.
- [4] Meeting Frequency: 4 times per year.
- [5] Agenda/Minutes: Developed with input from the Department of Nursing Standards Committee. Minutes are kept in the Committee Meeting Minutes book.
- [6] Reports to: Clinical Practice Council

(h) Competency Committee

- [1] Chairperson: Clinical Nurse Specialist.
- [2] Membership: Staff RNs
- [3] Purpose: To establish a core group of people responsible for validation of staff on annual competency checklists.
- [4] Meeting Frequency: As needed.
- [5] Reports to: Nursing Leadership Group.
- [6] Reports to: Professional Practice Council

(i) Pharmacy committee

- [1] Chairperson: Elected from Committee
- [2] Membership: Staff RN's, Clinical Nurse Specialists, Neonatal Pharmacist, Neonatologist, Advanced Practitioner.
- [3] Purpose:
  - [a] To develop standards of care associated with medication administration as needed.
  - [b] Review medication errors and strategize effective ways to minimize errors.
  - [c] Participate in quality improvement activities that are related to medication administration.
  - [d] Collaborate with pharmacy to identify systems and safety issues related to medications and to propose and implement solutions as needed.
- [4] Meeting Frequency: Monthly

- [5] Agenda/Minutes: Agenda developed by chairperson with input from members.
  - [6] Reports to Clinical Practice Council.
- (j) Lactation Support Committee
- [1] Chairperson: Lactation Consultant
  - [2] Membership: MDs (OB and Neonatal), RN representatives of OB, L&D, NBN, NICU, Developmental program staff, Dietitian
  - [3] Purpose: Provide a forum for dialogue among specialties regarding knowledge and research about breastfeeding. Educate staff about breastfeeding and recommended practice. Make recommendations about practice changes based on current evidence. Data collection and analysis of breastfeeding initiation, duration, and other performance improvement markers.
  - [4] Meeting frequency: Monthly
  - [5] Agendas/Minutes: Developed by the chairperson with input from members
  - [6] Reports to: Nursing manager of OB-GYN/L&D and Clinical Practice Council
- (k) Nursery Performance Improvement Committee
- [1] Chairperson: Clinical Nurse Specialist
  - [2] Membership: Neonatologist, Advanced Practitioner, RNs other disciplines as needed
  - [3] Purpose: Provide a forum for discussion of improvement activities as identified by staff; Data collection and monitoring of select activities; Provide an interface with the hospital QRM Committee.
  - [4] Meeting frequency: Monthly
  - [5] Agendas/Minutes: Developed by the chairperson with input from members
  - [6] Reports to: Clinical Practice Council
- (l) Equipment Education Committee
- [1] Chairperson: Staff RN Co-chairs
  - [2] Membership: Staff RNs from NICU/NBN/SCN, Clinical Nurse Specialist, Advanced Practitioner, Nursing Care Associate, respiratory therapist, materials management supply chain coordinator

- [3] Purpose: Identify and problem solve issues related to equipment and supplies; Explore new options; Conduct trials and evaluations of new products; staff education about new products and equipment
- [4] Meeting frequency: Monthly
- [5] Agendas/Minutes: Developed by the chairperson with input from members
- [6] Reports to: Clinical Practice Council
- (m) Action teams may be established for addressing short-term issues in the unit as directed by the Administrative Council.
- (n) Family Support Programs: Several programs are available to assist families throughout their infant's hospitalization.
  - [1] Parent Library: loans out books and videotapes to families
  - [2] Infant CPR Classes: certify parents in infant and pediatric CPR
  - [3] Lactation Consultation Services: available to assist/support breastfeeding mothers throughout and after their infant's hospitalization
  - [4] Cuddler Program: specially trained volunteers provide unhurried quiet time with infants when their parents cannot be there
  - [5] Family Newsletter: monthly publication of information helpful to families
  - [6] H.E.A.L. (Helping Endure Infant Loss): support group for families who have had an infant die
  - [7] NICU family support therapist supported by a grant from the March of Dimes
  - [8] Patient advocate: available to address issues related to hospitalization

d. 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 Nursing Manager.
- (2) Unit Hierarchy
  - (a) Staff nurses are responsible for providing nursing care to

assigned patients on a shift basis. Primary nursing teams are used. Each nurse accountable is to the Charge Nurse/Assistant Nursing Manager or designee.

- (b) The Assistant Nursing Manager functions in administrative/clinical role as an assistant to the Nursing Manager by (providing nursing care to a select group of patients) coordinating aspects of clinical care on a designated shift, assisting in the management of human and financial resources and to meet the needs of the patients being served. The Assistant Nursing Manager is accountable to the Nursing Manager.
  - (c) Nursing Manager (see Department of Nursing Structure Standards).
  - (d) Support Services to the NICU/SCN/NBN
    - [1] Weekend and off-shift department coverage is vested in the Administrative Manager or the Assistant Administrative Manager. (See Department of Nursing Structure Standards for job description /responsibilities).
    - [2] Hospital Administration Support Services (see Department of Nursing Structure Standards).
    - [3] Clinical Nurse Specialist (CNS) - Available to NICU/SCN/NBN staff (refer to CNS job description). Accountable to the Nursing Manager.
    - [4] Coordinator of Nursing Outreach and Transport Services. Accountable to the Nursing Manager.
    - [5] Advanced Practitioners (AP) These practitioners include Neonatal Nurse Practitioners, Neonatal Nurse Practitioner candidates and Physician Assistants.(refer to job description). Accountable to Nursing Manager and Neonatal faculty.
    - [6] Case Manager - Responsible for discharge planning and patient flow. Accountable to Department of Case Management.
    - [7] Nurse Analyst/Neonatal Health Information Management) - Responsible for coordinating computerized documentation. And maintaining the security and integrity of the system.
    - [8] Nurse Preceptor - Responsible for the clinical preceptorship of new orientees and students to the NICU/SCN/NBN.
- [a] Criteria for becoming a preceptor:

{1} Employed in NICU/SCN/NBN at JDH for a minimum of one year.

{2} Documented clinical expertise by performance appraisal.

[b] Criteria for maintenance of preceptor role.

{1} Documentation of clinical expertise maintenance by performance appraisal.

{2} Evaluation of effectiveness of performance by orientees.

{3} Attendance at preceptor workshop recommended.

[c] Nurse preceptors are identified by the Nursing Manager, Assistant Nursing Managers, and Clinical Nurse Specialist and are asked to participate in preceptorship role as needed. Nurse preceptors are responsible to the Nursing Manager.

[9] Non-Nursing Support

[a] Nursing Care Associates - Available 24 hours a day to carry out all aspects of job description. Responsible to the Nursing Manager.

[b] Office Assistants - Available 24 hours a day to carry out all aspects of job description. Responsible to the Nursing Manager.

(3) Medical Direction of Patient Care

(a) Director of Neonatology - 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 Chairman of Department of Pediatrics.

(b) NICU/SCN/NBN Attending Physician's Role - All patients will receive a clinical appraisal by a qualified Neonatal attending. All newborn patients will receive a clinical appraisal by a qualified attending pediatrician. Only attending physicians are responsible for taking transport calls and, if necessary, making arrangements for referrals if the NICU at JDH cannot take the infant. Refer to Department of Nursing Structure Standards with the following exception: No telephone orders will be accepted.

(c) Physician Consultants - Refer to Department of Nursing Structure Standards. All orders written by consulting physicians must be cosigned by attending physicians or fellows. A written order must be written when a consult is requested. This order is in addition to the completion of the consult request form.

(d) Teaching Staff - Refer to the Department of Nursing Structure Standards. Daily teaching rounds conducted by the NICU/SCN/NBN attending or fellow incorporate input from the nursing staff.

C. RESOURCE DEVELOPMENT/ALLOCATION/UTILIZATION

1. Financial: Refer to Department of Nursing Structure Standards.

2. Facilities

a. Patient Care Areas

- (1) Unit specific guidelines are developed jointly with nursing, medical and administrative input.
- (2) Admission Criteria to NICU. (This is not all inclusive and should only be used as a guideline.)
  - (a) In general, infants less than one month of age will be admitted to the NICU.
    - [1] Gestational age of less than 35 weeks.
    - [2] Birth weight of less than 2000 grams.
    - [3] Respiratory distress lasting beyond one hour of age or accompanied by one or more of the following:
      - [a] oxygen requirements
      - [b] sustained tachypnea
      - [c] grunting or retracting
      - [d] central cyanosis
    - [4] Recurrent apnea.
    - [5] Perinatal asphyxia: Apgars less than four at one minute and less than seven at five minutes, followed by no improvement at ten minute and twenty minute evaluations.
    - [6] Infants of diabetic mothers who display hypoglycemia (blood glucose less than 30) or have polycythemia (venous/central Hct > 65) displaying symptoms.
    - [7] Seizure activity with or without abnormal neurologic exam.
    - [8] Abnormal head circumference and/or cranial exam.
    - [9] Suspected or documented infection.
    - [10] Congenital anomalies requiring observation, evaluation, and/or medical-surgical intervention.
    - [11] Physiologic instability.
    - [12] Hyperbilirubinemia with suspected pathological etiology or having reached maximum acceptable levels.

[13] Coagulopathy.

[14] Failure to void urine by 24 hours of age.

[15] Failure to pass meconium by 48 hours of age.

[16] Suspected gastrointestinal abnormalities.

(3) Admission criteria to SCN.

There will be NO direct admissions to Special Care, that is, all new admissions will be admitted to NICU. Only rare exceptions will be made to this rule. Newborn Nursery will continue to accept direct admissions > or = 35 weeks gestation.

The following will NOT be admitted to Special Care:

- (a) Those infants requiring mechanical ventilation including NCPAP.
- (b) Those infants requiring vasopressor support.
- (c) Those infants requiring an arterial line.

Infants admitted to SCN will be clinically stable with minimal risk for deterioration.

NICU Attending, Charge Nurse and Case Manager (who will discuss infant's medical issues with primary caretaker) will decide which infants can be transferred to SCN/NBN.

The same will notify the SCN Attending and respective Charge Nurses of such transfers with a brief synopsis of infant's hospital course.

Transfer Orders will be written by the primary caretakers prior to transfer to SCN/NBN. The nursing transfer summary will be completed and the standard care plan will be updated by nursing staff prior to the infant's transfer.

The Case Manager will make necessary arrangements to fill SCN/NBN prior to the weekend or have a running list of the next potential infants ready to be moved.

Any infant from NBN who needs additional monitoring that can be handled by SCN will be moved there providing there is bed space.

Any infant from SCN/NBN that deteriorates and is felt to need more intensive care will be transferred back to NICU, except in those circumstances in which isolation measures and cohorting take precedence.

(4) Admission criteria to NBN:

- (a) Direct admissions from delivery room:

[1] Wellborn infants greater than or equal to 35 weeks without

physiologic instability requiring intensive care monitoring or intervention.

- [2] Birth weight > or = 2000 grams.
- [3] APGAR score at 10 minutes is > 7.
- [4] Infants of diabetic mothers when intrauterine growth is normal and diabetes is well controlled. If IV therapy is needed to maintain the infant's glucose meter levels above 40 mg %, the infant will be transferred to the NICU.
- [5] Infants born to mothers with infectious diseases may be admitted with precautions as outlined in Unit Practice Manual and/or Infection Control Manual. This includes infants born to mothers with histories of:
  - HIV
  - Hepatitis
  - HSV (refer to Unit Practice Manual)
  - Infants born to women with active gonorrhea or active syphilis may be admitted after diagnostic work up completed and treatment begun.
- [6] Infants born to mothers with duration of ROM equal to or greater than 24 hours or with maternal fever may be admitted to the newborn nursery. They must be evaluated in the DR or the nursery by the medical staff. A CBC with differential should be obtained.
- [7] Infants born to mothers with a history of substance use (including heroin and methadone). The following interventions will be initiated:
  - a. Abstinence scoring per protocol
  - b. Social work referral
  - c. Urine and meconium tox screens
  - d. Transfer to SCN when mother is discharged from the hospital or after appearance of signs of withdrawal because extended hospitalization may be needed. These infants may be admitted to the NICU service.
  - e. No breastfeeding until infectious disease status determined. Mother must be enrolled in a treatment program.
- [8] Healthy infants born outside the hospital or in the ER may be admitted to the nursery. Isolate in incubator until verification that there has been no exposure to individuals with actual or suspected airborne infectious disease (such as chickenpox)
  - a. The infant must be evaluated immediately by a member of the medical staff.
- [9] Transfers from NICU. These are general guidelines and exceptions may be made on a case by case basis. Prior to transfer, availability of a monitored bed must be

ascertained. Eight monitored beds collectively are available for NICU service and newborn service needs.

- a. Stabilized infants > 28 weeks and > 1200 grams (unless otherwise documented IUGR) who are on intermittent feedings and do not require IV infusion or oxygen therapy.
- b. Modes of Admission
  - (1) The attending physician accepts patients for admission to the NICU who are:
    - (a) in-born
    - (b) referred from a community hospital/physician
  - (2) The attending physician accepts patients for admission to the Newborn Nursery who are in-born or transfers.
- c. Relationships Between the Charge Nurse, Neonatal Medical Director, and Attending Physicians:
  - (1) The attending physician/designee and Assistant Nurse Manager or designee collaborate regarding all admissions.
  - (2) Considerations for admission:
    - (a) Adequate staffing.
    - (b) The attending/designee and Assistant Nurse Manager or designee decide when an admission is to be denied. If the denial is based on unit census/patient acuity or cardiac diagnosis, the attending physician is responsible for finding an appropriate facility to manage the patient's care.
      - (i) The attending physician and Assistant Nurse Manager or designee are responsible for arranging the transportation of the infant.
- d. Attending Physician Responsibilities:
  - (1) Evaluate the patient promptly after admission and daily to provide indicated patient care.
  - (2) Collaborate with the house staff, advanced practitioners, and nursing staff to keep families informed about their infant's care.
  - (3) Communicate with MFM, referral hospitals/community physicians regarding bed status and availability for admissions.
- e. Admitting Physician Responsibilities:
  - (1) The responsibilities of the Admitting Physician in conjunction with the covering MD/AP include, but are not limited to the following:

- (a) Evaluating the infant and writing orders for admission.
- (b) Obtaining consent for special procedures, including blood transfusion, if anticipated.
- (c) Providing around-the-clock coverage for in-house patients.
- (d) Retaining responsibility for specific diagnostic procedures and medical therapy.
- (e) Appropriately documenting clinical status.
- (f) Admitting Nurse's Responsibilities:
  - (1) Operating within the primary team model, it is the responsibility of the admitting nurse to initiate the NICU or NBN Admission Protocol and Discharge Planning Protocol as well as the appropriate Standard Care Plan, care path, database, and Patient and Family Teaching Record.
  - (2) Complete admission documentation as per Department of Nursing procedure.

### 3. Provision of Care:

- a. All patients are assigned to Registered Nurses.
- b. Appropriate tasks may be delegated by RNs to nursing care associates by RNs.
- c. All medications will be administered by licensed professionals.
- d. Nutritional supplements (e.g. multivitamins, iron, and calorie supplementation) may be fed to infants by unlicensed personnel. The supplements will be placed into the feeding by the RN.
- e. When preparing for and/or resuscitating a newborn, standards outlined in the Handbook of Neonatal Resuscitation by the American Academy of Pediatrics will be followed.

### 4. Transfers

#### a. In-house:

- (1) The NICU Attending, the case manager, and the Assistant Nurse Manager or designee make the assessment that the patient no longer requires Neonatal Intensive Care and collaborate on the plans for transfer.
- (2) Responsible house officer/Advanced Practitioner must write transfer orders prior to transfer to SCN or NBN.
- (3) Assistant Nurse Manager or designee ensures admitting office is notified of all transfers. The nursing transfer summary is completed by the patient's nurse. Verbal nursing report is given to

the receiving unit prior to transfer.

- (4) Ideally, families are notified prior to transfer unless an emergency necessitates making beds immediately available in the NICU.

b. Other Facilities:

- (1) The Attending Physician makes the decision that the infant requires care not available at this facility or requires greater involvement of an on-site pediatric sub specialist. The Attending Physician makes arrangements with the accepting physician. The Assistant Nurse Manager or designee makes arrangements with the receiving hospital.
- (2) The Attending Physician, case manager, and Assistant Nurse Manager or designee make the decision that the patient no longer requires Neonatal Intensive Care. The case manager and/or Assistant Nurse Manager or designee makes arrangements with the receiving hospital. The attending physician makes arrangements with the accepting physician. The case manager verifies that the infant's insurer will approve the transport.
- (3)..All transfers utilizing the Neonatal Van are coordinated with the UConn Health Center Fire Department. When the Neonatal Van is not in service the transfers are coordinated with an outside ambulance agency. The patient is accompanied by the appropriate care providers. Prior to transfer, Nursing and Physician Discharge Summaries are completed. Telephone nursing report is made to the receiving facility. A photocopy of portions of the patient's record is provided for the receiving physician. Insurance is cleared by the case manager as possible.

5. Discharge

- a. Minimum Discharge criteria for normal newborns and healthy premature infants to home:
  - (1) Weight greater than 4.5 lbs. (2000 gm) or per physician discretion.
  - (2) Free of acute disease/illness.
  - (3) Nutrition adequate for positive weight gain.
  - (4) Private pediatrician identified, notified, and discharge order written.
  - (5) Parental teaching completed and documented on the Patient and Family Teaching Record.
  - (6) Mandated state screening completed or parental refusal documented in writing.
- b. Minimum Discharge criteria for infants with chronic disease processes to home:

- (1) All minimum discharge criteria for normal, healthy newborns.
- (2) Specialized parent teaching completed relating to specific needs of individual infant as patient and family teaching records.
- (3) Appropriate in home services have been arranged.
- (4) Referrals made to appropriate follow-up agencies.
- (5) Arrangement of follow-up appointments with consulting physicians (unless parents choose to make appointments).

c. Minimum Discharge Criteria for infants transferred to other acute care institutions:

- (1) Level I Nurseries (See Guidelines for Perinatal Care for definition of Level I, II, and III nurseries)
  - (a) > 1500 g.
  - (b) Intermittent enteral feeds having demonstrated a positive growth trend.
  - (c) Temperature stable in an isolette or open crib.
  - (d) Apnea/Bradycardia controlled.
- (2) Level II Nurseries
  - (a) Stable nutritional and fluid status.
  - (b) Non-acute respiratory status (i.e. conditions that require low-flow oxygen therapy only).
  - (c) Infection free: may be nearing completion of antibiotic therapy.
  - (d) Therapeutic level of drugs administered for chronic disease condition (i.e. caffeine, Phenobarbital, etc.).
  - (e) Temperature stable in an isolette or open crib.
  - (f) Free of disease processes requiring specialized consultation.
- (3) Level III Nurseries
  - (a) Stable on supportive therapy.
  - (b) Able to tolerate transport procedure.
- (4) ECMO Center
  - (a) Infants in severe life threatening conditions are preferably stabilized and transported to an ECMO Center via van/ambulance. However, on occasion, the severity of the infant's condition warrants transport to the ECMO Center via the Life Star helicopter (or the ECMO center's transport team.)

d. Discharge Documentation

- (1) Completion of Nursery Discharge Sheet/Clinical Resume, Patient and Family Teaching Record, and closure of Standard Care Plan or care path.
- (2) Discharge Orders written by physician/AP and transcribed by nurse.
- (3) Discharge progress note, transfer note, or back transport progress note completed.
- (4) Nursery Discharge Sheet/Clinical Resume signed by MD/AP, RN, and parent or guardian

e. Modes of Discharge

- (1) Modes include home or transfers (refer to above section 3), or to foster care. Refer to Department of Nursing Structure Standards.

6. Geography

- a. The nursery area is secured by locked doors, security alarms, and video camera observation. Access to the area requires verification of identity.
- b. The NICU consists of 4 adjoining rooms containing 10 modules each. Each module contains electrical outlets, oxygen, air and vacuum sources. Emergency carts are accessible to each room. There is an emergency call/alarm system in place, which connects all nurseries, resuscitation rooms, delivery rooms, parent rooms, and MFICU to the NICU.
- c. The Newborn Nursery is an open room containing 10 monitored bed spaces. There is an emergency cart in the NBN. There are electrical outlets, oxygen, air and vacuum sources available in the NBN.
- d. Resuscitation Room 1 is adjacent to Delivery Room #1 and across from NICU Room 2, provides two bed areas for resuscitation of newborns at birth. There is an emergency cart in this room. There are electrical outlets, air, oxygen and vacuum sources available in the resuscitation room. Resuscitation Room 2 is adjacent to the Delivery Room 3 and three and across from NICU Room 3. There is an emergency cart in this room. There are electrical outlets, air, oxygen and vacuum sources available in the resuscitation room. There is a preheated transport isolette in on in resuscitation Room 2, at 25% power, at all times.
- e. There are four parent-visiting rooms. Oxygen, suction and air are available. Parent rooms are located in the hallway opposite Nurses Station A. Parent room 3 is adjacent to SCN and parent room four is adjacent to NBN.
  - (1) Toys for use by siblings are checked and cleaned daily.
- f. One formula preparation area is adjacent to the NBN, NICU Room 3, and SCN. A second area is located at Nurses Station A next to the Pharmacy

- area and between NICU Room 1 and 2. A formula room for use by the dietary department is in the hallway adjacent to the procedure room.
- (1) Refrigerators for formula and breast milk are located in each room and in NBN. The refrigerators are labeled "Breast Milk and Formula ONLY".
  - (2) Breast milk freezers are located in the storage alcove across from NBN. Freezers are labeled "Breast Milk ONLY".
  - (3) Refrigerators and freezers are cleaned monthly by housekeeping.
- g. There are medication refrigerators labeled "Medication Only", located in each pharmacy area adjacent to Nurses Station A and B. Housekeeping cleans this monthly.
  - h. Refrigerator and freezer thermometers are checked daily by nurses' aides and the temperature is recorded on the temperature log on all refrigerators and freezers.
  - i. There are clean storage closets in each of the nurseries for supplies. There is a clean supply room and equipment room at the end of the hallway adjacent to Room 1. The Pyxis storage system will be used.
  - j. There is a clean utility room and a dirty utility room in the hall across from Room 1 Nursery equipment is cleared in the dirty utility room.
  - k. Transport equipment is stored in the neonatal ambulances and in the Equipment Room.
  - l. A refrigerator labeled "Lab Specimens Only", is located in the dirty utility room.
  - m. The EKG machine is located in an alcove, adjacent to the dirty utility room.
  - n. Offices for the Nursing Manager, Assistant Nurse Managers, Neonatal fellows, Neonatal Advanced Practitioners, case manager, clinical nurse specialists, NIDCAP® Program Director and Developmental Nurse Educator are located in close proximity to the nurseries.
  - o. The on-call rooms for the house staff and advanced practitioners are located in close proximity to the nurseries.
  - p. Staff lounge and male and female locker rooms with showers are located adjacent to the nursery.
  - q. There is a procedure room located in proximity to the nurseries. This room is used for special procedures such as circumcisions and IV placement.
  - r. There is a patient waiting area across from the 3 bank elevators off the visitor hallway to the nursery.
  - s. There is a research lab off of the staff hallway. The lab is used for

- physician research.
- t. There is a respiratory blood gas lab off of the visitor hallway.
  - u. Patient record (chart) is kept at chart racks in the NICU and SCN. In NBN, the patient chart is kept on a shelf in the nursing station; the clipboard containing the current flow sheet and current order sheet, is at the patient bedside. Original records of patients admitted from outlying hospitals are kept at the NICU nursing station and sent to the Medical Records office when the patient is discharged.
  - v. There are two medication areas, one at each Nurse's Station.
  - w. Two clean areas with scrub sinks are available for scrubbing. They are adjacent to NICU/SCN/NBN. There are sinks available in each nursery for hand washing. Hand cleansing products are at each bedside.
  - x. There are 2 bed Isolation rooms in the SCN and in Room one.
  - y. Bookshelves in Nurses Stations A and B and NBN store reference manuals, including Infection Control Manual, Unit Practice Manual, and Safety Manual. There are computers available for staff use at both nurses' stations. The Department of Nursing Practice Manual and the Nursing Practice Manual are available electronically by accessing the Nursing Web Page.
  - z. Daily cleaning of all areas is the responsibility of the Housekeeping Department.
7. Utilization Crisis
- a. Refer to Department of Nursing Structure Standards.
8. Classrooms, Offices, Files
- a. Refer to Department of Nursing Structure Standards.
9. Human Resource Development
- a. Orientation
    - (1) Health Center/Hospital and Department of Nursing Orientation:
      - (a) Refer to Department of Nursing Structure Standards.
    - (2) Unit-Specific Orientation:
      - (a) Clinical Orientation: Each newly hired staff member will be assigned a clinical preceptor who will provide orientation to bedside nursing care activities, unit standards of care and documentation. An Orientation Competency Check-list will be provided to the new staff member during the first week of clinical orientation. The Orientation Competency Checklist identifies skills/assessments, which are required by the neonatal nurse. The clinical preceptor(s) will document the orientee's progress towards acquiring competencies needed for

successful performance in the neonatal units. The Orientation Competency Checklist will be periodically reviewed jointly by the preceptor and the orientee so that patient care assignments may be identified which will help to achieve the orientee's learning needs. The orientation packet is revised regularly.

- [1] Scheduling considerations/patient assignments may necessitate that the orientee be assigned to a staff nurse who is not the designated preceptor. Some degree of flexibility is recommended when optimal learning is the desired outcome.
- [2] Duration of neonatal clinical orientation is approximately 10 weeks. This may be modified on an individual basis through communication between the orientee, the preceptor, Assistant Nursing Manager, the Nursing Manager and Clinical Nurse Specialist.
- [3] Clinical orientation of new staff members to like units (Newborn Nursery) will occur during the unit orientation period.
- [4] Ongoing feedback will be provided to the orientee from the preceptor, Assistant Nursing Manager, Nursing Manager and Clinical Nurse Specialist.
- [5] Evaluation of the orientee (refer to Department of Nursing Structure Standards).

(b) Didactic Orientation

- [1] Didactic orientation will be provided informally by the clinical preceptor(s) and formally through a series of class days coordinated by the Clinical Nurse Specialist.
- [2] The unit orientation plan is kept on file with unit CNS and in the Education Services Department.
- [3] Nurse Pro Orientation
  - {a} Newly-hired Nurse Pros will attend General Orientation, which is coordinated by the Education Services Department. Neonatal staff that transfer their status to Nurse Pros are not required to attend this orientation.
  - {b} Clinical Orientation of Nurse Pros will occur as defined in Appendix C: Orientation Guidelines for Agency Staff/Nurse Pros/Float Pool/Status changes in Neonatal Units.
  - {c} Nurse Pros will receive the competency checklist during their clinical orientation in the Neonatal Units. The competency Checklist will remain on the unit until it has been completed.

- {d} Nurse pros who are oriented to care of the infant on ventilators or CPAP are those who:
  - (1) Have worked as permanent staff in the NICU at JDH.
  - (2) Have worked in other level III Neonatal units and have the approval of the Assistant Nursing Manager.
- {e} Nurse Pros will not be oriented to the transport System. Former JDH NICU Staff may be assigned to acute incoming transports as long as they are able to maintain their competency in transport.
- {f} Nurse Pros who have been former permanent staff members of the NICU at JDH, may accompany Neonatal patients on transport at the discretion of the ANM and with the approval of the Nurse Pro involved. Competency with transport supplies and equipment and with the transport environment must be maintained.
- {g} Nurse Pros who have been former permanent staff members of the NICU at JDH will be assigned patients based on their competency and the patient and unit needs, at the discretion of the ANM or charge nurse. They may continue to care for infants receiving high frequency oscillatory ventilation and/or nitric oxide or during transport (acute and back transport) if they are able to maintain competency with sufficient clinical exposure.

[4] Travelers

- {a} Agency nurses will receive the competency checklist from the ANM at the beginning of the clinical orientation.
- {b} Clinical orientation of Travelers will occur as defined in Appendix: C. "Orientation Guidelines for Agency Staff/Nurse Pros/Status changes in Neonatal Units.

[5] Float Pool

- (a) As above for nurse prns.
- (b) Receive their competency checklist from the Manager of the float pool or designee.
- (c) Assignments are made according to their competency

[6] Nursing Care Associates

- (a) Complete designated portions of general orientation
- (b) Receive their competency checklists from the ANM
- (c) Preceptors for utility role are other NCAs
- (d) Clinical orientation is scheduled after successful completion of orientation to the utility role
- (e) RNs in NBN/SCN/NICU function as preceptors for clinical orientation
- (f) Hearing screen orientation validated by CNS or designee

b. Continuing Education/Staff Development

- (1) Each nursing staff member is expected to participate in continuing education programs in conjunction with clinical advancement requirements for professional development. The Clinical Nurse Specialist is responsible for the coordination of staff development with input from staff and Nursing Manager.
- (2) Available programs include but are not limited to:
  - (a) See Department of Nursing Structure Standards for general educational opportunities.
  - (b) Unit specific mandatory in-services, which are scheduled as dictated by unit needs. These include Neonatal Resuscitation Program.

Unit specific in-services and programs including:

- [1] equipment updates
- [2] clinical issues
- [3] research activities
- [4] patient care conferences
- [5] neonatal nursing courses
- [6] self-learning programs
- [7] documentation issues

c. Maintenance of Competencies

- (1) Each staff member completes the Annual Competency Checklist. Competencies are validated by the clinical nurse specialists or members of the competency committee.

- (2) Decentralized laboratory competencies are validated annually by unit experts.

d. Support Services Outside of the Division of Nursing

(1) Respiratory Therapy

- (a) A respiratory therapist is available 24 hours a day and a therapist is on call on off shifts and weekends for transports.

- (b) Respiratory therapy provides the following services:

- [1] supply, maintenance, and monitoring of ventilators
- [2] blood gas analysis
- [3] supply of some oxygen equipment
- [4] set-up and maintenance of the INOVENT for nitric oxide administration
- [5] performance of stress oximetry
- [6] make recommendations for respiratory management of infants
- [7] attend high risk deliveries to provide respiratory management
- [8] assist with surfactant administration

- (c) Dedicated respiratory therapists have expanded clinical competencies that are outlined in the competency checklist

(2) Occupational Therapy/Physical Therapy

- (a) A designated developmental therapist is available Monday - Friday.

- (b) Occupational/Physical Therapy provides the following services:

- [1] range of motion exercises
- [2] infant developmental assessment and consultation
- [3] positioning
- [4] feeding assessment and support
- [5] Assist in developing plan of developmental care through discussions with medical staff, nursing staff, families, and Discharge Planning rounds.
- [6] makes referrals based on developmental needs at discharge

- (3) Radiology
  - (a) Portable X-ray machine and a radiology technician are available 24 hours a day for STAT and routine X-rays.
  - (b) MRI, CT Scan, Nuclear scans and other tests are available when needed.
- (4) Laboratory Medicine and Blood Bank
  - (a) Laboratory testing and blood components are available 24 hours a day.
- (5) Pharmacy
  - (a) A pharmacist is available 24 hours a day.
  - (b) Pharmacy provides the following services:
    - [1] verification of medication orders
    - [2] consultation/education of staff
    - [3] stocking all Pyxis machines
    - [4] reviewing orders, mixing all parenteral nutrition solutions
    - [5] preparation of selected medications and special dilutions
- (6) Neurological Testing
  - (a) Electroencephalograms (EEG) are available Monday-Friday, 8:00 am to 4:00 PM. Emergency weekend EEG is available upon request of a neurologist.
- (7) Cardiology Testing
  - (a) Electrocardiograms (EKG) are available Monday-Friday 8:00 am to 4:00 PM.
  - (b) Echocardiograms are available upon request to cardiologists at CCMC.
- (8) Social Worker
  - (a) A Neonatal Social Worker is available Monday-Friday, 8:30 am to 4:30 pm. In an emergency, a Social Worker is always on call. The social worker attend(s) Discharge Planning weekly conference, and collaborates with nursing and medical staff regarding their patients' support needs.
- (9) Pastoral Care
  - (a) Services of a chaplain are available

- (b) Parents/families may contact the spiritual leader of their choice for counseling, support, prayer services and/or blessings/baptisms.

(10) Audiology

- (a) Universal Newborn hearing screening is performed according to State of Connecticut Mandate and Procedure for Hearing Screening: Newborn. Infants who "refer" X2 on screening will be referred for audiology evaluation after discharge.

(11) Dietary

- (a) Neonatal Dietitian available Monday-Friday, 8:00 am to 4:00 PM for consultation and education. Dietary Department is available 8:00 am to 4:00 pm to prepare infant formulas.

(12) Volunteers

- (a) Cuddler Program available to patients in NICU/SCN/NBN See Protocol for Cuddlers: Use of

(13) Other Support Services

- (a) Other support services available as per Department of Nursing Structure Standards: Environmental Services, Clinical Engineering, Health Information Management, Central Supply, Radiation Safety, Infection Control, Housekeeping, Public Safety, and Information Technology.

e. Consultants - See Department of Nursing Structure Standards.

- (1) Materials Management - Refer to Department of Nursing Structure Standards.

- (a) Equipment - Manuals are located in resuscitation room #1. drawer located next to Health Unit Clerk desk in NICU.

- (2) Supplies - Refer to Department of Nursing Structure Standards.

- (3) Linen - Refer to Department of Nursing Structure Standards.

- (4) Product Safety Evaluation - Refer to Department of Nursing Structure Standards

- (5) Evaluation of Resources - Refer to Department of Nursing Structure Standards.

- (6) Staff

- (a) Professional - and Non-Professional Staff

- (b) Status - Refer to Department of Nursing Structure Standards.

[1] Staff may be hired full or part-time, as determined by

the Nursing Manager and based on unit needs.

[2] Positions available range from part to full-time in 8 hour and 12 hour shifts.

(c) Temporary Staff - Refer to Department of Nursing Structure Standards.

[1] Private duty nurses are not utilized in the NICU/SCN/NBN, as per Nursing Practice Manual.

[2] Temporary assignments may be filled by traveler nurses based on the Nurse Manager's discretion and approved by the Associate Hospital Director/Director of Nursing.

(d) Non-Nursing Staff

[1] Office assistants are employed to provide secretarial support to the nurseries.

#### D. STAFFING

1. Responsibility for providing adequate staffing - (Refer to Department of Nursing Structure Standards).
2. Unit Staffing - Refer to Department of Nursing Structure Standards.
  - a. Patient/staffing ratio is based on the daily classification of patients.
  - b. Usual staffing for the NBN consists of 2 RNs per shift.
3. Delivery of Care Methodology - Refer to Department of Nursing Structure Standards.
4. Patient Classification System - Refer to Department of Nursing Structure Standards.
5. Shift Assignments - Refer to Department of Nursing Structure Standards.
  - a. All patients in the NICU/SCN/NBN are assigned to an RN.
6. Scheduling - Refer to Department of Nursing Structure Standards.

E. EMPLOYMENT - Refer to Department of Nursing Structure Standards.

#### F. QUALITY ASSURANCE PLAN

1. IOP reports identify quality improvement initiatives.
2. Unit-specific performance improvement activities may be initiated in any nursery committee and are coordinated through the Clinical Practice Council.
3. Risk identification reports (RIRs), injuries and medication errors will be tracked by the nursing manager.

4. Issues regarding quality of care may be brought up in staff meetings or standards meetings and delegated to the appropriate committees/involved parties for resolution.

IV. NURSING PROFESSIONAL PRACTICE POLICIES

A. NURSING PROCESS

1. Assessment

- a. An initial physical assessment on each patient is performed and documented within 8 hours of admission by the admitting nurse. The database is completed within 24 hours.
- b. Assessments are done as indicated by the patient's status and active protocols.
- c. Refer to Department of Nursing Structure Standards.

2. Planning

- a. Refer to Department of Nursing Structure Standards.

3. Nursing Interventions

- a. Refer to Department of Nursing Structure Standards.

4. Evaluation

- a. Refer to Department of Nursing Structure Standards.

5. Documentation/Retention of Records

- a. Refer to Department of Nursing Structure Standards.

B. NURSING RESPONSIBILITIES

1. Refer to Department of Nursing Structure Standards.
2. Decentralized lab quality control testing is a responsibility of NICU/SCN/NBN nurses, and nursing care associates.

C. PROFESSIONAL BEHAVIORS

1. Refer to Department of Nursing Structure Standards.

D. CREDENTIALING

1. Refer to Department of Nursing Structure Standards.

E. RESEARCH

1. Refer to Department of Nursing Structure Standards.

F. STANDARDS

1. Refer to Department of Nursing Structure Standards.

V. CLINICAL POLICIES

A. REFER TO DEPARTMENT OF NURSING STRUCTURE STANDARDS

1. Clinical Policies: Patient Bill of Rights/Privacy/Confidentiality
2. Clinical Policies: Safety and Risk Management
3. Clinical Policies: Legal Issues
4. Clinical Policies: Infection Control
5. Clinical Policies: Fire and Disaster Plans
6. Clinical Policies: Patient and Public Relations

B. RESUSCITATION/CODE BLUE

1. Refer to Department of Nursing Structure Standards.
2. Current Certification as a Neonatal Resuscitation Provider is required.

C. MEDICATIONS

1. Refer to Department of Nursing Structure Standards.
2. Medications orders in the NICU/SCN/NBN are reviewed and rewritten weekly. Narcotics are renewed every 7 days.
3. Medications in the NICU/SCN/NBN are not generally provided under the unit dose system. All medications are verified by a second RN for correct medication and dose. All dosage calculations, volume, and rate of infusion are verified with another RN prior to administration.

D. VISITING

1. Refer to Department of Nursing Structure Standards and NICU/SCN/NBN protocols for: Visitation in the Nurseries, Sibling Visitation, and Visitation: Maternal Fever and

E. SHIFT RESPONSIBILITIES

1. All nurses are responsible for reviewing the previous shift's orders for assigned patients with the off-going nurse. The order sheet must be signed by the on-coming nurse to document the order review has been done.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/92

REVISION DATES: 12/92, 7/92, 3/96, 12/97, 4/03, 5/03, 6/06