

I. DESCRIPTION AND MISSION

A. Description

1. Type of Units

The Perioperative Division includes direct patient care units and support services in the main hospital building and the Farmington Surgery Center. Patients who receive care in the Division include ambulatory surgical patients, GI endoscopy patients, and specific cardiopulmonary, radiology and pain management patients as well as patients to be admitted to the hospital following any of these procedures.

- a. The JDH Procedures Center includes the surgical preadmission testing area, inpatient and ambulatory Holding Area for preoperative day of surgery, radiology and cardiology patients, and the patient reception area. The Holding Area is located on the basement level of the Canzonetti building. The patient reception area is located on the basement level of the Canzonetti building.
- b. The JDH Operating Room and Procedure Rooms include 10 ORs, GI Endoscopy / Lithotripsy / Bronchoscopy rooms, and a PACU procedure room. The PACU procedure room and GI Endoscopy/ Lithotripsy / Bronchoscopy rooms are located on the basement level of the Canzonetti Building. The operating rooms are located on the basement level of the Hospital building.
- c. The JDH Post Anesthesia Care Unit (PACU) is located on the basement level of the Canzonetti building.
- d. The JDH Central Sterile Supply/Instrument Room (CSS) department is located in the basement of the Hospital and clinic building. This area supports the hospital, Dental School and ambulatory clinics as well as the Perioperative Division.
- e. The Farmington Surgery Center is located on the second floor of the Medical Arts and Research Building (MARB). It includes 4 operating rooms and 1 procedure room, a preoperative area that includes 8 cubicles, a PACU area that includes 12 adult recovery bays and 2 pediatric recovery rooms, and a Sterile Processing Area.

2. Physical Design

- a. JDH Procedures Center: There is one large reception area, a waiting room, a holding area for up to 8 pre-procedure patients, a Physician/Family Consult Room, and support offices. Overflow volume from the holding area can be relocated to the PACU, as needed. All patient bays are equipped with oxygen and suction; select bays have cardiac monitoring and pulse oximetry capacity and are assigned to appropriate patient populations (e.g., cardiac surgery, regional nerve blockade).

Dietary supplies are monitored daily by Dietary personnel; patient and staff restroom facilities are monitored daily by Housekeeping personnel.

- b. JDH Intraoperative/Intraprocedure areas: JDH Main Operating Room and Procedure Rooms (1-7) operating rooms are located between a common center core and a common outer core. Three additional ORs (8-10) are located off the hallway between the OR Front Desk and the main entrance to the CSS/IR

department, and have access to a single hallway only.

- c. GI Endoscopy - JDH: Located on the main hallway leading to PACU are two GI Endoscopy procedure rooms. A third GI procedure room that also accommodates lithotripsy and bronchoscopy procedures is located adjacent to the Preoperative area. A fourth GI room is adjacent to the Holding Area and simple GI procedures performed by the nursing staff only can be done there. Pre- and post-procedure care is delivered in the 6-bay room adjacent to the Main OR Front Desk.

All JDH Main ORs and GI Procedure Rooms 1, 3 and 4 are equipped with gases and equipment to support moderate and deep sedation as well as general anesthesia. ORs are terminally cleaned on a regular scheduled determined by Housekeeping, in accordance with current *AORN Recommended Practices for OR Sanitation*.

- d. JDH Post Anesthesia Care Unit (PACU): One large room with 13 bays is available for Phase 1 and 2 patients recovering from anesthetic and operative/invasive procedures. The ambulatory holding area with 8 bays can be converted to space for Phase 2 postanesthesia patients, if needed. All patient bays have full monitoring capability.

Dietary supplies are monitored daily by Dietary personnel Juices and selected food items (e.g. muffins and crackers) must be kept on the unit for patients with diabetes and ambulatory patients, as requested; limited meal service is provided on request for patients with diabetes and other patients who will be in the PACU for longer durations. Patient and staff restroom facilities are monitored daily by Housekeeping personnel.

- e. JDH CSS/IR area: There is a decontamination room located off the Main OR outer core, a clean area for processing instruments and supplies, limited storage area within the department for sterilized instrumentation and clean supplies, office space for purchasing and materials management, and an adjacent Perioperative Materials Management Storeroom.
- f. FSC Preoperative/Preprocedure area: There is a large reception area, including a waiting room with two physician consultation rooms, a holding area for up to 8 pre-procedure patients, and support offices. Overflow volume from the holding area can be relocated to the PACU, as needed. Four patient bays are equipped with oxygen and suction; select bays have cardiac monitoring and pulse oximetry capacity and are assigned to appropriate patient populations (e.g. regional nerve blockade and other select patients, as appropriate). Dietary supplies are monitored daily by nursing staff.
- g. FSC Intraoperative/Intraprocedure areas: Operating rooms are located on the second floor of the Medical Arts and Research Building (MARB). They consist of 4 operating rooms along a central semi-restricted corridor with sub-rooms behind each OR. The procedure room is located adjacent to the operating rooms.
- h. FSC Postoperative/Postprocedure area: Two pods with 6 bays each are available for Phase 1 and 2 patients recovering from anesthetic and operative/invasive procedures. The preoperative area with 8 bays can be converted to space for Phase 2 postanesthesia patients, if needed. All patient bays have full monitoring capability.

Dietary supplies are monitored daily by nursing staff. Juices and limited food items (e.g., crackers) must be kept on the unit for patients with

diabetes and other patients, as requested.

- i. FSC Sterile Processing: There is a decontamination room located off the sub-sterile corridor, a clean area for processing instruments and supplies, and a storage area adjacent to the department for sterilized instrumentation and clean supplies. Office space for purchasing and materials management and a storeroom are located within the suite.

j. Perioperative Scheduling and Billing

JDH - The scheduling office located off the central traffic corridor adjacent to the 3-bank patient elevators.

FSC - The scheduling office is located in the administrative corridor.

All Perioperative Billing is located adjacent to and across from the main entrance to the JDH CSS/IR area.

k. Central Module (refer to maps)

JDH - There are male and female locker rooms and a lounge area for staff located in the OR, as well as smaller staff lounges in the Procedures Center and the PACU. A staff lounge and female locker room are located in the CSS/IR area. A Pathology lab is located off the hallway leading to the OR Staff Lounge.

FSC - There are male and female locker rooms and a lounge area for all staff located adjacent to the OR corridor.

l. Offices

Office	Location
JDH Director, Perioperative Services	In hallway adjacent to GI Procedure Rooms 3 and 4.
FSC Perioperative Nurse Manager	In administrative corridor
JDH ANMs: a. Procedures Center - PACU - Interventional Radiology; b. GI Endoscopy; c. OR	Office nearest elevators.
FSC OR ANM	Adjacent to the semi-restricted corridor
FSC PACU ANM	In hallway adjacent to pre-/post-operative area
CNS	At far end of JDH Postoperative Recovery
Perioperative Clinical Systems Administrator	Adjacent to JDH Patient Reception Area entry and Chart Prep Room
FSC Administrative Program Assistant	Along the administrative corridor.
Scheduling	JDH - At entrance near 3-bank elevators. FSC - Along administrative corridor.
Materials Management and Billing	JDH - In CSS/IR Area. FSC - Along sub-sterile corridor adjacent to ORs.
Perioperative Administrative Director	Off JDH preoperative corridor

m. On-Call Room

Anesthesiology on-call space (JDH only) is located on the basement level of the hospital building in close proximity to the OR. Daily cleaning is the responsibility of the Housekeeping Dept.

n. Utility Rooms

JDH - Cleaning of all utility rooms is the responsibility of Housekeeping.  
 FSC - Cleaning of all utility rooms is the responsibility of Housekeeping.  
 Facilities Management is responsible for cleaning and maintenance of ice machines. The machines are cleaned and disinfected every 6 months, or more frequently by Work Order request, and water inflow filters are changed every three months.

3. Scope of Nursing Services

a. Clinical

Nursing care is provided to patients from infants to elderly. Standards of Care (procedures and protocols) are developed and final approval granted through the Nursing Standards subcommittee of the Clinical Forum. Practice concerns may also be addressed through management and the CNS.

b. Professional

The Perioperative Division employs:

Title	Preoperative	Intraoperative	Postoperative
<b>Registered Nurses</b>	<ul style="list-style-type: none"> <li>• Preoperative Nursing Care</li> <li>• Patient and Family Teaching</li> <li>• Preadmission Testing and Admission Day of Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Intra-operative Nursing Care</li> <li>• Scrub</li> </ul>	<ul style="list-style-type: none"> <li>• Postoperative Nursing Care</li> <li>• Patient and Family Teaching</li> <li>• Discharge</li> </ul>
<b>Surgical Technologists</b>	X	<ul style="list-style-type: none"> <li>• Scrub</li> </ul>	X
<b>Medical Assistants</b>	<ul style="list-style-type: none"> <li>• Clerical Duties</li> <li>• Patient Testing</li> <li>• Patient Preparation</li> <li>• Ordering and Stocking Supplies</li> </ul>	X	<ul style="list-style-type: none"> <li>• Assist RN as directed</li> <li>• Patient Discharge</li> <li>• Ordering and Stocking Supplies</li> <li>• Clerical Duties</li> </ul>
<b>OR/Anesthesia Aides</b>	<ul style="list-style-type: none"> <li>• Assist in Patient Transport</li> <li>• Preoperative Patient Preps</li> </ul>	<ul style="list-style-type: none"> <li>• Support patients undergoing various anesthetic and surgical procedures, as directed</li> <li>• Ordering and Stocking Supplies</li> </ul>	<ul style="list-style-type: none"> <li>• Assist in Patient Transport, as appropriate</li> </ul>

		• Room Turnover	
Health Unit Clerks	• FSC Preoperative / Waiting Room		

**c. Administration**

The structure and organization of the Perioperative Division is written in these standards for the purposes of planning, organizing, implementing, and evaluating the operations of the Division. Administrative responsibility falls under the nursing management.

**A. Mission**

The mission of the Perioperative Division is consistent with that of the Department of Nursing and John Dempsey Hospital, as identified in the Nursing Practice Manual.

**II. PHILOSOPHY AND GOALS**

**A. Philosophy**

The philosophy of the Perioperative Division is consistent with that of the Department of Nursing and John Dempsey Hospital, as identified in the Nursing Practice Manual.

**B. Goals**

1. The purpose of the goals is to establish the major activities believed to be important for the on-going operations, continued development and success of the Perioperative Division.
2. The Perioperative goals are developed from the Department of Nursing goals and the Hospital work plan and are approved at Perioperative leadership level. These goals are developed in consultation with the Perioperative nursing staff.
3. Many individuals are involved in implementation of goals during the year, which requires participation of all levels of staff. Goals are dynamic and will be communicated by multidisciplinary leadership, as appropriate.

**III. ADMINISTRATIVE POLICIES**

**A. Organization**

**1. Relationships**

**a. Administrative**

The Perioperative Division falls within the Department of Nursing.

**b. Interdepartmental**

The Director, Perioperative Services is responsible for all clinical and non-clinical activities. The Director oversees clinical activities in coordination with the, Assistant Nurse Managers and the CNS, and non-clinical activities in coordination with Scheduling & Billing and Materials Management staff who report directly. The Director reports to the Assistant Hospital Director/Director of Nursing.

c. Organizational Chart

The organizational chart for the Division can be found in Unit Practice Manuals appended to the end of this document. Performance Descriptions exist for each position on the chart, and are on file in Human Resources.

2. Communication Mechanisms

a. Administrative

Information is received, reviewed, and transmitted through the Perioperative Leadership and staff representatives on committees.

b. Interdepartmental and Intra-unit

Communication flow is based on the Organizational Chart.

c. Mechanisms

- Communication Books (unit-based)
- Shift report
- Telephone paging system
- Bulletin boards
- Mailboxes (hard copies and individual email accounts)
- Staff meetings
- Meeting minutes and memos
- Availability of foreign language and deaf and hard of hearing interpreters, in accordance with UConn Health System policy and state and federal regulations.

Change of shift report must occur regularly to communicate status of:

- ongoing or pending patient load/procedures,
- changes in OR schedule,
- case cart completion,
- equipment and supply related information,
- the following day's schedule, as appropriate
- new entries in communication book

3. Unity/Extent of Command

- a. Overall management of the Perioperative Division is the responsibility of the Director, Perioperative Services with supervision, direction, and support from the Director of Nursing. Collaboration with physicians and appropriate department heads occurs periodically through formal and informal meetings.
- b. The Director, Perioperative Services is a registered nurses with appropriate clinical and management skills and/or potential for same. He/she is responsible for effective management of the Division, and have 24-hour accountability for the effective functioning of the staff, including their development and evaluation, the efficient functioning of the unit, and the quality of patient care provided.
- c. The Director, Perioperative Services assigns Assistant Nurse Managers (ANM) or charge nurses each shift for the purpose of decision making,

facilitating unit communication, and for coordination and delivery of nursing care.

- d. The authority, final responsibility for, and control of all actions directed toward the medical goals of the Perioperative Division are vested in the OR Medical Director. The Medical Director appoints a qualified alternate in his/her 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 Perioperative Division is reviewed as necessary.
- b. The organizational structure is approved by the Nursing Administrative Council and the Medical Board.

B. GOVERNANCE

1. Functions of the Perioperative Division

a. Institutional and Interdepartmental

Qualified nurses are selected to represent the Division on Hospital and Health Center standing committees based on the recommendation of the Director, Perioperative Services and Assistant Nurse Managers. Nurses may volunteer or be appointed. Refer to the Dept. of Nursing Structure Standards for the role and responsibilities of the stated hospital/Health Center committees.

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 Perioperative Division.

2. Nursing Direction

a. Type of Governance

The Perioperative Division is decentralized and organized under the Department of Nursing and conforms to 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 JDH Director, Perioperative Services and FSC Nurse Manager and directing operations of the Perioperative Areas to fulfill unit function is vested in the OR Medical Director and OR Committee.

2. OR Committees

	OR Committee	Perioperative Staff Meetings
<b>Chair</b>	Chair, Dept. of Surgery	Assistant Nurse Manager, Nurse Manager, or Director, Perioperative Services
<b>Membership</b>	Representatives of	Staff of each unit

	Medical Staff, Hospital Administration and Nursing Leadership	
<b>Purpose</b>	Policy-making in reference to relationships among services and the use of equipment and the facility.	To enhance the flow of information to and from staff; identify staff problems and concerns, to facilitate unit-based problem-solving.
<b>Meeting Frequency</b>	Once per month	Minimum quarterly, more often as needed.
<b>Agenda/ Minutes</b>	Developed by Chair, with input from committee members; minutes are distributed to members	Developed by chair with input from unit staff and CNS; minutes filed on units, with copies circulated to Director, Perioperative Services and Director of Nursing.

**d. Day-to-Day Operations**

**1. Authority**

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 - Staff nurses are responsible for providing nursing care to a specific patient assignment throughout their shift. Primary nursing is the delivery of care model utilized, and each staff nurse is accountable to the charge nurse.**
- b. **Assistant Nurse Managers/Charge Nurses - are responsible for decision-making, facilitation of unit communication, and coordination and delivery of care. On evenings, nights, and weekends, this person is responsible to the Administrative Manager on duty for staffing and patient care decisions.**
- c. **Director, Perioperative Services - assumes 24-hour accountability for the management of patient care in the Division, including resource allocation, planning and development, information development, educational endeavors, and development and evaluation of staff. All staff members are responsible for completing an annual competency checklist and educational record. The competency checklist is reviewed and learning needs are identified, with modification of staffing assignments, as needed.**
- d. **Director of Nursing/Associate Hospital Director - refer to Department of Nursing Structure Standards.**
- e. **Perioperative Division Support Services**
  - 1. **CNS - is responsible for supporting clinical practice, consultation, education, and research within the Division; reports to the Director, Perioperative Services. The CNS has primary responsibility for clinical aspects of the perioperative information system.**

2. Preceptors - for assisting new employees in the initial orientation period (refer to Dept. of Nursing orientation protocols).
3. Non-RN Nursing Support
  - a. Surgical Technologists provide scrub assistance on operative procedures and are ultimately accountable to the Director, Perioperative Services or designee.
  - b. Perioperative Medical Assistants facilitate patient flow and provide patient care as directed by the RN in the preoperative and postoperative areas, and are accountable to the Assistant Nursing Manager of those units.
  - c. OR / Anesthesia Aides support patients and care givers in delivery of all anesthetic and surgical procedures, and are accountable to the charge nurse followed by the Perioperative Nurse Manager.
  - d. Clinical Office Assistants (COAs) are responsible for reception of patients, scheduling, billing, and data entry, and are accountable to the Director, Perioperative Services.
  - e. Administrative Program Assistants orient and oversee staff in OR Scheduling Office and is accountable to the Perioperative Administrative Director and FSC Nurse Manager, respectively.
  - f. Perioperative Materials Management staff are responsible for Value Analysis and UHC affairs, conducting trials and evaluations, ordering and stocking, and updating Materials/Inventory portions of Perioperative information system. They are responsible to management within the Materials Management Department and collaborate as needed with the perioperative nursing management.
  - g. Perioperative Information Systems Specialist oversees all computerization issues and assures functioning of the Scheduling and Billing System, and is responsible to the Perioperative Administrative Director.
4. Support Services within Department of Nursing
  - a. Administrative Managers - are resources to the ANM or charge nurse (in the absence of the Director or Nurse Manager) to provide direction and support in the decision-making process during weekends, off-shifts and holidays (refer to Department of Nursing Structure Standards).

### 3. Medical Direction of Patient Care

#### a. Medical Director

##### 1. Preoperative and Intraoperative

The Director, member of the anesthesiology attending staff, will represent the best interests of the institution in attempting to obtain

consensus on Division protocols and procedures. The Medical Director's authority will flow from the Chair and Clinical Chief of Surgery, the Hospital Director, and the Chief of Staff. The Medical Director may function as chair of the OR Committee.

2. Postoperative

The Director is responsible for the medical care and management of patients recovering from anesthesia. This include providing and or delegating medical coverage, establishing medical standards within the unit, collaborating with the ANMs to establish the type and amount of equipment used in the unit, and participating in the formulation and approval of Postoperative Unit standards.

b. Anesthesiology Clinical Coordinator

These members of the anesthesiology attending staff collaborate with nursing management or charge nurses to ensure efficient use of the perioperative areas, by making staff and room assignments. The Coordinator reviews the following day's schedule with the charge nurse/Director, Perioperative Services or designee and the OR Scheduling Office staff to make personnel assignments, troubleshoot questions and problems, to integrate special needs' considerations, and adhere to scheduling guidelines.

C. RESOURCE DEVELOPMENT/ALLOCATION/UTILIZATION

1. Financial

Refer to Department of Nursing Structure Standards.

2. Staffing Pattern

The RN administrator is accountable for staffing perioperative nursing services. The RN administrator defines the qualifications, competencies, and staffing complement for perioperative nursing services.

A. A master staffing plan is defined in writing and meets the needs of the population served and scope of services.

B. Staff selection is based on facility needs and applicant qualifications.

C. Staff assignments are based on patient needs, available resources, and staff competencies

Surgical Phase	Minimum Requirements	Comments
Scheduling	1 clerical person under the supervision of a perioperative RN	This activity may be combined with other business or clerical duties. Additional staff members are used depending on volume and the hours that the scheduling office is open.
Preadmissions	1 RN at each location	Depending on the OR schedule and level of activity, additional RNs and ancillary support are provided.

		This may include preoperative telephone calls/interviews or planning for special supplies and equipment to meet patient needs.
<b>Registration</b>	1 clerical personnel at each location	The number of clerical staff members depends on the setting, level of activity, number of patients scheduled, patient acuity, and types of procedures and may be combined with other tasks.
<b>Day of surgery: preoperative</b>	1 RN at each location	The number of RNs is based on the number of patients, the number of ORs/procedure rooms, patient acuity, types of procedures, complexity/intensity of patient care requirements, time required to perform tasks, a patient's age-specific needs, and the average time for individual patient preparation. Medical assistants and other unlicensed assistive personnel may be included in preoperative staffing plans, to help with delegated patient care tasks as determined by the RN and according to the state board of nursing scope of practice and other local, state, and federal regulations.
<b>Intraoperative</b>	1 RN per patient per OR in the role of the circulating nurse. 1 scrub person per patient per OR, may be RN, or surgical technologist. In some circumstances a scrub person may not be required.	Additional staff members, with appropriate competencies, may be used as appropriate for the following: <ul style="list-style-type: none"> <li>• moderate sedation—one RN dedicated to monitoring the patient</li> <li>• local anesthesia—depending on patient needs, nursing assessment, and type of procedure, an RN may be needed to monitor the patient in addition to the RN circulator;</li> <li>• complex surgical procedures and patients with compound needs may require an additional RN circulator and scrub person</li> </ul>

		<ul style="list-style-type: none"> <li>• technological demands (eg, lasers, robotics, audiovisual equipment, auto transfusion device);</li> </ul>
<p><b>Postoperative Phase I level of care</b></p>	<p>Two licensed nurses, one of whom is a RN competent in Phase I postanesthesia nursing, are present whenever a patient is receiving Phase I level of care." Staffing will reflect the American Society of Perianesthesia Nurses' (ASPAN's) "Patient classification / recommended staffing guidelines".</p>	<p><b><u>Phase I level of care</u></b></p> <p>Class 1:2—One nurse to two patients who are</p> <ul style="list-style-type: none"> <li>• One unconscious, stable, without artificial airway, and older than the age of 8; and one conscious, stable, and free of complications.</li> <li>• Two conscious, stable, and free of complications.</li> <li>• Two conscious, stable, 8 years of age and younger, with family or competent support staff member present</li> </ul> <p><b><u>Class 1:1—One nurse to one patient</u></b></p> <ul style="list-style-type: none"> <li>• At the time of admission, until the critical elements are met;</li> <li>• Requiring mechanical life support and/or artificial airway;</li> <li>• Any unconscious patient 8 years of age and younger;</li> <li>• A second nurse must be available to assist as necessary.</li> </ul> <p>Class 2:1—Two nurses to one patient</p> <ul style="list-style-type: none"> <li>• One critically ill, unstable, complicated patient.</li> </ul> <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations</p>
<p><b>Postoperative Phase II level</b></p>	<p>Two licensed nurses, one of whom is a RN competent in Phase II</p>	<p>Phase II level of care</p> <p>Class 1:3—One nurse to three</p>

<p><b>of care</b></p>	<p>postanesthesia nursing, are present whenever a patient is receiving Phase II level of care." Staffing will reflect the American Society of Perianesthesia Nurses' (ASPAN's) "Patient classification / recommended staffing guidelines".</p>	<p>patients</p> <ul style="list-style-type: none"> <li>• Older than 8 years of age.</li> <li>• 8 years of age and younger with family present</li> </ul> <p>Class 1:2—One nurse to two patients</p> <ul style="list-style-type: none"> <li>• 8 years of age and younger without family or support staff member present</li> <li>• Initial admission of patient postprocedure</li> </ul> <p>Class 1:1—One nurse to one patient</p> <p>Unstable patient of any age requiring transfer</p> <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations.</p>
<p><b>Discharge from service</b></p>	<p>An RN assesses the discharge readiness of the patient and confirms the order from anesthesiologist/surgeon for discharge according to facility protocol.</p>	<p>The perianesthesia nurse uses sound judgment in determining the appropriate method of communication and mode of transport to transfer care of the perianesthesia patient.</p> <p>The professional nurse determines the mode, number, and competency level of accompanying personnel based on patient need, including Fall Risk Assessment on intake.</p> <p>The professional nurse ensures the availability of appropriate transportation of the ambulatory patient from the facility.</p> <p>An appropriate means of transportation from FSC to JDH main hospital will be used in emergency situations.</p> <p>A professional nurse or EMT should accompany patients who:</p>

		<p>require continuous cardiac monitoring;</p> <p>are receiving blood component transfusions; or</p> <p>require evaluation and/or treatment during transport (ie, vasopressor infusions or pulse oximetry).</p> <p>Additional staff members may include support staff. Unlicensed assistive personnel may be assigned to help with delegated patient care tasks according to local, state, and federal regulations.</p>
<b>Postoperative Follow-up</b>	An RN completes discharge follow up	Ambulatory surgery patients are reassessed postoperatively. The time frames for reassessment are based on patient needs and the care, treatment, and services provided.

**3. Facilities - Patient Care Areas**

The JDH perioperative area provides 24-hour care; the FSC perioperative area provides care weekdays early morning into the evening.

**a. JDH/FSC Preoperative**

The preoperative units open for patient care at 6:00 a.m. all weekdays except Wednesday (7:00 a.m.). The JDH unit closes daily at 8:00 p.m.; FSC closes daily at 7:00 p.m. Patients may be scheduled for preadmission testing through the IDX system either in the clinic or by the preoperative staff. Unscheduled patients are served on a first come, first served basis.

**b. JDH/FSC Intraoperative**

JDH - Nine ORs, three Endoscopy rooms, and a PACU procedure room are available for patient care. OR start time is 7:30 a.m. (8:30 a.m. on Wednesdays); three ORs are available past 3:30 p.m. until 6:00 p.m.; one cardiac OR is available as needed, and one OR is available 24 hours a day. FSC - four ORs and a procedure room are available for patient care. OR start time is 7:30 a.m. (8:30 a.m. on Wednesdays); ORs are available past 3:30 p.m. dependent on staffing and space availability until 5:00 p.m.

Elective bookings are taken weekdays (excepting major holidays) JDH - 8:00 a.m. / FSC - 7:30 a.m. until 4:30 p.m. in the scheduling offices, and are placed in block or open time, as appropriate. The next weekday's Perioperative schedule is printed weekdays by 12 noon. All non-emergent procedures booked after the schedule has closed are designated as "add-on" cases, and are done pending staff and space availability. Emergency and

urgent cases are done as soon as possible; refer to "Scheduling Guidelines" procedure in OR Unit Practice Manual and "Immediate Patient Access to the OR" in the HAM/Clinical Practice Manual.

The JDH OR staff must notify the Administrative Manager during emergency cases on nights, weekends, and holidays to inform them of the availability of OR staff for additional emergencies or for Caesarian section coverage; C-section scrub person coverage is provided on an as needed and as available basis.

The JDH OR staff must notify PACU staff regarding any need for the Isolation room for patient recovery at least 15 minutes in advance of patient arrival to PACU.

c. JDH/FSC Postoperative

JDH - The PACU provides in-house coverage from 7:00 a.m. until 11:30 p.m. weekdays, and on-call coverage the remainder of the time. The staff provide recovery service for all Perioperative patients as well as selected patients who have undergone operative/invasive procedures under sedation/anesthesia elsewhere within the facility. Patient bay assignment is made according to patient acuity, as follows:

- Level 1: Outpatients expected to have an uncomplicated recovery.
- Level 2: Inpatients and complicated outpatient recovery.

The ANM or charge nurse will make patient bay assignments according to patient acuity and staffing availability.

Assignment of patients to the JDH PACU Procedure Room; the order of priority for use of the room is:

- respiratory isolation
- non-respiratory infectious processes
- reverse isolation
- radioactive implant
- procedures under deep sedation or general anesthesia
- special needs: e.g., select mentally handicapped or DOC patients

When the room is used for isolation patients, a portable HEPA filtration unit must be obtained from Facilities Management and run continuously for at least one hour prior to use. When the room is used for a respiratory tuberculosis patient, it must be kept closed for two hours following patient discharge.

JDH PACU staff may recover patients in the ICU should additional backup be required (e.g., anesthesiology is tied up with other obligations). Anesthesiology will remain medically responsible during the recovery phase.

FSC PACU staff provide in-house coverage from 7:00 a.m. until 7:00 p.m. weekdays for ambulatory perioperative and pain management patients, or until all patients have been discharged.

1. JDH and FSC Admission

a. Admission Criteria

Patients of attending physicians with appropriate admitting privileges may be electively or urgently admitted to either location in accordance with posted OR Scheduling Guidelines and with properly documented informed consent and history and physical, per policy. Patients who need emergent access to the JDH OR will be admitted in accordance with the HAM policy (8-036) on Patients Requiring Immediate Access to the Operating Room.

b. Modes of Admission

Patients may be scheduled as ambulatory admissions at either location. Patients scheduled to be admitted to the hospital postoperatively or who are inpatients are scheduled at JDH only. If ambulatory patients require services only available at the main hospital building (e.g. blood component transfusions), they will be scheduled at JDH only.

c. Admitting MD responsibilities

It is essential that patients are admitted with required paperwork and medical orders. The nursing staff must have medical direction/support at all times. The required paperwork and orders may include, but are not limited to the following:

1. Informed consent that has been signed by the patient or the appropriate patient representative and has been signed, dated and timed by the involved physician, dentist, or physician delegate within 30 days of the procedure (HAM 06-002). Transfusion consent also is to be completed for all JDH patients to be admitted as an inpatient following surgery.
2. History and Physical that has been completed and signed, dated and timed by the involved physician, dentist, or physician delegate no more than 30 days prior to admission of ambulatory patients or within 24 hours of admission for inpatients. Any existing history and physical greater than thirty (30) days old must be redone. For a history and physical less than thirty (30) days old, a note documenting that the history and physical has been reviewed, and documenting any salient changes shall be written (JDH Medical Staff By-laws section 4A2).
3. Admitting location
4. Lab testing
5. Transfusion services
6. Preoperative prophylactic antibiotics
7. Venous thromboembolism prophylaxis
8. Preoperative patient skin preparation
9. Vital signs
10. Postoperative orders, including follow-up instructions and other postoperative care instructions for patient/family for ambulatory patients.

d. Admitting Nurse Responsibilities

It is the responsibility of the admitting nurse to confirm required paperwork is present and valid. For ambulatory patients, the admitting nurse will complete an initial assessment of the patient's current physical status and preparation for the procedure; including but not limited to acute and chronic pain status; medication history with date/time of last dose(s) taken; required paperwork, site verification and marking, as appropriate; pregnancy screening; religious/cultural needs; impairments/barriers to learning; interpreter needs; NPO status; isolation precautions; vascular access/vital signs. Falls risk assessments will be done for all JDH patients who are to be admitted postoperatively. Pulse strength and location will be assessed and documented pre-procedure for all patients undergoing procedures performed in Interventional radiology and Cardiac Cath Lab, for whom postoperative vascular compromise is a risk.

As the patient is transferred within the perioperative area, the nursing staff will complete all admitting responsibilities and document per the electronic nursing record for their unit.

e. Other (JDH)

1. Open Heart - Patients undergoing open heart procedures will not be admitted to the PACU and will be transferred directly from the OR to the ICU.
2. Neonates - NICU patients may be transferred directly into the OR and bypass the Holding Area, depending on anesthesiology preference and OR readiness.
3. Isolation patients - patients on specific isolation precautions that preclude them from being held in the Holding Area common room will be transferred directly into the OR and bypass the Holding Area.
4. ICU patients, originating from the ICU - patients who originate from the ICU generally will be transferred directly into the OR and bypass the Holding Area, always if intubated / ventilated. Postoperatively, pending final approval by the anesthesia care providers, critical care team and nursing, these patients will be transferred postoperatively directly from the OR to the ICU, bypassing PACU.
5. ICU patients, new postoperative admissions - patients will be evaluated for the potential to be transferred directly from the OR to the ICU, bypassing PACU, pending final approval by the anesthesia care providers, critical care team and nursing.

2. JDH and FSC Discharge

All perioperative patients who have received anesthesiology care must be signed out by an attending surgeon or anesthesiologist within 30 minutes of discharge. All other patients may be signed out by a fellow or attending from the appropriate service. Patients will receive written and oral discharge instructions from an RN prior to exiting the unit.

a. Discharge Criteria

Discharge of patients can occur once identified patient outcomes have been met. Desired patient outcomes are identified in the electronic nursing care record and attainment of the outcomes are documented for each individual patient by the RN. For JDH inpatients and FSC transfers, notification of impending patient arrival must be given to the receiving unit; report must be given prior to transport if the patient is stable and RN accompaniment to the receiving unit is not required; report may be given prior to transport or upon arrival to the receiving unit if an RN accompanies the patient during transport. Documentation must be completed at time of discharge, regardless of patient type.

b. Modes of Discharge

Ambulatory patients are discharged directly from either facility, customarily with a responsible adult who has received necessary postoperative care instructions. Patients who undergo a procedure without any anesthesia or under local/topical infiltration anesthesia may be discharged under their own care.

3. Human Resource Development

a. Orientation

The orientation of new staff throughout the Division is organized by the Clinical Nurse Specialist in collaboration with nursing management, according to the unit of hire. The specific content of the orientation is outlined and contained in:

- Unit Orientation Competency Checklist
- Unit Orientation Plan
- Unit Educational Manual and Self-Learning Packets
- Unit Annual Competency Checklist

In addition, a schedule of didactic and clinical experiences will be developed by the CNS and nursing management for the orientee, and will be modified as necessary.

Preceptors are primarily used throughout the initial orientation period to provide continuity for the orientee and support optimal education and training. Additional staff members are assigned as necessary to support the preceptor(s), as necessary. The CNS and ANMs work with the preceptor(s) and orientee to meet specific goals, to resolve issues, and to assure remediation of problems. The initial orientation period varies in length according to experience and demonstrated ability. After the initial phase, the orientee rotates through specific direct and indirect care experiences which impact on identified patient populations and job tasks, as appropriate to the role, and works with a variety of staff involved with the care delivered. All staff members are expected to contribute positively to the growth and development of the orientee throughout the orientation period.

RN orientees will receive a performance appraisal in compliance with Human Resources guidelines. A satisfactory appraisal at the CN2 level must be reached by the end of the sixth month of employment, or by the

end of 12 months pending extension of the orientation period by nursing management.

Float cluster orientation between JDH and FSC will be included in the orientation plan for all RNs and STs. Critical Care Cluster orientation for JDH PACU RNs will include rotation to the ICU for a period of time mutually determined by the orientee, ANM, and the ICU preceptors; recent PACU experience may be substituted for the ICU rotation. JDH RN and ST staff will rotate to Labor and Delivery to orient to the scrub role in C-sections.

The orientation of non-RN staff will follow the general format of the RN staff, with a satisfactory performance appraisal being required only by the end of the probation period.

The orientation of Nurse Pros and Agency Staff is modified from that of new permanent employees, in accordance with applicable Educational Services and Human Resources guidelines. A unit specific orientation competency checklist must be completed, as appropriate. Agency staff are precepted as needed by the general staff and should be functioning independently within a short time frame, as identified by the CNS and nursing management.

Orientation of Medical and Nursing students is facilitated by the Perioperative staff. The CNS may collaborate with the School of Nursing Clinical Instructor to meet specific educational and experiential objectives of those students.

b. Staff Development

Unit decentralized staff development is organized by the Clinical Nurse Specialist in collaboration with the nursing management and the staff of the unit. All educational programs shall be documented and retained on file. All staff members are required to maintain an educational activity record as part of the annual evaluation process. All staff members are encouraged to participate in the presentation of educational programs to their colleagues. Centralized nursing education and development programs are offered through the Department of Patient and Staff Education, including Nursing Grand Rounds

c. Continuing Education

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

d. Support Services Outside the Department of Nursing

Refer to Department 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 Department of Nursing Structure Standards.

2. Nursing

Additional nursing resources can be found in the Clinical Nurse Specialists and Acute Care Nurse Practitioners, who are Master's prepared in a clinical specialty.

### 3. Management

- a. Consultation about management can be obtained from appropriate Administrative officers, members of the NAC, Management Forum and the Department of Staff and Patient Education. Networks have been established with peer groups outside of the Hospital.

### 4. Materials Management

#### a. Equipment

Refer to Department of Nursing Structure Standards.

##### 1. General Equipment

##### 2. Emergency Equipment

- a. Appropriate emergency equipment will be maintained on the perioperative units. This equipment must be checked each shift and will include:

1. code cart: FSC OR, FSC PACU, JDH OR, JDH PACU
2. ECG machine: FSC x 1, JDH Procedures Center, JDH PACU
3. defibrillator - FSC x 1, JDH OR, JDH PACU
4. oxygen tanks - on code carts, wall outlets
5. Ambu bag, O<sub>2</sub> set-up, airways, non-rebreather mask: on code carts, GI procedure rooms
6. Tracheostomy Set - OR
7. OR Emergency Carts - (e.g. open heart bleeder, craniotomy)
8. MH supplies: FSC cart, JDH tackle boxes in OR medication room

#### b. Supplies

Refer to Department of Nursing Structure Standards.

#### c. Linen

Refer to Department of Nursing Structure Standards.

#### d. Product Safety Evaluation

Refer to Department of Nursing Structure Standards.

### 5. Evaluation of Resources

- a. Departmental review is conducted by the Nursing Administrative Council.
- b. Unit review of resources is the responsibility of the Nursing Manager.

### 6. Staff

The Perioperative Staff includes professional and non-professional personnel who deliver direct patient care or indirectly support the delivery of care. Full time employment is considered to be 40 hours per week, except for JDH CSS Aides, who are full time at 37.5 hours.

Refer to Department of Nursing Structure Standards for the following:

- Responsibility for providing adequate staff
- Administrative staffing
- Master staffing
- Unit staffing
- Delivery of care methodology
- Shift assignments
- Scheduling responsibilities and general scheduling practices

#### 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

###### a. Minimum Staffing Requirements

If staffing levels are determined to be inadequate, each unit will be assessed to determine availability of staff to cross-cover or the need to change the starting time for staff assigned to subsequent shifts. If this is not viable, the Administrative Manager is contacted regarding availability of staff to float interdepartmentally or between the FSC and JDH locations, in accordance with contractual obligations. Overtime may be utilized according to bargaining unit contracts.

###### b. JDH Procedure Center

Staff RNs and MAs are hired for day rotating positions. Shifts are set to coincide with patient volume, beginning at 6:15 a.m. (7:00 a.m. Wednesdays). The unit is open into the early evening hours to accommodate waiting families.

###### c. JDH Operating Room

OR staff members are generally hired for day-rotation and provide coverage for the Operating Room 24/7. This includes various shift assignments and on-call coverage. The shifts to be covered include day shift: 7:00 a.m. - 3:30 p.m., relief shift: 9:30a - 6:00p, evening shift: 3:00 - 11:30p, and night shift: 11:15p - 7:15a. Depending on availability, some 10-hr shifts are available. All other shifts are 8 hours, according to union contracts. On-call coverage means that the staff member is ready for duty within 30 minutes of being called.

Staff are assigned to the 9:30a - 6:00p relief shift approximately once per week. This frequency may change depending on the staffing needs of the unit. This shift provides break coverage for day shift staff, prepares case carts for the following day's cases, performs assorted duties to maintain proper

work flow on the unit (e.g. cart and temperature checks), and provides permanent relief for day shift staff at 3:00p.m. To facilitate providing breaks, STs assigned to this shift may permanently replace an RN in the scrub role. Other duties may be assigned as designated by the charge nurse. When staff orient to the relief shift, they are counted in the regular staffing pattern.

RN staff cover off shifts as needed, depending on the staffing needs of the unit. Charge designation is made on the posted schedule. When new staff orient to evenings, it is in addition to the minimum staffing level.

STs are responsible to cover night shifts; RNs are assigned night call (OCN). A permanent ST covers Sunday through Thursday nights, and the remaining STs who do not take cardiac call rotate to cover Friday and Saturday evenings. STs receive a night shift assignment approximately once each month. When the permanent night ST has vacation scheduled, the ST hired most recently and who is not a member of the cardiac team is obligated to cover the shift(s). If the permanent ST calls out sick or has any other non-scheduled absence, coverage may be either in-house or as a second on-call person, at the Director, Perioperative Services or designee's discretion. When new staff orient to nights, it is in addition to the minimum staffing level.

Weekends are staffed with two staff members on duty on day shift, and one staff member on evenings with another person on call (OCE) and the ST on nights. RNs cover the evening shift in house. Frequency of weekend assignment for day and evening shifts is about once per month or a full two-day assignment every other month. This frequency may change depending on the staffing needs of the unit. When new staff orient to weekends, it is in addition to the minimum staffing level.

Ten to twelve staff members belong to the cardiac team, pending availability of positions. The cardiac team includes RNs and STs, who provide coverage weekdays 3:30p - 7:00a and the entire weekend year round, including holidays. Members of the cardiac team are not assigned any other call and do not rotate coverage of weekends, evenings, or night shifts.

A Laser Operator course is held for new employees in both ORs and is taught by the Health Center's Laser Safety Officer. Time spent in class in excess of regular duty hours is compensated monetarily.

d. JDH PACU:

Staff RNs and MAs are hired for day rotating positions. Shifts are set to coincide with patient volume, beginning at 7:00 a.m. and ending at 11:30 p.m. Nights and weekends are staffed by two on-call RNs; additional staff may be recruited to cover unusual patient volume/acuity.

e. GI Endoscopy

Staff RNs and MAs are hired for day rotating positions. Shifts are set to coincide with patient volume, beginning at 7:00 a.m. and ending at 4:30 p.m.

f. FSC PACU (preoperative/postoperative)

Staff RNs and MAs are hired for day rotating positions. Shifts are set to coincide with patient volume, beginning at 6:00 a.m. and ending at 7:00 p.m. Additional staff may be recruited to cover unusual patient volume/acuity.

g. FSC OR

OR RNs are hired for 10-hour day-rotations of 6:30am - 5:00pm through 7:00 a.m. - 5:30 p.m. OR STs are hired for 8 hour day shift rotations of 7:00am - 3:30pm through 9:00am - 5:30pm.

h. JDH On-Call Coverage

All staff assigned to call must be available by phone or beeper for immediate access and for duty within 30 minutes of being called. Beepers may be signed out. Changes from originally assigned schedule must be communicated to the Health Center operator and Nursing Staffing office by staff generating the change. Persons living outside the 30 minute radius must make arrangements to be available within this time frame. Call shortages resulting from sickness will be filled by volunteers, preferentially, or per union agreement.

i. Urgent, Emergent and Off-shift Staffing

The JDH OR staff must notify the Administrative Manager at the start of emergency cases on nights, weekends, and holidays so that JDH PACU staff may be alerted to a case in progress; the OR must re-alert the Administrative Manager approximately 30 minutes prior to the completion of surgery for Postoperative staff to arrive. Alternate communication between OR and PACU staff must be by mutual consent.

5. Scheduling

a. Responsibility

Refer to Department of Nursing Structure Standards.

b. General Scheduling Practice

Staffing patterns are projected to match block time allocations and projected patient volume in all perioperative areas.

D. EMPLOYMENT

Refer to Department of Nursing Structure Standards.

E. PERFORMANCE IMPROVEMENT

Refer to Department of Nursing Structure Standards.

IV. NURSING PROFESSIONAL PRACTICE

A. NURSING PROCESS

The nursing process is used throughout the perioperative phase, from preoperative visits and admission through inpatient transfer/discharge and post-discharge follow-up phone calls.

1. Assessment (Supplement to Department of Nursing Structure Standards).

- a. Each electively scheduled patient is assessed by a registered nurse prior to the day of the procedure and upon admission to the preoperative area.

Patients scheduled urgently during hours when the preoperative area is staffed will be assessed by an RN, while emergent cases will be transferred directly into the OR, pending availability. This initial admission assessment by the preanesthesia is documented in the electronic nursing record under Preadmissions and Holding clinical modules, respectively.

- b. All patients are assessed prior to or upon transfer into the OR or procedure room, timing dependent on the case status of elective, urgent or emergent. This assessment information is documented in the Nursing Intraop clinical module.
- c. All patients are assessed upon admission to the PACU, prioritizing for airway, breathing and circulation, then a head-to-toe assessment of all systems. This assessment information is documented in the Nursing PACU clinical module.
- d. Ambulatory surgical patients may be assessed and evaluated post-discharge; JDH patients are called the following day; FSC patients receive a follow-up call the next business day due to scheduled closures of the unit. All information, including unsuccessful attempts to reach patients, is documented in the Post DC Nursing module.
- e. All patients have baseline vital signs (VS) documented preoperatively; any subsequent documentation of preoperative VS is patient-specific. Intraoperative VS documented during procedures according to applicable policy (Local/Topical Infiltration Anesthesia [OR] or Moderate Sedation [HAM 08-013]).

Postoperative VS are documented at least q 15 min for the first hour, more frequently as patient condition warrants or per order. Patient condition that would warrant more frequent monitoring of vital signs may include:

- vital signs not within 20% of baseline:
- receiving medications to treatment hypo- or hypertension
- frequent need for pain medications
- significant intraoperative events such as cardiac event or large blood loss

- f. Each patient is re-assessed by a registered nurse every 30 minutes, and more frequently as condition warrants or per order.

## 2. Planning

Refer to Department of Nursing Structure Standards.

## 3. Implementation of Nursing Interventions

Refer to Department of Nursing Structure Standards.

## 4. Evaluation

Review, revision and evaluation of patient care plans are done by the RN and are patient oriented and based on achievement of outcome criteria.

## 5. Documentation/Retention of Records

- a. The John Dempsey Hospital documentation system is devised to reflect the delivery of professional care, nursing process and the status of the patient

on admission, progress through the perioperative/perianesthesia phases, transfer and/or discharge. The perioperative electronic documentation system is continuously revised to reflect best practices, national recommendations, and current regulatory recommendations and requirements. General policies regarding requirements for, frequency of and guidelines for documentation are addressed in NPM.

- b. Evidence of discharge planning will be documented in the patient record for all for ambulatory patients, including but not limited to prescriptions, medication reconciliation, diet, activity, hygiene, pain treatment plan, postoperative follow-up care, and contact information for questions or concerns.

## B. 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 Nurses are authorized to perform all JDH protocols and procedures contained in the Department and Unit-specific Practice Manuals, along with identified procedures from the on-line *Lippincott Manual of Nursing Practice*.

Orientation programs, ongoing educational activities (e.g. BLS certification, mandatory inservices) and completed annual evaluations which include competency checklists ensure that 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. JDH Procedures Center nursing staff do not perform:

- a. Care of ventilated patients
- b. Drawing blood gases
- c. Maintenance of arterial lines, CVP or PA (Swan Ganz) lines
- d. Maintenance of epidural / spinal infusions

### 2. FSC PACU (pre- & postoperative) nursing staff do not perform:

- a. Administration of blood components
- b. Administration of fluids through pumps
- c. Monitoring during moderate sedation
- d. Drawing blood gases

### 3. JDH and FSC OR nursing staff do not perform:

- a. Administration of blood components
- b. Administration of fluids through infusion pumps
- c. Administration of medications through the IV route
- d. Monitoring during moderate sedation
- e. Care of ventilated patients
- f. Drawing blood gases
- g. Maintenance of epidural/spinal infusions

### 4. JDH GI Endoscopy nursing staff do not perform:

- a. Care of ventilated patients

- b. Drawing blood gases
- c. Maintenance of arterial lines, CVP or PA (Swan Ganz) lines
- d. Maintenance of epidural/spinal infusions

5. Bedside testing may be performed by nursing staff as follows:

- a. Glucosemeter - JDH Procedures Center, GI Endoscopy and PACU; FSC PACU (pre- and postoperative)
- b. Hemocue - JDH Procedures Center, GI Endoscopy and PACU
- c. H pylori - JDH GI Endoscopy
- d. Hemocult - JDH GI Endoscopy
- e. IStat - JDH Procedures Center, FSC PACU

Bedside and cognitive testing skills are validated annually.

- b. Telemetry skills and successful completion of the arrhythmia course during initial orientation are required by nursing in JDH Procedures Center, GI Endoscopy, and PACU; and FSC PACU.
- c. Process Improvement occurs through review of processes in all phases of perioperative care. Review mandated by regulatory agencies (e.g., code carts, decentralized lab testing) is done in an ongoing manner; systems improvement review (e.g., chart preparation, turnover times, pain management) is done on a rotating basis, according to identified needs and departmental goals.
- d. Patient and Family Education is a prime focus of the Perioperative Staff. Development and support of materials occurs in collaboration between the nursing and physician staff. Whenever possible, discharge planning is enhanced through appropriate development of these materials.

C. PROFESSIONAL BEHAVIORS

Refer to Department of Nursing Structure Standards.

D. CREDENTIALING

Refer to Department of Nursing Structure Standards.

E. RESEARCH

Refer to Department of Nursing Structure Standards.

F. STANDARDS

Refer to Department of Nursing Structure Standards.

FSC/JDH Perioperative Unit Nursing Standards are reviewed at least triannually by nursing managers and Clinical Nurse Specialist with input from unit staff.

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