LAC+USC MEDICAL CENTER

DEPARTMENT OF NURSING SERVICES

Unit Structure Standards Manual

PROGRESSIVE CARE UNIT

C5F-PCU

Originating Date: 9/2017
Revised: 6/22

DEPARTMENT OF NURSING SERVICES
PROGRESSIVE CARE UNIT – 5F

UNIT STRUCTURE STANDARDS
DEPARTMENTAL APPROVAL

_____ _____
[redacted] Date
Nurse Manager

_____ _____
[redacted] Date
Clinical Nursing Director, Intensive Care Units

_____ _____
[redacted] Date
Medical Director, 5F Progressive Care Unit

_____ _____
[redacted] Date
Attending Staff Association, President

_____ _____
[redacted] Date
Chief Nursing Officer

_____ _____
[redacted] Date
Chief Medical Officer

_____ _____
[redacted] Date
Chief Executive Officer

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I. DESCRIPTION

Ensuring the health and safety of our patients is our top priority focused on providing our patients with outstanding care. 5F Progressive Care Unit is a complement unit of Intensive Care Units, organized and operated to provide specialized intermediate level of care to patients with care needs beyond what the regular medical surgical ward provides; less complex care than the ICU patients but require medical treatment and nursing care for potential physiologically unstable condition. The types of patients on this unit require specialized equipment for continuous cardiac monitoring and staff trained to provide the intermediate level of care and augmented medical and nursing interventions.

The Progressive Care Unit is in the Inpatient Tower on the 5th floor designated 5F. It is comprised of a total of 10 beds, all are single bed private rooms, 4rooms equipped with negative air pressure. The negative pressure rooms are used for patients with airborne infection but may also be used for all types of isolation precautions.

The patient population consists of young adult through the geriatric patient who may require specific assessments and vital signs checked more frequently than every 4 hours. These patients have various medical-surgical diagnoses which may include but not limited to diagnoses such as: moderate congestive heart failure, post cardiac catheterization patients who require admission and close monitoring for 24 hours, low probability myocardial infarction, hemodynamically stable patients with evidence of potential worsening of respiratory insufficiency who require frequent observation or continuous positive airway pressure, hemodynamically stable GI bleeding with minimal orthostatic hypotension; patients in need of electrolyte replacement; drug overdose requiring frequent neurologic, pulmonary or cardiac monitoring. The patient population meets the criteria for lower acuity* than the intensive care patients.

*Aster/ Clairvia ® Patient Classification System is used to define the patient's acuity level for nursing care needs.

Methods Used to Assess Patient Needs

An interdisciplinary approach to patient care management is used to assist the patient in making an educated decision regarding his/her care. Nursing and the Medical Team will collaborate with Dietary, Physical Therapy, Occupational Therapy, Pain Management, and other services deemed necessary to develop an appropriate plan of care. Additional collaboration exists with Social Services, Spiritual Care and Radiology, Epidemiology, home care.

Scope of Service and Complexity of Care

The unit cares for patients for the purpose of supporting patients in varying states of recuperation from cardiac, surgical, or medical interventions that require medical treatment and nursing care for potential physiologically unstable conditions; preventing complications and promoting healing; evaluating and treating specific problems; providing a therapeutic environment: educating patient/family to improve

self – care abilities, health maintenance and rehabilitation; and facilitating discharge or transfer to a medical surgical ward.

II. PURPOSE

The Progressive Care Unit is established for admission of the patients who require intermediate level of care beyond the acute medical-surgical ward and lesser level of care than that of the critical care units with a staffing ratio of 1 nurse to 3 patients. These beds are designated as intermediate level of care beds as approved by the State Department of Public Health. The care of the patients is assumed by the interdisciplinary team collaboratively responsible for the patient and may be assigned to a specific Primary Service Team. The nursing care includes continuous cardiac monitoring, close nurse observation and assessment of all body systems, administration of medications and treatments including intravenous fluid resuscitation and intravenous medication drips such as Heparin, Nitroglycerin, low dose Dopamine, specialized level of nursing care and monitoring. Nursing and medical care are delivered to meet the needs of patients during the acute phase of their illness and recuperation while receiving diagnostic, therapeutic, medical or surgical interventions. The unit also provides patient/family education, information and support during their acute illness or potentially unstable condition to make appropriate health care decisions and to prepare and address patient's discharge planning needs. The 5F Progressive Care Unit is part of LAC+USC Medical Center, a teaching, tertiary care hospital-based facility. The purpose is to service the economically and culturally diverse community of Los Angeles County. The nursing staff of the unit ascribe to the philosophy and goals of the Department of Nursing of the LAC+USC Medical Center.

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III. OBJECTIVES

A. Objectives exist to direct the overall operation of the unit.
B. Developed by the Nurse Manager in collaboration with the Nursing and multidisciplinary team staff and approved by the Clinical Nursing Director, Medical/Surgical Services.
C. They are used to:

i. Orient new staff, pool, registry assigned to the unit to ensure delivery of safe and quality care.

ii. Provide reference for Nursing staff and student affiliations regarding the provision and standards of care of the unit

iii. Support the objectives of the Department of Nursing and LAC+USC Medical Center

D. The long-term objectives are:

i. Administer safe and effective care using a collaborative and multidisciplinary approach to appropriately coordinate the diagnostic procedures, treatment and management of the patient's acute illness.

ii. Support and maintain the physiologic stability of the patients.

iii. Provide an environment conducive to healing through prompt identification of significant changes in patient condition and respond/ initiate interventions to manage any potentially unstable condition.

iv. Provide courteous, respectful, responsive care and communication to the patients and families to meet their patient/family satisfaction and learning needs.

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v. Provide resources and learning experiences for nurses, student nurses and nursing assistants, physicians, physician assistants, and dietary interns.

vi. Utilize the nursing process in the planning and the implementation of intermediate level of nursing care and the evaluation of desired goals and outcomes.

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IV. ADMINISTRATION/ ORGANIZATION OF UNIT

A. Unit Structure Standards

The Unit Structure Standards are reviewed and revised as necessary every 3 years by the Nurse Manager and staff with input from other disciplines. The Clinical Nursing Director and the Medical Director of the Intensive Care Unit Services and executive medical staff and administrative leadership review and approve the revisions.

B. Organizational Chart

The Progressive Care Unit 5F is organized as a nursing unit within the Inpatient Services. Overall management of the unit is the responsibility of the Nurse Manager with supervision, direction, and support by the Clinical Nursing Director, Intensive Care Units or his/her designee. Collaboration with physicians and appropriate department heads takes place periodically through formal and informal meetings. An organizational chart exists to explain these relationships and is reviewed and updated as necessary. The organizational charts are discussed with each new employee during orientation to demonstrate the lines of communication, organization, and accountability. **See Addendum A entitled: "Organizational Chart."**

C. Narrative

A narrative exists to describe and explain the organizational chart. Sec Addendum B entitled: "Organizational Chart Narrative."

D. Policy Statement

1. Nursing Direction

a) 5F Progressive Care Unit Nurse Manager is a Critical Care Nurse with appropriate education, training, experiences, and demonstrates current trend competencies and managerial experience. He/She is selected by Nursing Administration to assume responsibility for the effective organization and management of the complex. The Nurse Manager is responsible for implementing all elements as outlined in the Unit Structure Standards. The Nurse Manager has 24-hour responsibility 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 therein. The Nurse Manager works closely with the Clinical Nursing Director regarding planning, resource allocation including staffing, direction of the unit, development of standards of care, and quality assessments and performance improvement activities and resolution of patient care and staff issues.

The Supervising Staff Nurse (SSN) is a Critical Care Nurse with requisite clinical and supervisory experience. He/She is selected by the Nursing Management to assist the Nurse Manager for the effective organization and management of the unit and the supervision of staff for each shift. They have the responsibility for the safe and effective functioning of the staff, including their development and evaluation, the effective functioning of the complex, and the quality of patient care provided in the setting. A relief charge nurse is
Assigned each shift in the absence of the Supervising Staff Nurse. The relief
charge facilitates communication, coordination, and delivery of patient care.

b) The Nursing Supervisor is a Registered Nurse member of the Nursing Leadership Team who serves as a resource person to the Supervising Staff Nurse providing direction, support and guidance to all units during the evening, night shifts, weekend s and holidays. During the shift, the she/his is also responsible for upholding the Network policies, standards of care and collaborates with the Supervising Staff Nurse or charge nurses to ensure the patient flow and delivery of care are maintained in an effective, safe and appropriate manner. The Nursing Supervisor contributes to staff development and evaluation of the nursing staff and communicates with the Nurse Manager on a regular basis regarding staff performance and any problems concerning unit operation or patient care. Ultimately, the Nurse Manager maintains authority and accountability on a 24-hour basis.

c) The Clinical Nursing Director (CND) of Intensive Care Units provides overall direction, support and guidance to the Nurse Manager and assists in managerial development. The CND is responsible primarily for the planning and development of the service as a subsystem of Patient Care Services. The CND links the Unit Services with the executive level of Patient Care Services.

d) The Clinical Nursing Director meets with the Assistant Nursing Director of Administration (ANDA), the Nurse Managers and along with the Nurse Manager also meets with the nursing staff. The Nurse Managers conducts

regular meetings with the staff on the nursing units. It is expected that decisions will be made in the group at the lowest appropriate level.

e) The Chief Nursing Officer has the overall responsibility for all the Nursing Units' patient care services and is ultimately accountable for the quality of personnel performance and patient care delivered within the Department of Nursing. Responsibilities are delegated to the Nursing Management Team which includes the Clinical Nursing Director of Medical/Surgical Services. The Chief Nursing Officer Links Nursing with Administration and Medicine at the Executive level. He/She is responsible for the growth of the department as a whole and responding to the needs of the institution specifically and the community in general for the provision of care.

f) Unit-based collaborative activities are fostered to facilitate quality patient care. Physicians, Nursing, Clinical Social Worker, Dietitian, Physical Therapist, Respiratory Therapist, Wound Care Nurses, Utilization Review Nurse, Financial Worker, Chaplain, etc. attend meetings and patient care conferences to discuss the treatment and discharge plans for the patients.

g) Staff Meetings

1. The Nurse Manager meets with the staff at least ten times a year. The purpose of the meeting is to keep the staff informed, to resolve problems that impact on patient care and to discuss the implementation of strategic goals of the department. Staff members are encouraged to forward agenda items for discussion and to participate in decision-making process. Minutes with rosters are maintained.
2. All employees are to attend all staff and Quality Improvement (QI) meetings, mandatory meetings and conferences and to sign an attendance roster. In the event of a missed meeting, the employee is to review the material and minutes and sign the roster.

h) The employees are responsible to document all educational activities on the "Educational Activity Record."

i) Employees are responsible to identify his/her own learning needs and submit applications for attendance at continuing education programs. This may include non-Medical Center programs.

j) Professional staff are selected by the Nurse Manager to participate in committees within the Nursing Division, as well as in the Medical Center. These staff members represent the complex and assist with committee objectives and communication of activities.

2. <u>Medical Direction</u>
   a. Medical supervision/administration
      1) The overall medical supervision/administration for the Progressive Care Unit is that of the Unit Medical Director.
      2) The Medical Director is responsible for implementing policies established by the medical staff for the continuous operation of

the Progressive Care Unit, maintaining appropriate standards of medical care, and works with the Office of Graduate Medical Education regarding the credentials and privileges of the medical staff. The Medical Director for the Unit, in consultation with the responsible physician, makes the decision for the disposition of patients when patient demand exceeds the capacity of the unit.

3) The Medical Director of the Progressive Care Unit is responsible to the Chief of Division.

4) In the absence of the Director, a staff physician may be designated to be responsible for the Progressive Care Unit.

b. Physicians

1) Consultation may be obtained by the primary team as appropriate and transfer of primary responsibility for the care of the patient to another service may be arranged as appropriate.

2) Patients may be admitted from the Emergency Room, the Medical-Surgical Wards, from the post procedure areas such as the GI Lab, Cardiac Catheterization Laboratory, the Operating Room or transfers from the PCUs. The scheduled of the assigned medical team is in the Web listing. The medical team schedules outlines the levels of physicians who are responsible for the patient care management including the Attending Physician, Fellow, Resident, Intern, and Nurse Practitioner.

c. Orientation

1) An orientation is conducted by the Unit Medical Director and the Nurse Manager or designee when Interns and Residents first rotate to the unit to review the general operation of the unit, the roles and responsibilities of the team in the patient flow, care processes and communication with Nursing and the multidisciplinary team in the Progressive Care Unit.

2) Specific instructions regarding the unit's admission and discharge criteria and the unit utilization are outlined in the Unit's Structure Standards.

d. Functions and responsibilities

1) The Attending Staff works collaboratively with Nursing and the multidisciplinary team in the following activities:

a) Lead the daily rounds with Progressive Care Unit Medical

and multidisciplinary team and keep communication with the Nursing staff regarding the coordination of the patient's treatment plan and referral need.

b) Provide clinical care, expertise and guidance in the management of progressive care unit patients.
c) Approves discharges and transfers.
d) Participate in educational activities for nursing staff.
e) Meet with the Nurse Manager weekly/more often as as needed to discuss patient care issues and updates in patient care modalities.
f) Participate in unit-based quality assurance/ improvement activities.

3) Resident's role in the Progressive Care Unit
   a) Performs or oversees admission history and physical examinations for submission to the attending physician and submits admission orders.
   b) Develops, implements and communicates the diagnostic and therapeutic plans on all admissions.
   c) Makes rounds at bedside each day with Progressive Care Unit Staff physician.
   d) Provides instruction and supervision to Medical Students assigned to the unit.
   e) Is available to confer with nursing staff regarding patient management issues always when assigned on duty.
   f) May be present at first dose of investigational drugs.
4) Integration of Nursing and Medical Practice
   a. The Physician team members collaborate with the Nursing staff on a regular basis regarding the plan of care, progress, prognosis and discharge plan.
   b. The Nurse Manager meets regularly, through rounds and conferences, with Progressive Care Unit Director and the Unit Medical Director, Social Worker, Dietitian, Pharmacy to discuss patient care needs and issues that may occur in the Progressive Care Unit.
   c. The Nurse Manager is a member of the Critical Care Nurse Manager/Educator Committee to plan and review critical care education issues for the critical care unit and the Progressive Care Unit.

V. HOURS OF OPERATION

The Progressive Care Unit -5F operates th-bed inpatient unit 24-hours, 7 days a week. Staffing is provided to meet the intermediate level of care needs of the patients and adjusted for census changes and acuity levels of the patients in the unit.

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VI. UTILIZATION OF THE UNIT

E. Admission:

i. Admission Privileges:

1. Admission to the Unit is determined by the admitting resident, under the supervision of the Attending Physician. Prioritizing of admission is based on the patient acuity, consultation may be obtained with the Medical Consult physician and/or the Medical Director and is coordinated through the Patient Flow Manager.

ii. Criteria for Admission:

1. Generally, patients considered for admission to the 5F Progressive Care Unit have moderate instability or potentially unstable condition requiring monitoring and intermediate level of medical and nursing care and may

require nursing interventions and or vital signs more frequently than every 4 hours. Patients may be admitted from the Emergency Room, the Medical-Surgical Wards, from the post procedure areas such as the GI Lab, Cardiac Catheterization Laboratory, the Operating Room or transfers from the ICUs. These patients are lower acuity patients than the critically ill ICU patients and may include the following criteria:

	PCU Criteria
Patient Assessment and Monitoring Requirements	• Nursing intervention q 2-4 hours
Physiologic Stability/Criticality (Clinician and nursing judgement may apply here)	• Vital signs and other physical exams • Pulse Oximetry • Continuous cardiac monitoring • Assessments frequency requirement • Neuro checks • Neurovascular checks
Medical Equipment Devices / Protocols	• Alcohol withdrawal requiring IV or IM medications (not continuous drip) • Nasal Bi-valve Positive Airway Pressure (BIPAP) • Continuous cardiac monitoring • Application of high-flow oxygen via Nasal Cannula • Central line /Vas-Cath insertion including Femoral lines. • Thoracentesis • Transesophageal Echocardiogram (TEE). • Cardioversion • Tissue Oximetry (TiO2) w/q 2-hour flap checks
Medical Care Requirements may include	• ABG • Pulse Oximetry • End Tidal CO2 Monitoring • Pericardiocentesis (Pericardial drainage) • Stroke (no sooner than at least 24hrs post Thrombolytic therapy administration (tPA)

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iii. *Process of Admission:*

Patients are admitted in the following ways:

1. Department of Emergency Medicine Admissions: Patients are admitted directly from the Department of Emergency Medicine.
2. Transfer admissions: Patients are admitted from the Medical Surgical Wards, Cardiac Cath Lab, Diagnostic procedural areas, other inpatient areas or from the Intensive Care Units, Transfer orders will accompany the patient upon transfer.

iv. Circumstances of Admission:

1. Notification

a. The Charge Nurse is notified of pending admission through the Patient Flow Manager, Bed Control, and the primary admitting physician.
b. When the patient arrives, the primary admitting Resident is notified.
c. A hand off communication is done from nurse to nurse on the baseline condition of the patient, medications and treatment received and the concurrent double check of IV continuous infusions, drips and medical devices.
d. The transferring ward is responsible for notifying the family of the patient's transfer to this unit. The receiving RN will be notified by the transferring RN if the family has not been reached regarding the patient's transfer.
e. If the patient is incarcerated, the deputy on the jail service will provide continuous supervision and watch the patient during the stay on this unit.
f. Bed Control is notified by the admitting unit of the patient's arrival to the unit through either the computerized ORCHID system or Teletracking system.

2. Nursing Responsibilities
    a. Completion of the Interdisciplinary assessment and discharge planning documentation by the RN within one hour of admission. While non-licensed staff members may assist in the admission of a patient, gather data, and document this information, only the RN can validate the data and complete the initial admission assessment.
    b. Completion of a systems assessment including skin condition, an admission note by the admitting RN during the shift and reassessment a minimum of every four hours according to unit standards.
    c. Notify admitting physician immediately for admission orders.
    d. Initiate all medical admission orders including medication, treatments and alleviation of patient's pain.
    e. Development of an individualized patient care plan based on patient assessments and the implementation of the Standards of Care including pertinent clinical protocols and patient/family education.

    f. Documentation of patient's property and valuables and release of property to immediate family to take home.

v. Unit Capability and Monitoring

1. Patient Monitoring
    a. Circulation –
        i. Non-invasive arterial blood pressure monitoring at a frequency that is clinically appropriate.
        ii. Continuous ECG monitoring as clinically indicated.
    b. Respiration

i. Respiratory function will be assessed at frequent and clinically appropriate intervals by observation, supported by capnography and blood gas analysis (when ordered).

c. Oxygenation
   i. Oxygenation will be assessed continuously via pulse oximetry and blood gas analysis (when ordered).

2. Equipment for Monitoring the Patient
   a. Electrocardiograph- capacity to monitor and continuously display the ECG
   b. Temperature – capacity to monitor bladder and cutaneous temperature.
   c. Pulse oximeter- continuously SpO2.
   d. End tidal CO2 monitor - capnography monitoring will be available when ordered
   e. Non-invasive arterial pressure monitoring
   f. Point of Care Testing equipment
   g. Central monitoring station

vi. Limitations of Area

1. The unit is limited to two negative pressure isolation rooms.

2. Staffing/Acuity*: Based on approval of program flexibility, the unit will maintain the Evalysis® Patient Classification System for the lower acuity intermediate level of care patients.

3. Age Limitations: The unit will admit adult, geriatric, and adolescent patients.

4. Patients who are hemodynamically unstable, medically complex patients requiring higher level intensive care will not be admitted to the Progressive Care Unit. These include patients who require acute ventilatory support for respiratory failure, hemodynamic management with PCU approved intravenous vasoactive medications, patients who need invasive hemodynamic monitoring with arterial lines and Pulmonary Artery Catheters: acute myocardial infarction, patients needing cardiac circulatory assistive devices such as Intra-aortic balloon pump, Impella or Cardio-Help and patients who need complex critical care management due to multi-systems failure. These types of patients will be transferred to an Intensive Care Unit for appropriate level of care.

vii. Demand for Beds Beyond Capacity

1. The unit will follow the Surge Plan to expedite admission and discharges based on the status of the Emergency department and the hospital available capacity

2. The Critical Care Medical Director along with the Service physician or his/her designee determines which patients may be transferred in the event of conflict over available bed space.
3. The Patient Flow Manager will coordinate the bed assignment, for admission and transfer with the unit charge nurse and Bed Control to make a bed available.

F. Duration of Stay
   i. Generally, length of stay is determined by the patient's physiological stability and whether cardiac and frequent nurse monitoring and intermediate level of care are still required as determined by the primary physician and the nursing staff.
   ii. Patient's length of stay should be consistent with the average stay for intermediate level of care patients with similar conditions and acuity levels. The primary physician and the nursing staff maintain quality care and evaluate whether patient no longer meets the criteria for stay in the Progressive Care Unit so that the patient can be transferred to the ward or discharged as early as possible.
   iii. All available resources should be used to facilitate a timely transfer and discharge: for example, the charge nurse coordinates patient rounds with the physician and the communication between the physician and the family.
   iv. The Utilization Review Committee receives notification from Utilization Review Nurse of all patients with extended lengths of stay. Periodic care conferences are utilized to determine priorities for these patients and plan their care accordingly
   v. The patient care team and primary nurse review the patient's length of stay and physician will document the justification for the patient's extended length of stay in the Progressive Care Unit on patient's medical record in Electronic Health Record (EHR).

G. Pre /Post Procedural or Pre/Post-Operative Care of Patients.
   i. All patients receive pre/ post procedural or pre/post-operative teachings relevant to the type of procedure or surgery scheduled.
   ii. All patients with special devices/equipment are assessed according to established clinical protocols.

H. Transfers/Discharges
   i. Transfers
      1. Patients may be transferred to the medical surgical unit when the patient's status no longer requires cardiac and close monitoring and potential instability has resolved.
      2. Two types of transfers exist:
         a. Out of the facility: This transfer occurs when the patient needs long-term care/rehabilitation therapy or when patient/family requests transfer to another facility and condition is stable and permits safe transfer of patients

and a medical physician accepts the transfer. Upon concurrence of the accepting physician, report is given by the responsible RN and the transfer occurs.

b. Within the Facility: Transfer to the ward may occur when the patient's condition no longer requires monitoring but still requires hospitalization. Transfer to the PCU occurs when the patient condition deteriorates to an actual or potential life-threatening emergency and requires intensive care management.

3. Criteria for Discharge/Transfer to the Ward.
   a. Discharge/Downgrade Criteria:
      i. Stable vital signs and stable cardiac rhythm.
      ii. Stable arterial blood gas levels (PaO2 >60 mmHg on room air or supplemental O2.
      iii. No special IV drug infusions that cannot be managed on the med-surg ward.
      iv. No signs of hemorrhage in 24 hours.
      v. Patient no longer requires cardiac monitoring and frequent vital sign.
4. Criteria for Transfer to ICU:
   i. Patient condition deteriorated to a level requiring intensive care; meets ICU admission criteria.
   ii. Acute change in condition requiring continuing advanced life support measures.
5. Procedure:
   i. Patient Flow Manager is notified for need for ICU bed for higher level of care needs and for pending transfers out from the Progressive Care Unit.
   ii. Bed control is notified of pending ward transfer and provides available bed location.
   iii. Transfer orders are written by the primary team.
   iv. The transferring RN contacts the receiving ward and gives a verbal report to the accepting RN.
   v. The staff notifies the patient's family/significant other of the pending transfer.
   vi. A staff member accompanies the patient to the receiving unit.

ii. Discharges:
1. A Discharge Lounge exists to facilitate the availability of beds in the unit for admission. (See Addendum H), "Discharge Lounge" for detail.
   a. Discharge planning begins on the day of admission.
   b. Patients may be discharged when they no longer require hospitalization.
   c. Multidisciplinary discharge rounds are conducted weekly to determine discharge status of patients on the unit.

d. Patients are assessed daily by the primary physician and RN to determine discharge status.
e. Patients may be discharged from the unit on written order or approval of the primary team.
f. Final decisions regarding the discharge of every patient remains the responsibility of the Attending Physician.
g. Patient discharge documentations are completed by both the primary resident and RN.
h. To facilitate the discharge process, it is the unit's goal to have the discharge documentation and prescriptions written the night before and provide needed discharge instructions.
i. Clinic appointments are ordered by primary provider and included in the discharge instructions. Clinic appointments are reviewed by RN and or the unit's intermediate clerk.

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VII. GOVERNING RULES

I. General Safety Issues

i. Code Blue Team

1. In the event a patient experiences a cardiopulmonary or respiratory arrest within the Medical Center the Code Blue Team may be utilized to assist in the patient's management. The ICU Nurse carries a Code Blue Pager as designated and responds to the Code Blue. (See Nursing Policy #925: Resuscitation/ Code Blue Team /Emergency Response for details).

ii. CPR Cart/Emergency Equipment

1. The Progressive Care Unit maintains emergency resuscitation (CPR) cart that is always kept inside the unit. (See binder on emergency resuscitation cart for inventory details).
2. Additional equipment in the /PCU-CPR cart:
    a. Defibrillator with external pacemaker capability
    b. Tracheostomy and Chest Tube Insertion Trays
    c. Pleur-evac and Chest Tubes: 28fr, 32fr
    d. Fingertip Pulse Oximeter
3. The outside contents of the cart are checked each shift and the results are recorded on the "Equipment Log Sheet" which is stored on the cart. The used CPR cart will be replaced by Clinical Equipment.
4. The CPR cart is secured with a disposable numbered lock.

iii. Electrical Safety and Preventive Maintenance

1. The Maintenance & Power and Clinical Engineering departments maintain patient care equipment to ensure compliance with codes and standards. (See Nursing Policy #601: Electrical Safety and Preventive Maintenance Activities for further details).
2. These departments maintain documentation for safety checks.
3. When equipment is not working, it is labeled "out of order" taken out of service and reported to the Maintenance & Power department.
4. The Nurse Manager is ultimately responsible to ensure that broken or malfunctioning equipment is replaced and/or repaired.

iv. Fire/Disaster

1. The Progressive Care Unit adhere to the Fire and Disaster Plans, Emergency Preparedness Training, and participate in monthly mandatory safety classes and bi -annual fire/safety and disaster drills as outlined in the following Nursing Policies:
    a. #610: Emergency Preparedness: Fire, Evacuation, Threat, Disaster, Earthquake, Hazardous Spills, Oxygen Shut Off
    b. #512: Mandatory Training- Continuing Education Programs.
2. Fire Extinguishers and other safety equipment are in the unit environment as outlined in the Unit Floor Plan.

v. Illness/ injury Prevention

a. Progressive Care Unit follow the Medical Center's Illness and Injury And Prevention Program. Special emphasis i s placed on the prevention of needle stick injuries, Hazardous Drug/Chemotherapy Administration and

I. General Safety Issues (cont.)

Management, and Radiation Safety. (See Infection Control Manual for further details).

b. All employees must be aware of situations that are hazardous or potentially hazardous and, if unable to correct them, must report those situations to their Nurse Manager or Nursing Supervisor

i. MSDS: The Material Safety Data Sheets are in the Medical Center's intranet system and in a binder in the unit with specific substance information in the event an employee ingests, inhales, absorbs through the skin or eyes or otherwise comes in contact with a hazardous substance.

ii. Industrial Accidents (IA): In the event an illness or injury occurs to the employee as a result of the work environment, there is a procedure for completing IA forms. See Network Policy Manual for further details.

J. Infection Control Mechanisms

i. The Progressive Care Unit adheres to the infection control measures outlined in the LAC+USC Medical Center Infection Control Manual Universal Precautions are utilized for all direct patient care.

ii. For specific infection control guidelines for the Progressive Care Unit please see Network Infection Control Plan.

iii. Personal protective safety equipment is kept in the Progressive Care Unit and is always available for the unit. The protective equipment must be worn whenever there is a risk of contact with blood or bodily fluids. This equipment includes:

a. protective eye, ear and face shields
b. Isolation gowns
c. Gloves and masks
d. Hats and shoe covers

See LAC+USC Medical Center relevant Policies and Procedures

- **HAND HYGIENE POLICY # MC1201**
- **AIRBORNE TRANSMISSIBLE DISEASE POLICY # IC-11**
- **REPORTABLE DISEASES AND CONDITIONS TITLE17**

K. Patient Care Issues

i. Patient Bill of Rights/Privacy/ Health Insurance Portability and Accountability Act of 1996 (HIPAA) Confidentiality

1. The Patient Bill of Rights is posted on each unit and is developed using a multidisciplinary perspective.
2. Staff must protect the patient's right to privacy and abide by HIPAA regulations by keeping all records and patient information confidential. (5036: all computers must be logged out when not in immediate use).
3. Release of information is given only with the patient's, guardian, court order or other HIPAA approval process.
4. Requests for patient chart information / copies are referred to the Department of Health Information.
5. See LAC+USC Medical Center relevant Policies and Procedures
   - **PROTECTED HEALTH INFORMATION (PHI): MC203.7**

ii. Consents

See LAC+USC Medical Center relevant Policies and Procedures

- **CONSENT FOR CARE # MC205**
- **INFORMED CONSENT TO BLOOD TRANSFUSION # MC236-B**

iii. *Legal authorization must be obtained from the patient or the patient's authorized representative prior to performing treatments, specialty procedures, blood transfusions, or operations. The consent is a legal document and must be dated, signed and witnessed. Consent forms generally authorize the facility to assist the physician in the provision of medical treatment or services.

iv. Patients in Custody

1. See Medical Center Policy

- **PATIENTS IN CUSTODY OF LAW ENFORCEMENT AGENCY #MC182**

v. Transporting Patients

1. The Progressive Care Unit comply with the Medical Center's transport guidelines as recorded in the Nursing Policy Manual. These guidelines maintain that the level of nursing care during transport of patients is determined by the patient's condition. Comparable care shall be provided during transport.
2. Patients who arrive to the unit post general anesthesia (e.g. from Neuro-interventional Radiology) shall be accompanied by the certified nurse anesthetist (CRNA) or anesthesiologist. Pre-and post-treatment vital signs shall he documented in the patient's medical record. Baseline changes during transport shall also be documented
3. See relevant Nursing Clinical Standard:

- **TRANSPORT FOR CRITICALLY ILL PATIENTS #NCP704**

vi. Patient Education

1. Patient teaching is designed to provide information and skills to support recovery from illness and return to function and participation in health care decisions.
2. The RN is responsible for initiating patient education including assessment, planning, and implementation and may delegate selected components of patient teaching to other patient care personnel.
3. Patient Teaching Protocols are interdisciplinary. The RN initiates the protocol and notifies the physician of protocol activation.
4. If the patient is not capable of understanding or following instructions, the caregiver shall be provided with instruction.
5. Patient teaching not included in the Patient Teaching Protocol is documented on the Nursing Record.
6. See Department of Nursing Services Policy

- **PATIENT TEACHING # NUR1000**

vii. Guidelines for Visiting

1. Access to Patient Care Areas
    a. All individuals entering the hospital are screened by security staff. Individuals are identified as either visitors or employees.
    b. Visitors are directed to the appropriate area for issuance of an armband PRIOR to accessing the unit in accordance with the visiting policy.
    c. Visitors are not permitted to access restricted areas.
    d. Individuals on patient care units without an appropriate pass are directed to obtain one.
    e. Medical Center Safety Police are available to help maintain a safe environment.
2. Unit Visiting Policy
    a. The visiting hours in the Progressive Care Unit is every hour, with some flexibility provided as warranted. Two people may visit at one time.
    b. The Unit Clerk monitors the visitor flow and enforces the unit's visiting policy.
    c. The nursing staff on the unit may adjust the patient visitation as requested by the patient or as warranted by the patient's condition or emergency activity on the unit.
    d. In the absence of the Nurse Manager or Assistant Nurse Manager, visitor concerns should be directed to the Nursing Supervisor. Medical Center Safety Police are available to assist as necessary.
    e. Visitors may be allowed to stay with patients under special circumstances as determined by the unit's nursing management team. Special circumstances include, but are not limited to:
        - Pediatric or adolescent patient
        - Comfort care patients
        - Patients with unique language barriers
        - Agitated patients calmed by visitor's presence
        - Mentally disabled patients

L. Support Services

i. The unit has ready access to emergency and routine laboratory services, diagnostic radiology, blood bank, pharmacy and pulmonary support on a 24-hour basis.

ii. Progressive Care Unit patients have access to portable bedside x -rays, approved procedures, hemodialysis and plasmapheresis.

iii. The following services are offered in Progressive Care Unit:

i. Respiratory Care: upon written orders of the physician, the respiratory care practitioner sets up and adjusts all components of Hi flow, BiPAP or any respiratory equipment, administer respiratory related medications and obtain ABG when ordered.

ii. Pharmacy: consult ·with staff regarding medication therapy, dosing, administration and the therapeutic effectiveness.

iii. Pharmacists detect and prevent possible adverse drug reactions and drug incompatibilities.
iv. Food and Nutrition: Dietitians perform nutritional screening assessments on all patients within three days, including those receiving enteral or parenteral nutrition or as ordered.
v. Clinical Social Work provide necessary services to patients and families, these services include:
    1. Ongoing emotional support to aid patients who are gravely ill and their families
    2. Intervention with patient problems
    3. Participation in multidisciplinary team meetings including discharge rounds and end of life discussions
    4. Counseling of staff with respect to end of life issues.
vi. Spiritual Care: spiritual support is offered through our chaplain's service.
vii. ORCHID: The Enterprise Help Desk staff offers technical support for the Progressive Care Unit's computerized charting and is available to facilitate analytical data retrieval.
viii. Other Services: Many other support services such as Facilities management Volunteers office may be utilized and are referred to in the GSS.

M. Ethical Issues

Guidelines for Professional Ethics exist.

Patients, healthcare workers, and visitors may contact the Ethics Resource Committee (ERC) or the Fetus, Infant, Child Ethics Committee 24- hours, seven days per week to address specific questions regarding ethical issues.

i. Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients:
    1. Refer to Attending Staff Manual
ii. Organ / Tissue Donation: California law requires that whenever possible, the patient's wish to donate organs and/or tissue is honored and that hospitals establish protocols to identify potential candidates. Refer to Medical Center Policy #232 for more information.
    1. All deaths and all "imminent" brain deaths must be reported to the regional organ procurement organization, One Legacy. They will provide us with a death confirmation number, which is recorded in ORCHID and becomes part of the legal medical record
    2. The staff of One Legacy will review patients charts and clarify appropriateness for organ/tissue donation.
    3. If the patient is a potential donor, One Legacy's staff will approach the family/significant other after receiving approval from nursing or medical staff to do so. It is imperative that organ/tissue donation not be discussed by the medical staff prior to declaration of death, in the absence of questions by the

caregivers/guardians. Ample "decoupling" time must be permitted from the notification of death and the discussion of organ/tissue donation.

4. If the family consents to donation, the staff of One Legacy assumes medical management of the donor after declaration of death.

N. Medication Guidelines

Refer to Nursing Policy Manual for detailed policy information.

- The Progressive Care Unit utilizes the Pyxis System for Medication access.

See Department of Nursing Services Policy

- **GENERAL MEDICATION POLICIES # NUR900 FOR DETAILS.**
- **MEDICATION USE #MC900**
- **PYXIS SYSTEM ACCESS AND RESPONSIBILITY#923**

O. Event Notification

A Safety Intelligence (SI) report will be completed by the accountable nurse whenever any of the following events occur:

1. Unusual occurrences (e.g. unexpected cardiopulmonary arrest)
2. A patient or visitor sustains an injury.
3. A patient or his/her relative seems unhappy about the treatment or results of a treatment.
4. A negative outcome occurs or is anticipated, regardless of whether the treatment has been effective or ineffective.
5. A therapeutic mishap occurs.
    a. The SI report shall be completed, and the Nurse Manager notified promptly. The SI report will be reviewed by Risk Management department as soon as possible.
    b. **Critical Sentinel Events:** Incidents resulting in the severe injury or death of a patient or non–patient shall be reported immediately by calling Risk Management, anytime, twenty-four hours a day, seven days per week. The SI report shall be completed and reported as above.

See Medical Center Policy

- **EVENT NOTIFICATION GUIDELINES# MC300**

i. Research Studies:

See Nursing Policy

- **RESEARCH AND INVESTIGATIONAL DRUGS # NUR912**

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VIII. UTILIZATION OF STAFF

A. Staffing

ii. The Progressive Care Unit is staffed with licensed and non-licensed nursing staff.

iii. A pattern exists which is, in compliance with departmental and regulatory agency requirements. See Nursing Policy #515 for details.

1. Both licensed and non-licensed nursing staff work together to deliver safe and effective patient care.
2. Licensed staff includes Registered Nurses; non-licensed staff includes Nursing Attendants and Intermediate Clerks.
3. All non-licensed nursing staff function require the supervision and direction of the RN.
4. All RN must be competent in providing advanced life support and undertake refresher training annually. All RNs responsible for direct patient care in the PCU should be a critical care nurse.
5. The RN assumes accountability for the delivery of patient care.

B. Delivery of Care Methodology

iv. Method

1. The method of patient care delivery in the Progressive Care Unit is total patient care by an RN responsible for performing all aspects of the nursing process, including:
    a. Assessment
    b. Development of a plan of care
    c. Performance of patient care tasks
    d. Evaluation of the effectiveness of both medical and nursing interventions
    e. Implementation of standards of care and appropriate protocols
    f. Teaching patient and family
    g. Interaction with the health care team to achieve the goal of care

v. Assignment

1. Nurses will be assigned to patients based on:
    a. Patient acuity
    b. Nurse's capability
    c. Individual workload required for care
    d. Staff learning needs
    e. Continuity of care
    f. Physical layout of the unit
    g. Infection control measures
2. Daily Assignment Sheet
    a. The daily assignment sheet contains the ward number, date, shift, Registered Nurse in charge during that shift, and the name of the nurse manager. In addition, all staff are listed by first initial and last name, along with their category. Specific room and bed number assignments are indicated, as are break times and any special assignment such as narcotic keys, CPR cart check. Each patient's name is listed on the daily assignment sheet. The management team maintains these records.

vi. Charge Nurse:

a. The Supervising Staff Nurse (SSN) is the Charge Nurse for her/his specific shift. In the absence of the SSN, the Nurse Manager/designee assigns a "relief" charge nurse.
b. The following are responsibilities of the nurse in charge:

i. Makes appropriate assignments for:
   1. Patient care
   2. CPR Cart check
   3. Data collection: e.g. acuity/restraints/holds/ audits
   4. Narcotics inventories.

c. Coordinates staff activity during emergency situations.
d. Coordinates patient activity, admissions, transfers and discharges with the healthcare team including Patient Flow Manager/Bed Control.
e. Communicates with the Nurse Manager or Nursing Supervisor regarding unresolved staffing issues.
f. Arranges an orientation to the environment for nurses unfamiliar with the unit: e.g. staff reassigned from another ICU/PCU, pool, registry, and students. (See Addendum E "Unit Orientation" for details).
g. The relief charge nurse/ designee will supervise the care delivered to ensure standards are met.
   i. Nursing Students work under direct supervision of their Clinical Instructor in conjunction with the primary nurse assigned to the specific patient.

C. Preparation of Staff

vii. Hiring Process
   1. The Nursing Resource Center pre-screens, tests, and refers suitable candidates to the Nurse Manager for interview. The Nurse Manager hires candidates based on qualifications, experience, and current vacancies.

viii. Orientation
   1. All new staff completes an orientation process. Orientation is provided by the Office of Human Resources, Education and Consulting Services at the Medical Center, and the unit (See Addendum E "Unit Orientation").
   2. Evidence of completion of orientation is documented and is placed in the employee's area file.
   3. Orientation is individualized, and additional time is provided as needed at the unit level.

ix. Training
   1. Each RN must successfully complete the Core Critical Care Program (CCCP). Participation in the program may be waived at the Nurse Manager's discretion based on the RNs previous work experience and training.
   2. All Progressive Care Unit nurses must demonstrate clinical competency.
   3. All PCU RNs will complete a Unit specific-ICU Standards based checklist as part of the CCCP. (See ADDENDUM O) "Unit specific-ICU Standards based Checklist"
   4. Nurses who do not successfully complete the program may be reassigned to a ward level of care for additional preparation/training based on their individualized

   learning needs. This decision is to the discretion of the Nurse Manager and Clinical Nursing Director.

x. Continuing Education / Training

1. Continuing education activities are provided at the Medical Center both on a hospital-wide and unit-based level.
2. The educational activities are based on routine and new responsibilities of nursing staff identified learning needs, and data obtained from patient care review activities.
3. Identified needs are shared with the Education and Consulting Services Department (EDCOS), for the development and meeting the educational needs.
4. Ongoing in-services and educational needs may also be provided by the ICU nursing department's Clinical Educators.
5. Staff attends all mandatory events dealing with the following issues:
    a. CPR
    b. Safety: including general fire, and disaster review
    c. Infection control review
    d. Family abuse
6. Education rosters are maintained for the Progressive Care Unit: additionally, each staff member maintains his/her own record. The records are reviewed annually during the employee's evaluation. Participation in educational activities is an important part of the employees' appraisal process as well as the Progressive Care Unit's Quality Assurance/Improvement Program.

7. All Progressive Care Unit nurses are assessed on an annual basis for clinical competency. **See Addendum P "Annual Validation of Standards Based Practice".**

8. All staff is encouraged to participate in identifying learning needs through surveys, questionnaires, and suggestions for continuing education events.

xi. Credentials

1. A Basic Arrhythmia Certificate must be obtained during the Core Critical Core Program.
2. Certification of completion of Core Critical Care Program.

3 Advance Cardiac Life Support (ACLS) certification for all nurses in the PCU

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IX. NURSING RESPONSIBILITIES

The Unit Structure Standards are reviewed and revised as necessary every 3 years by the Nursing Management Team. The Director of Medical I Surgical Services for Medical Center, Administrator and Department Chair reviews and approves the revisions.

See Addendum G Entitled: "Performance Standards."

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X. QUALITY ASSURANCE/IMPROVEMENT

A. The nursing staff participate in the Department of Nursing Quality Assurance/ Improvement Program through LAC+USC Medical Center.
B. LAC+USC Quality Improvement (QI) Department runs a Quality Academy Program, the goal is:
    a. Develop leaders using QI strategies
    b. Promote a learning culture of quality and safety
    c. Provide tools to engage the voice of the customer to improve the patient experience
    d. Engage staff in quality efforts at all levels in organization

C. Quality Assurance/Improvement information is disseminated and discussed with staff at least six times per year in staff meetings.

For more information see LAC+USC Quality Improvement

Quality Control Indicators

- Central Line Associated Blood Stream Infection
- Hand Hygiene
- Pressure Ulcer Prevention and Management
- Blood transfusion monitoring
- Pain
- Patient/Family Teaching.
- Patient Falls

Recognized Standards

Care is provided consistent with applicable regulatory and professional standards inclusive of but not limited to the California Board of Registered Nursing, the American Association of Critical Care Nurses, Occupational Safety and Health Administration (OSHA), Joint Commission, Title 22, the American Nurse Association. The FDA, the American Medical Association, the American College of Cardiology and the American College of Medicine

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ADDENDA

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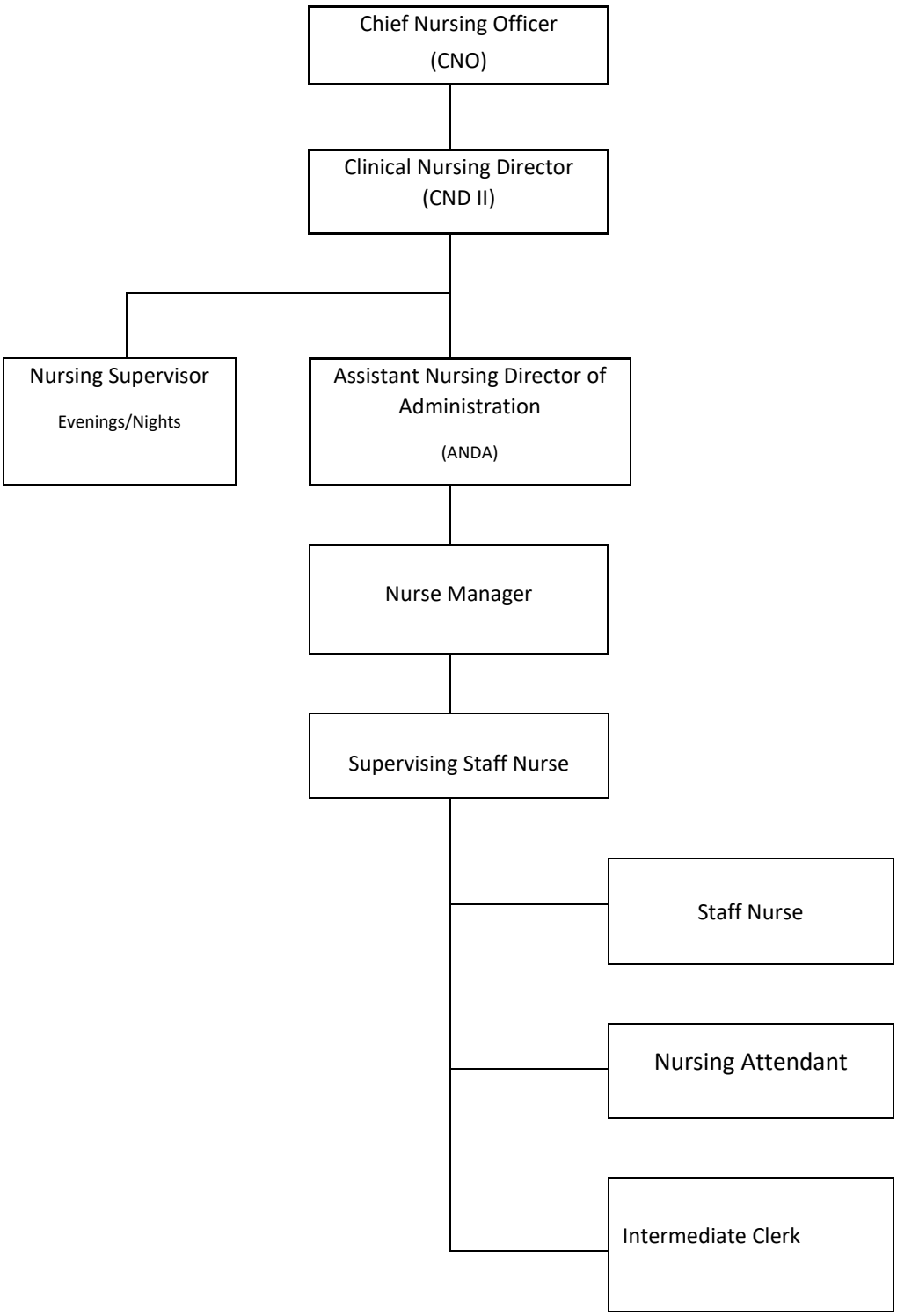
ADDENDUM (A)
ORGANIZATIONAL CHART



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ADDENDUM B
ORGANIZATIONAL CHART NARRATIVE

The Nurse Manager is responsible for the daily operation of the Nursing Unit and for daily coordination and collaboration with the medical staff as well as with other Department Heads and the Nursing Service Administration. The position carries the authority to identify and work towards the resolution of problems affecting her/his unit both directly and indirectly in all clinical and managerial areas. Her/his authority is both informal within her peer group for analysis and decision-making and formal through interaction with the Director, Medical/Surgical Services and other members of the Nursing Management Team.

Further, the Nurse Manager is responsible for implementing all the elements outlined in the Nurse Manager's job description as well as performance standards. Her/His focus is the direction and development of the Progressive Care Unit through standards and appropriate participative supervisory methods and the maintenance of effectively running nursing units. Her/his overall goal of optimum patient care is achieved through adhering to Title 22 and Joint Commission Standards. He/She works closely with the Director of Medical/Surgical Services in the creative resolution of issues, development of standards and quality assurance activities.

The nursing staff consists of both professional and non-professional staff members. Professional staff will always be on the unit in sufficient numbers to assume responsibility for directing, planning, and evaluating patient care using the nursing process. All patients on the unit are assigned to Critical Care Nurse staff and are assigned responsibility for the non-professional staff members consisting of Nursing Attendants and Intermediate Clerks. There is a Charge Nurse designated for each shift (CCN). RNs have total patient care assignments and are responsible for both the continuity and quality of care delivered to their patients. All staff are expected to actively participate in the affairs of the unit such as unit goal achievement, standards development and implementation, and quality assurance activities.

The Nurse Manager reports directly to the Clinical Nursing Director of Intensive Care Unit Services who in turn reports directly to the Director of Medical/Surgical Services. The Director of Medical/Surgical Services reports to the Director of Patient Care Services. The Clinical Nursing Director, (Intensive Care Units)is responsible for the supervision and development of the Nurse Manager and serves as a resource person and role model while assisting the Nurse Manager in the dissemination of communication, establishment and implementation of unit/department objective, unit policy and standards, and staff development.

The Progressive Care Unit nurses work collaboratively with Nursing Leadership to identify training and educational needs for the unit. There are identified clinical preceptors responsible for bedside education working collaboratively with Educational Consulting services to facilitate the orientation and training of new staff members.

The Nursing Office Supervisor functions in a line position on the alternate shifts (evenings and nights) as a supervisor for staff' and patient care as well as an administrative support and resource person to

assigned units. Her/his responsibilities focus on ongoing implementation of' nursing service, hospital, and unit standards, identification and communication of problems and participation in resolution methods. Both the Clinical Nursing Director and the Nurse Manager are in a collaborative role with the Medical Director and Attending physicians from various services. Both members of the nursing administrative team are expected to maintain open lines of communication and high level working relationship with these designated physician leaders to ensure safe and quality care to the patients in the Progressive Care Unit and to address any areas of concern and need for improvement in the flow process or services to patients and families during the patient's stay in the PCU.

Please see Addendum G: "Performance Standards" for Staff Nurse, Nursing Attendant and Intermediate Clerk.

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ADDENDUM C
PHYSICIAN ORIENTATION TO THE UNIT

1. Refer to Handbook of Policies for Physicians and Residency Training Program at LAC+USC Medical Center.
2. See PCU Handbook.

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ADDENDUM D
DELIVERY OF CARE METHODOLOGY

1. The Registered Nurse is accountable for the application of the nursing process to achieve identified individualized treatment plans and patient outcomes.
2. The method of delivering patient care in the Progressive Care Unit can be described as total patient care.
3. Patient care is goal oriented, focused on the total patient/family and is based on the nursing process.
    a. RNs provide total patient care for three patients working on a shift basis and with as much consistency as possible.
    b. Assignment of patients is based on patient acuity and skill level of staff. The assigned RNs will assume ongoing responsibility for updating Interdisciplinary Plan of Care (IPOC).
    c. Two twelve-hour shifts of nurses will provide patient care over a 24-hour period.
    d. The relief charge nurse will serve as unit coordinator. They will assign staff and supervise the delivery of patient care. They will accomplish this task through oral instructions and through use ORCHID and shift report.
    e. The RNs will perform initial and ongoing assessment of patients assigned under their care during their shift.
    f. Total patient care means carrying out all aspects of the nursing process, including assessment, nursing diagnosis, formulating the (Interdisciplinary Plan of Care) (IPOC), and evaluating the effectiveness of both medical and nursing interventions. It also implies the use of relevant standards (especially protocols and standards of care); medication administration, documentation (including physician orders); interaction with the physician, the nurse in charge, and the patient's family; and required discharge preparation and patient teaching.
    g. Discharge planning and patient educational needs are assessed on admission. Appropriate patient/significant other education is provided on an ongoing basis throughout hospitalization. Educational content and response is documented. Referrals to follow-up care are made when appropriate. Patient readiness to manage self-care is evaluated and documented at time of discharge.
4. Assignment:
    a. The SSN/relief charge nurse makes the assignments before each shift to give the staff members an opportunity to focus on their patients during report. The assignments are written on the unit assignment sheet and whiteboard. This is posted on the ward where they can be referred to by the Nursing Office Supervisor and physicians.
    b. Nurses will be assigned to patients based on:
        i. Patient's needs
        ii. Nurses' capabilities
        iii. Available licensed and support staff
        iv. Training and skills mix
        v. Continuity of patient care
        vi. Care planning assignments
    c. Assignments may be changed during or after report, if necessary, by the SSN or relief charge nurse to meet changing patient acuity.

d. The care of individual patients will be planned, directed, and evaluated by the RN assigned to the patient.
e. Student nurses and Nursing Attendants will work as support to the RN staff.

5. Report:
    a. Brief group report is given by outgoing charge nurse to the incoming shift at 0700 and 1900 with focus on the following:
        i. Patient's name, diagnosis, medications, new orders, etc.
        ii. Status (procedures done, hemodynamic lines, IV medications) checks.
        iii. A unit huddle is also done during the shift to get an update on changing situation of the unit.

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ADDENDUM E
UNIT ORIENTATION

All nursing personnel assigned to the Progressive Care Unit attend orientation programs conducted by the Department of Education and Consulting Services and are provided with specific ward orientation when newly appointed. Documentation of successful completion of the orientation programs is maintained in the Nursing Office area personnel file.

LAC+USC MEDICAL CENTER

RN ORIENTATION TO STANDARDS BASED PRACTICE (Part I)

EMPLOYEE NAME (print or type) _____ EMPLOYEE NUMBER _____ DATE HIRED

Methodology Legend: I=Inservice, DO=Direct Observation, RD=Return Demonstration, WE=Written Exam, VE=Verbal Exam
CO= indicates topics taught/reviewed in Central Orientation

PERFORMANCE EXPECTATIONS	METHODOLOGY	DATE	INITIALS	
			Employee	Reviewer
Mission Statement, Vision, and Values / Philosophy of Nursing	I	CO		
Department of Nursing Organizational Chart and Lines of Communication	I	CO		
CORE ORIENTATION				
Age Appropriate Care	I	CO		
Blood and Blood Product Administration	I, WE	CO		
Code Gold – Violence Prevention – Restraints and Holds	I, RD	CO		
Cardiac Arrest • Role in an emergency	I, RD	CO		
CPR Cart, Check and Maintenance – Defibrillator Check – Bag-Valve-Mask (Ambu Bag) – Other emergency equipment	I, RD	CO		
Documentation Standards	I, WE	CO		
Emergency Codes • Code Assist, Code Blue, Code Gold, Code Gray, Code Green, Code Orange, Code Pink, Code Purple, Code Rapid Response, Code Red, Code Silver, Code Triage Alert, Code Triage External, Code Triage Internal, Code White, Code Yellow • Team Activation - STEMI, Code OB, Stroke	I	CO		
Emergency Equipment	RD	CO		
Ethics Committee (Accessing)	I	CO		
Fall Prevention	I, WE	CO		
• Bed Alarms				
Hand Off Communication	I	CO		
Medication Administration	I,WE	CO		
• Controlled Substances	I,WE	CO		
Pain Management	I	CO		
Disclosure Training	I	CO		
I.V. Care (Peripheral, Central) – Dressing change – Accessing – Flushing – Peripheral Line Insertion – Medication Administration – Continuous Infusion – Monitoring	I, WE	CO		
Blood draws	I,WE	CO		
Palliative Care	I	CO		

1. After successful completion of the Core Critical Care Program, the new staff member will be precepted by a Critical Care Nurse preceptor and given orientation to the standards for the PCU Progressive Care Unit. This orientation period will have written objectives and structured content. It will consist of a review of standards, a period of closely supervised patient care, assisting with emergencies (code blue) various non-invasive/invasive procedures. This orientation will last for six weeks on the day shift and is individualized based on how the nurse is learning/adjusting to the Progressive Care Unit routines.
2. New staff members are expected to meet the minimum requirements for continued employment by the end of the six-month probationary period. These requirements include, but not limited to the following on the next pages.

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ADDENDUM F
DISASTER: EVACUATION AND RELOCATION

See Unit Safety Handbook.

See LAC+USC Medical Center **Emergency Operation Plan (EOP)**

1. Definition/Purpose
    A. Evacuation/relocation is horizontal or vertical movement of patients from a dangerous area to a comparatively safe area within the building or to a location outside the building.
    B. Evacuation/relocation may be indicated due to fire, smoke, earthquakes, explosions or any such emergency.
2. Key Points
    A. Evacuation/relocation will be undertaken only when authorized by the Command Post.
    B. All personnel are to be prepared for immediate instructions to evaluate patients.
    C. Patients in immediate danger are moved first.
    D. Hospital identification bands or tags must be worn by all patients being evacuated.
    E. Medication and medical charts should accompany patients if situation allows.
    F. DO NOT use elevators (unless directed to do so by Command Post or Fire Department).
    G. All windows and doors should be closed in evacuated areas.
    H. Vacated rooms; restrooms; should be checked to ascertain all have been evacuated.
    I. Panic and confusion can be avoided by employees' familiarity with evacuation procedures.
3. Responsibility in Evacuation/Relocation:
    A. The decision to evacuate/relocate is made by the Command Post.
    B. Patients are evacuated/relocated only when necessary.
    C. The SSN/Relief charge nurse is responsible for preparation of patients for evacuation/relocation and for directions to personnel and visitors on the unit they are assigned to.
    D. The SSN/Relief charge Nurse may make the decision to move patients from immediate danger.
    E. A record of the number of patients and their relocation is kept by the SSN/Relief charge nurse.
    F. The SSN/Relief charge nurse is responsible for an accurate count of' patients after arriving in the evacuation area.
4. Evacuation/Relocation Preparation:
    A. The Command Post will notify the area/hospital of the need to evacuate. The safe areas will be designated by the Command Post.
    B. Unaffected areas/hospitals will respond to the General Hospital Nursing Office immediately to report available space and beds for relocation in their areas.
    C. The Hospital Nursing Office will communicate information to the Command Post.
    D. Determining Space and Bed Availability
        1.Consideration should be given to:
            i. Consolidating patients into as few rooms as possible.
            ii. Placing ambulatory patients in sitting rooms or conference rooms.

iii. Using gurneys, where available.
iv. Removing mattresses from beds to floor if no others are available from Facilities Management.
v. Padding empty bed frame, if adequate blankets and padding available, for additional patient use.

E. Prepare patients:
1. Inform patients of plan to evacuate, i.e. why, when, how.
2. Avoid statements prone to panic.
3. Reassure patients of their safety and the importance to remain calm.
4. All patients to have their ID bands.

F. Identify patient's ability to move using the code below and document on the patient evacuation record.
1.A: ambulatory
2.W: wheelchair
3.S: stretcher/gurney/bed.

G. Necessary medications along with their Medication Administration Record (MAR).

H. Personal belongings.

I. Necessary equipment and supplies.

J. **Evacuation Priorities**
1. By location
2. Patients, visitors, and staff in immediate threat.
3. Patients, visitors, and staff closest to the hazard.
4.Patients, visitors, and staff farthest from the evacuation route to closest.

K. By Status
1. Ambulatory
2. Wheelchair
3. Gurney / Bed

L. Critical patients (moved last when the maximum number of personnel and equipment are available)

M. **Evacuation Method**
1. Horizontal Evacuation
2. Ambulatory
3. "Human Chain": Lead patients and visitors to join hands to create a human chain. Staff (1 at the beginning and 1 at the end).
4. Non-ambulatory: Wheelchair, Gurney, Bed
5. Wheelchair: May lead several at once if independent functioning; 2 staff (1 at the beginning and 1 at the end). Otherwise, minimum 1 staff per wheelchair.
6. Gurney: Minimum 1 staff per gurney. 3 staff per Hospital Bed: Minimum 2 staff per bed.
7.Vertical Evacuation
8.Ambulatory: Use stairwells

See LAC+USC MEDICAL CENTER SAFETY POLICY

- EVACUATION PROCEDURES # SP 112
- See LAC+USC Medical Center Emergency Operation Plan (EOP)

ADDENDUM G
PERFORMANCE STANDARDS

Registered Nurse

A. Standards of Practice - describe a competent level of nursing practice as demonstrated by the nursing process critical thinking model.
    1. Assessment
    2. Diagnosis
    3. Outcomes Identification
    4. Planning
    5. Implementation
        a) Coordination of Care
        b) Health Teaching and Health Promotion
        c) Consultation
        d) Prescriptive Authority
        e) Evaluation

B. Standards of Professional Performance – describe a competent level of behavior in the professional role.
    1. Quality of Practice
    2. Education
    3. Professional Practice Evaluation
    4. Collegiality
    5. Collaboration
    6. Ethics
    7. Research
    8. Resource Utilization
    9. Leadership

The standards are incorporated into existing nursing policies and procedures. which are available on the medical center's SharePoint.

LAC+USC MEDICAL CENTER POLICY # 800

Standard	Measurement Criteria
1. Assessment. Use a systematic, dynamic way to collect and analyze data about a client, the first step in delivering nursing care. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic, and life-style factors as well.	1. Collects data in a systematic and ongoing process. 2. Involves the patient, family, other healthcare providers, and environment, as appropriate, in holistic data collection. 3. Prioritizes data collection activities based on the patient's immediate condition, or anticipated needs of the patient 4. Uses appropriate evidence-based assessment techniques and instruments in collecting pertinent data. 5. Uses analytical models and problem-solving tools. 6. Synthesizes available data, information, and knowledge relevant to the situation to identify patterns and variances. 7. Documents relevant data in a retrievable format.
2. **Diagnosis** The nurse formulates a clinical judgment about the client's response to actual or potential health conditions or needs.	1. Derives diagnoses or issues based on assessment data. 2. Validates the diagnoses or issues with the patient, family, and other healthcare providers when possible and appropriate. 3. Documents diagnoses or issues in a manner that facilitates the determination of the expected outcomes and plan.
3. **Outcomes /Planning** Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-term goals.	1. Involves the patient, family, and other healthcare providers in formulating expected outcomes when possible and appropriate. 2. Derives culturally appropriate expected outcomes from the diagnoses. 3. Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise when formulating expected outcomes. 4. Defines expected outcomes in terms of the patient, patient values, ethical considerations, environment, or situation with such consideration as associated risks, benefits and costs, and current scientific evidence. 5. Includes a time estimate for attainment of expected outcomes. 6. Develops expected outcomes that provide direction for continuity of care. 7. Modifies expected outcomes based on changes in the status of the patient or evaluation of the situation. 8. Documents expected outcomes as measurable goals.
4. **Planning** The RN develops a plan to attain expected outcomes. Assessment data, diagnosis, and goals are written in the patient's care plan so that nurses as well as other health	1. Develops an individualized plan considering patient characteristics or the situation (e.g., age and culturally appropriate, environmentally sensitive). 2. Develops the plan in conjunction with the patient, family and others, as appropriate. 3. Includes strategies within the plan that address each of the identified diagnoses or issues, which may include strategies for promotion and restoration of health and prevention of illness, injury, and disease.

professionals caring for the patient have access to it.	4. Provides for continuity within the plan. 5. Incorporates an implementation pathway or timeline within the plan 6. Establishes the plan priorities with the patient, family, and others, as appropriate. 7. Utilizes the plan to provide direction to other members of the healthcare team. 8. Defines the plan to reflect current statutes, rules and regulations, and standards. 9. Integrates current trends and research affecting care in the planning process. 10. Considers the economic impact of the plan. 11. Uses standardized language or recognized terminology to document the plan.
5. **Implementation** Nursing care is implemented according to the care plan to assure the continuity of care for the patient during hospitalization and in preparation for discharge needs	1. Implements the plan in a safe and timely manner. 2. Documents implementation and any modifications, including changes or omissions, of the identified plan. 3. Utilizes evidence-based interventions and treatments specific to the diagnosis or problem. 4. Utilizes community resources and systems to implement the plan. 5. Collaborates with nursing colleagues and others to implement the plan.
6. **Evaluation**	1. Conducts a systematic, ongoing, and criterion-based evaluation of the outcomes in relation to the structures and processes prescribed by the plan and the indicated timeline. 2. Includes the patient and others involved in the care or situation in the evaluation process. 3. Evaluates the effectiveness of the planned strategies in relation to patient responses and the attainment of the expected outcomes. 4. Documents the results of the evaluation. 5. Uses ongoing assessment data to revise diagnoses, outcomes, plan, and implementation as needed. 6. Disseminates the results to the patient and others involved in the care or situation, as appropriate, in accordance with state and federal laws and regulations.
A. Quality of Practice	1. Demonstrates quality by documenting the application of the nursing Process in a responsible and ethical manner 2. Uses the results of quality improvement activities to initiate changes in nursing practice and in the healthcare delivery system. 3. Uses creativity and innovation in nursing practice to improve care delivery

	4. Incorporates new knowledge to initiate changes in nursing practice if desired outcomes are not achieved. 5. Participates in quality improvement activities 6. Identifies aspects of practice that are important for quality monitoring. 7. Uses indicators developed to monitor quality and effectiveness of nursing practice 8. Collects data to monitor quality and effectiveness of nursing practice 9. Analyzes quality data to identify opportunities for improving nursing practice. 10. Formulates recommendations to improve nursing practice or outcomes. 11. Implements activities to enhance the quality of nursing practice. 12. Develops, implements, and evaluates policies, procedures, and/or guidelines to improve the quality of practice. 13. Participates on interdisciplinary teams rounds to evaluate clinical care or healthcare services. 14. Participates in efforts to minimize costs and unnecessary duplication. 15. Analyzes factors related to safety, satisfaction, effectiveness, and cost/benefit options. 16. Analyzes organizational systems for barriers. 17. Implements processes to remove or decrease barriers within organizational systems.
B. Education See LAC+USC Medical Center Employee Education Plan Mandatory Training - Continuing Education Programs # NUR532	1. Participates in ongoing educational activities related to appropriate knowledge bases and professional issues. 2. Demonstrates a commitment to lifelong learning through self-reflection and inquiry to identify learning needs. 3. Seeks experiences that reflect current practice in order to maintain skills and competence in clinical practice or role performance. 4. Acquires knowledge and skills appropriate to the specialty area, practice setting, role, or situation. 5. Maintains professional records that provide evidence of competency and lifelong learning. 6. Seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.
C. Collaboration The RN collaborates with patient, family, and others in the conduct of nursing practice.	1. Communicates with patient, family, and healthcare providers regarding patient care and the nurse's role in the provision of care. 2. Collaborates in creating a documented plan, focused on outcomes and decisions related to care and delivery of services, that indicates communication with patients, families, and others. 3. Partners with others to affect change and generate positive outcomes through knowledge of the patient or situation.

	4. Documents referrals, including provisions for continuity of care.
D. Ethics The RN integrates ethical provisions in all areas of practice.	1. Uses the Code of Ethics for Nurses with Interpretive Statements (ANA, 2001) to guide practice. 2. Delivers care in a manner that preserves and protects patient autonomy, dignity, and rights. 3. Maintains patient confidentiality within legal and regulatory parameters. 4. Serves as a patient advocate assisting patients in developing skills for self-advocacy. 5. Maintains a therapeutic and professional patient-nurse relationship with appropriate professional role boundaries. Demonstrates a commitment to practicing self-care, managing stress, and connecting with self and others. 6. Contributes to resolving ethical issues of patients, colleagues, or systems as evidenced in such activities as participating on ethics committees. 7. Reports illegal, incompetent, or impaired practices.
E. Research The RN integrates research findings into practice	1. Utilizes the best available evidence, including research findings, to guide practice decisions. 2. Actively participates in research activities at various levels appropriate to the nurse's level of education and position. 3. Identifies clinical problems specific to nursing research. 4. Participates in data collection. 5. Participates in a formal committee or program. 6. Sharing research activities and/or findings with peers and others. 7. Conducts research. 8. Critically analyzes and interprets research for application to practice. 9. Uses research findings in the development of policies, procedures, and standards of practice in patient care. 10. Incorporates research as a basis for learning.
F. Resource Utilization The RN considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.	1. Evaluates factors such as safety, effectiveness, availability, cost and benefits, efficiencies, and impact on practice when choosing practice options that would result in the same expected outcome. 2. Assists the patient and family in identifying and securing appropriate and available services to address health-related needs. 3. Assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, and predictability of the outcome. 4. Assists the patient and family in becoming informed consumers about the options, costs, risks, and benefits of treatment and care.

G. Leadership The RN provides leadership in the professional practice setting and the profession.	1. Engages in teamwork as a team player and a team builder. 2. Works to create and maintain healthy work environments in local, regional, national, or international communities. 3. Displays the ability to define a clear vision, the associated goals, and a plan to implement and measure communities. 4. Demonstrates a commitment to continuous, lifelong learning for self and others. 5. Teaches others to succeed by mentoring and other strategies. 6. Exhibits creativity and flexibility through times of change. 7. Demonstrates energy, excitement, and a passion for quality work. 8. Willingly accepts mistakes by self and others, thereby creating a culture in which risk-taking is not only safe but expected. 9. Inspires loyalty through valuing of people as the most precious asset in an organization. 10. Directs the coordination of care across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated tasks. 11. Serves in key roles in the work setting by participating on committees, councils, and administrative teams. 12. Promotes advancement of the profession through participation in professional organizations.

REFERENCES:

Nursing Scope & Standards of Practice. Silver Spring, MD: American Nurses Association; 2010.

https://www.nursingworld.org/ana/

Nursing Attendant

1. Direct Patient Care Activities

a. Prepares unit, patient room(s) and patient bed(s) for receiving patient admission, returning surgical patient, transfers or emergency situations.
b. Assists in admission, transfer and discharge procedures.
c. Provides personal hygiene and general care as directed.
d. Takes and records temperature, pulse, respirations, blood pressure, height and weight, and intake and output as needed
e. Assist RN in repositioning of patients.
f. Prepares patients for meals distributes and removes food trays, water and nourishments; assists or feeds patients.
g. May be required to function as a care companion.
h. Assists in providing postmortem care.
i. Makes rounds on patient's rooms, answers and responds to patient call lights and/or requests.

j. Reports to RN any changes observed in the condition or behavior of the patient.
k. Transports patients to and from various areas as directed by the RN.
l. Transports specimen to proper areas and pick up prescriptions from pharmacy.
m. Performs therapeutic measures as delegated.
n. Performs other patient care activities assigned by the RN
o. Implements safety measures to safeguard the patient, self and others.
p. Provides care in consideration of the emotional, social and spiritual needs of the patient.
q. Maintains knowledge in policies and procedures by attending staff meetings.

2. Indirect Patient Care Activities

a. Performs related clerical duties as assigned.
b. Provides a safe and clean environment and reports problems to the RN
c. Cleans all portable equipment, (e.g., IV poles, bedside carts, Alaris pumps, bedside commodes, bedside table, etc.) and prepares equipment for disinfection.
d. Receives and puts away stock supplies.
e. Restocks unit supplies.

3. Additional Expectations

a. Applies infection control precautions and handwashing techniques.
b. Follows hospital and nursing policy and procedures.
c. Maintains a courteous and helpful relationship with patients, public, and co-workers.
d. Attends in-service as assigned to maintain current skills.
e. Adheres to the Department of Nursing Dress Code.
f. Participates in quality improvement projects activities as assigned.
g. Maintains confidentiality of patient information.

Nursing Unit Clerk

1. Patient Care Activities

a. Maintains correct patient identification.
   1. Patient's MRN and FIN number
   2. Verifies name band of all patients for accuracy and completeness, daily.
   3. Makes and applies proper ID band.
b. Prepares and completes forms related to admissions, transfers and discharges.
c. Keeps informed of unit patient flow, such as pending admissions, transfers or discharges.
d. Provides support to the unit RNs as needed, such as paging a provider when requested to do so.
e. Calling the Pager Operator to request paging the appropriate responders for the various codes.
f. Maintains the patient's Paper Medical Chart and ensures that it is sent to Medical Records upon patient discharge.
g. Assist patients and visitors

h. Explains regulations
i. Gives appropriate handouts

2. Unit Services Activities

a. Maintains unit patient census.
b. Maintains patient records and confidentiality of patient information.
c. Handles patient Medical Records
d. Makes up new charts
e. Completes identification on all chart forms
f. Maintains unit logs
g. Carries out clerical processes for admission, transfer and discharges
h. Review Clinic Appointments for patients prior to discharge.
i. Communicates with Bed Control, Pharmacy, Dietary and all other appropriate
j. Orders unit supplies and equipment for patient care and unit management
k. Request and document repairs of ward equipment.
l. Maintains nursing station and updates whiteboard.

3. Other Expectations

a. Follows hospital and nursing policy and procedures.
b. Maintains a courteous and helpful relationship with patients, public, and co-workers.
c. Adheres to the Department of Nursing Dress Code.
d. Maintains the standard of attendance and observation of working hours.
e. Participates in quality improvement activities as assigned.

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ADDENDUM H
DISCHARGE LOUNGE

I. Purpose:
   A. The purpose of the Discharge Lounge is to provide an area for patients awaiting completion of the discharge process which will facilitate the availability or acute care beds for admissions.

II. Staffing:
   A. The Discharge Lounge is under the supervision of a RN. The unit is staffed with RNs, LVN, nursing attendants and clerks

III. Hours of Operation:
   A. The Discharge Lounge will be open 7 days/week from 7:00 am to 10:30 pm.

IV. Admission Criteria:
   A. Patients sent to this area must meet the following criteria:
      1.Alert and oriented
      2.Stable condition
      3.Capable of self-care
      4.Capable of self-medication (PO & SQ)
      5.Require no treatments
      6.Prescriptions cleared by pharmacy
      7.I.D. band intact
   B. The sending ward must complete the following activities prior to acceptance:
      1.Discharge Record must be complete, including discharge assessment, patient teaching regarding medications, and RN signature
      2.Valuables and property picked-up and given to patient
      3.Patient fully dressed
      4.Supplies provided
      5.Clinic appointments made
      6.Discharge arrangements made
      7.Family called
      8.Expected time for pick-up identified.

V. Operating Guidelines:
   A. The discharge unit can accommodate a maximum of twenty (20) patients.
   B. Prior to the patient leaving the ward must:
      1. Call the Discharge Lounge to obtain an available opening and give report.
      2. Notify significant other to pick up patient in the Discharge Lounge.
   C. The following must accompany the patient to the Discharge Lounge:
      1.Patient's Medical Record
      2.Physician's name and pager number
   D. The Discharge Lounge will be responsible to send the medical record to the Central Discharge Lounge.
   E. If the patient has not left by midnight, s/he will be re-admitted to a bed identified by Bed Control. Nursing staff on the ward of origin must notify the patient's physician of his/her continued hospitalization.
   F. The Discharge Lounge will maintain a patient census log containing the following information:

1. Patient name and MRUN/FIN number.
2. Ward of origin
3. Admission/discharge times
4. Physician name and beeper number
5. Status of discharge prescriptions
6. Final disposition

VI. Medication Management

A. The RN/LVN will perform the following tasks:

1. Check the medications received from Pharmacy against ordered medication
2. Review discharge medications and perform education on medications upon discharge
3. Monitor self-medication administration.
4. Administer medication from patient's cassette if prescriptions are not available
5. Screen patient for accurate knowledge base regarding prescribed medications
6. Educate patient regarding medication according to evaluated need:
    a. Show generic medication video
    b. Document response.

See Nursing Policy Manuals

- **DISCHARGE LOUNGE # NUR725**

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ADDENDUM I

CARDIOPULMONARY RESUSCITATION-ADULT (CODE BLUE TEAM)

Rapid Recognition and Response to Changes in Patient Condition (RRT)

See LAC+USC MEDICAL CENTER POLICY

- **CARDIOPULMONARY RESUSCITATION - ADULT (CODE BLUE) MC912**
- **RAPID RECOGNITION AND RESPONSE TO CHANGES IN PATIENT CONDITION (RRT) MC939**

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ADDENDUM J
INJURY/ ILLNESS PREVENTION PROGRAM

The Progressive Care Unit adhere(s) to the Department of Nursing Injury/Illness Prevention Program (IIPP)

1. Staff are encouraged to receive Hepatitis B vaccine from Employee Health Department.
2. Staff are not allowed to wear open toe/heel shoes while working
3. Staff are encouraged to keep hair neat and not dangling over their face or touching the bed or patient while performing patient care.
4. All staff must be checked/monitored closely when exposed to patients with active Tuberculosis (TB).
5. Staff is required to attend mandatory safety classes.
6. Staff will receive Inservice on all new equipment prior to use and have annual skills check thereafter.
7. All beds are maintained on the low position, and wheels locked at all times.
8. All equipment must be inspected by BioMedical Department prior to patient usage with a current biomed check date posted on the equipment.
9. All equipment requiring repair must be reported to Facilities Management at X6444 and marked before removing out of the patient's room.
10. Staff is recommended to wear protective gears (lead apron) when assisting radiologic procedures.
11. Staff will maintain orderliness/cleanliness of the unit; keeping doors and windows closed to prevent flies from getting into the units.

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ADDENDUM K
CONTINUOUS IV MEDICATION INFUSION

1. The RNs in the Progressive Care Unit may administer medications via Continuous Intravenous Infusion.
2. These continuous IV infusions are medications that don't require ongoing titration and monitoring more frequently than every two hours.
    a. The medication list may include, but not limited to the following:

Medication	Comments
Amiodarone	
Bumetamide	
Diltiazem	
Dopamine	Low dose, non-titrating
Furosemide	
Heparin	
Integrilin	
Methylprednisolone	
Octreotide	
Pantoprazole	
Patient Controlled Analgesia Morphine or Hydromorphone	
Nitroglycerine	For chest pain
Calcium Chloride	At rate and concentration specified for the unit
Calcium Gluconate	
Magnesium Sulfate	
Potassium Chloride	

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ADDENDUM L
APPROVED PCU INTRAVENOUS PUSH MEDICATION LIST – ADULT

Refer to Nursing Medical Center policy

- CONTINUOUS IV MEDICATION INFUSION

- CONTINUOUS IV MEDICATION INFUSION

The medications listed in "NUR 911-A" are approved intravenous push drugs that all Registered Nurses may administer upon a physician's order throughout the LAC/USC MEDICAL CENTER. Additional drugs may be approved in specific areas and are listed in the table attachment NUR 911-A

Refer to Nursing Policy Manual "policy NUR 911-A

Approved Intravenous Push Medication List - Adult

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ADDENDUM M
ANNUAL SKILLS VALIDATION

See Nursing Policy Manuals

- **MANDATORY TRAINING - CONTINUING EDUCATION PROGRAMS # NUR532**

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ADDENDUM N
5F UNIT SPECIFIC PROCEDURES

Please refer to Medical Center Policy- procedures performed Outside of the Operating Room – Inpatient Tower # 928 & Designated Locations – Procedures Performed #928A.

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ADDENDUM O

LOS ANGELES COUNTY+UNIVERSITY OF SOUTHERN CALIFORNIA MEDICAL CENTER

Unit specific-ICU

ICU Standards based Checklist

_____ _____ _____ _____

EMPLOYEE NAME (print) EMPLOYEE NUMBER START DATE END DATE

UNIT_____ DATE ATTENDED ICU PROGRAM_____

Skills are to be performed in accordance with Medical Center and Department of Nursing policy.

Skills are to be validated by preceptors. The RN is responsible for maintaining current skills.

Procedures not applicable to a particular unit may be marked N/A.

Methodology Legend: I = In-service, DO = Direct Observation, RD = Return Demonstration, WE = Written Exam, VE = Verbal Exam, SL = Self Reading (Lesson Plan, Policies & Procedures)

Pre-Phase I RN is allowed to document only on items on which they have been trained. For example, the RN is not allowed to document CVP readings, arterial line readings, pulmonary artery catheter readings and ICU medications.

PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials**	
			RN	**Preceptor**
UNIT-SPECIFIC ORIENTATION (Write-in)				
EQUIPMENT/ROOM SET-UP	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
Basic ICU Room set up – admission readiness - Equipment and supplies needed				
Cardiac Monitoring - Lead monitoring	RD			
- Lead application	RD			

- Orientation to Phillips monitor components				
- Setting alarm parameters	RD			
- Monitoring module				
- Transport monitor				
- Central station monitoring				
Use of the Progressa Bed System - Controls for various patient positions				
- Bed Alarms				
- Continuous Lateral Rotation Therapy				
- Weighing scale				
- Transporting patient on bed				
- Chest percussion				
- CPR function				
Use of the lifting equipment				
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
Crash cart orientation and defibrillator testing - Q shift check				
- Daily testing of defibrillator				
- Completion of logs				
Special trays/Procedure carts				
ADMISSION				
- Admission criteria				
- Communication with Patient Flow manager				
- Participate in admission process				
- Receiving patient from within facility (ER, inpatient, outpatient, OR)				

- Receiving patient from Outside hospital through MAC				
- Knowing the Assessment scales: o Wong Baker Numeric				
o FLACC	RD			
o RASS	RD			
o CPOT	RD			
o Braden and 4 eyes check				
o Morse	RD			
o NIHSS				
RESPIRATORY				
Airway adjuncts - Oral airway				
- Nasal trumpet				
Airway code - Supplies needed				
End tidal CO2 detector				
Endotracheal tubes - Prepare and assist with intubation				
- Supplies needed				
Securement of ET tube - Use of tape	RD			
- Anchor Fast	RD			
Care of the patient on the mechanical ventilator - Ventilator settings, alarms and modes	RD			
- Troubleshooting	RD			
- In line suctioning	RD			
VAP prevention bundle				

- Oral care with Chlorhexidine Oral Rinse.				
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
- Head of bed elevation 30-45 degrees				
Weaning parameters and assist with extubation - Extubation criteria				
In line medication administration per ventilator - Nebulizer	RD			
- Metered dose inhaler	RD			
Draw arterial blood gases - Modified Allen's test	RD			
- Set up and perform radial stick	RD			
- Post procedure care & monitor bleeding	RD			
Prepare and assist with tracheostomy procedure - Daily tracheostomy care	RD			
- Tracheal suctioning	RD			
Prepare and assist with Bronchoscopy - Indication				
- Set-up				
- Assist				
- Monitor				
Chest Tube/ Mediastinal tube - Set-up for chest tube insertion				
- Care of patient with chest tube	RD			
- Chest tube related assessments	RD			
- Recognition of abnormal drainage				
- Care after discontinuing chest tube				

- Troubleshooting	RD			
Autotransfusion - Set-up				
- Citrate use				
Nasopharyngeal swab collection for influenza				
CARDIOVASCULAR				
Cardiac rhythm identification - Print rhythm strip per unit standard	RD			
Intravenous Infusion: IV Pump - Set-up / Pump programming	RD			
- Review vasoactive medication	VE			
- Scanning				
- Medication Administration Wizard				
Code Blue: Cardiac Arrest / Respiratory Arrest - Review of ACLS				
- Medications				
- Documentation				
- Code Blue Team				
- Rapid Response Team				
Continuous Intravenous Infusion - Vasoactive medications	RD			
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
- IV sedation continuous infusion (Fentanyl, Propofol, Precedex)	RD			
- Paralytics – Vecuronium	RD			
- Heparin continuous infusion	RD			
- Insulin infusion	RD			

- T4 / Levothyroxine protocol	RD			
Defibrillation procedure - Indication				
- Set-up				
Cardioversion - Preparation				
- Indication				
- Medications given during cardioversion				
- After care and monitoring				
Manage pacemaker - Understanding types: Transvenous, External and Permanent Pacemakers	VE			
- Indications for pacemaker	VE			
- Set up for external pacemaker				
- Pads and lead placement				
- Checking pacemaker settings (milliamps, rate, captured beats)	RD			
- Troubleshooting	RD			
Arterial blood pressure - Set up for procedure / insertion				
- Level/zero balance	RD			
- Arterial line care	RD			
- Waveform recognition	RD			
- Trending mean arterial pressures	RD			
- Blood withdrawal	RD			
- Troubleshooting	RD			
- Arterial catheter removal	RD			
Central venous catheter Lines/ Pressure monitoring - Types: Cordis and Triple Lumen Catheter				

- Set up for insertion				
- Maximum barrier precautions				
- Level/zero balance	RD			
- **CLABSI** prevention				
- Central line care kits	RD			
- Waveform recognition	RD			
- Blood withdrawal	RD			
- Cordis blue end cap				
- Removal				
- Troubleshooting	RD			
Pulmonary artery & pulmonary capillary wedge pressure - Set up for procedure / insertion				
- Level/zero balance	RD			
- Waveform recognition	RD			
- Full line of data per unit standard	RD			
- Mixed Venous blood withdrawal	RD			
- Normal pressure readings	VE			
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
- Removal				
- Troubleshooting	RD			
Cardiac Output measurement - Set-up for procedure	RD			
- Calculations	VE			
- Waveform recognition	RD			
- Troubleshooting	RD			
PCA				

- Set-up				
- Maintenance and care	RD			
- Clearance every 4 hours				
- Review protocols				
- Troubleshooting				
Epidural - Set-up				
- Maintenance and care	RD			
- Clearance every 4 hours	RD			
- Review protocols				
- Troubleshooting				
On Q Pump - Settings				
- Monitoring				
Blood Administration - Set-up	RD			
- Review protocols and order set	VE			
- Consents	RD			
- Documentation	RD			
- Monitoring transfusion reactions	RD			
Rapid Infuser - Indication				
- Set-up				
- Troubleshooting				
Massive transfusion protocol - Review				
- Indication				
TPN Administration	VE			

- Indication: use of central line vs. peripheral IV				
- Review of order set	RD			
- Review of protocols	VE			
- Monitoring laboratory values	VE			
NEUROLOGICAL				
Neurological Assessment				
- Stroke Assessment Band in ORCHID				
- Glasgow Coma Scale (GCS)				
- Review NIH Stroke Scale				
- tPA administration				
- Stroke Patient Monitoring				
- Stoke Patient/Family education				
- Bedside Swallow Screening				
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
ICP Monitoring - ***Bolt*** - Indication	VE			
- Set-up				
- Monitoring	RD			
- Troubleshooting	RD			
ICP Monitoring • ***EVD*** - Indication	VE			
- Set-up: Level-zero	RD			
- Monitoring: Open vs. clamped	RD			
- Output documentation	RD			

- Troubleshooting	RD			
Cervical Immobilization - **C-Collars**				
- Application and removal				
- Types: Vista				
- Skin assessment and care	RD			
- **Halo device**				
- Skin assessment and care				
- **TLSO Brace** - Indication				
- Application and removal				
- Skin assessment and care				
Lumbar drains - Indication				
- Set-up				
- Monitoring				
- Output documentation				
• Troubleshooting				
Train of Four - Indication and use	RD			
One Legacy / Brain Death Declaration - Organ procurement				
- T4 / Levothyroxine protocol				
GI/GU				
Esophagogastroduodenoscopy (EGD) - Indication				
- Supplies needed				
- Procedure Assist				

- Monitoring				
Percutaneous endoscopic gastrostomy (PEG) - Indication				
- Supplies needed				
- Procedure Assist				
Intra-abdominal Pressure Monitoring ❖ ***Water manometer. Cm H2O*** - Indication	VE			
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
- Set-up	RD			
- Level /zero	RD			
- Monitoring	RD			
- Troubleshooting	RD			
❖ ***Abvisor. mmHg*** - Indication	VE			
- Set-up	RD			
- Level /zero	RD			
- Monitoring	RD			
- Troubleshooting	RD			
Nasogastric tube insertion				
- Set-up Kangaroo feeding Pump	RD			
- Single Use 3 way adapter	RD			
GI tubes - Fecal management system (Flexiseal)	RD			
Drains/Tubes - Wound Vac/ Abthera				

- Nephrostomy				
- Supra-pubic				
- Pigtail				
- Hemovac				
- Penrose				
- Jackson Pratt (JP)				
SKIN ASSESSMENT				
Pressure Ulcer - Four – eyes check				
- Identification of at-risk patient				
- Documentation				
- Reporting				
Ankle Foot Orthosis (Multi Podus Boots) - Indication	VE			
- Application and removal	RD			
- Skin assessment and care	RD			
SPECIALIZED SKILLS				
Point of Care Testing - Hemo Cue				
- Gem Premier				
Bladder scanning				
CAUTI prevention				
Continuous Renal Replacement Therapy - Indication				
- Set-up				
- Monitoring				
- Troubleshooting				
Balloon Pump				

- Indication				
- Set-up				
- Assessment				
- Troubleshooting				
PERFORMANCE EXPECTATIONS / PSYCHOMOTOR SKILLS	**Methodology**	**Date**	**Initials RN**	**Initials Preceptor**
- Documentation				
Extracorporeal Membrane Oxygenation (ECMO) Cardio Help - Indication				
- Set-up				
- Assessment				
- Troubleshooting				
- Documentation				
Impella Ventricular Assist Device - Indication				
- Set-up				
- Assessment				
- Troubleshooting				
- Documentation				
Therapeutic Hypothermia - Indication	VE			
- Cincinnati Sub-zero set-up	RD			
- Review protocols	VE			
- Monitoring	RD			
- Rewarming	RD			
Malignant Hyperthermia - Recognizing signs and symptoms				

- Review protocol				
- Location of MH cart				
- If applicable, daily check of supply				
Prostacycline Medication Administration - Review protocols				
- Indication				
- Assessment and documentation				
Critical Care Transport - Preparation and transport of ICU patient				
- Handoff to ICU Transport Nurse				
ICU Discharge process - Transfer to outside facility (non-DHS facility)				

Category	PRINT NAME	SIGNATURE	INITIAL	DATE
RN				
Preceptor				
Preceptor				
Instructor				
Supervisor/Designee				
Supervisor/Designee				
Supervisor/Designee				

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ADDENDUM P

"Annual Validation of Standards Based Practice".

LOS ANGELES COUNTY+UNIVERSITY OF SOUTHERN CALIFORNIA MEDICAL CENTER
DEPARTMENT OF EDUCATION AND CONSULTING SERVICES

RN ANNUAL VALIDATION OF STANDARDS BASED PRACTICE – Critical Care

Name:_____ Employee Number:_____

Unit:_____ Date:_____

I have watched the video set "Central Venous Catheter Care" within the last 3 months_____
Participant Signature

I have watched the Behavioral Response Team (Code Gold) video within the last 3 months_____
Participant Signature

I have watched the Handling Hazardous Medication (Licensed) 2 videos_____
Participant Signature

Station	Performance Expectations	Methodology	Reviewer's Signature
14	Arterial Line/Pulmonary Artery Line Monitoring • Level/Zero/Readings • Waveform Recognition • Troubleshoot	VE	
	Central Venous Catheter (Short Term) Removal (Adult ICUs only)		
11	Arterial Sticks • Set-Up and Performance • Modified Allen's Test	VE	
	Epidural Catheter – Continuous Infusion		
9	Blood and Blood Products	VE	
13	Cardiopulmonary Arrest • Defibrillation/Cardioversion/External Pacer • Drug Administration (ACLS)	VE	
	Pacemakers • External		
17	Central Venous Catheter Care	VE	
18	Handling Hazardous Medications	VE	
20	Chest Tubes	VE	
16	IV Medications • IV Medications/ High Alert Medications	VE	
5	Nasogastric Tube Insertion	VE	
15	Pacemakers • Internal	VE	
	Autotransfusion **(Adult ICUs only)**	VE	
8	Pain Assessment/Documentation	VE	

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LOS ANGELES COUNTY+UNIVERSITY OF SOUTHERN CALIFORNIA MEDICAL CENTER
DEPARTMENT OF EDUCATION AND CONSULTING SERVICES

RN ANNUAL VALIDATION OF STANDARDS BASED PRACTICE – Critical Care

Station	Performance Expectations	Methodology	Reviewer's Signature
22	ICP Monitoring • Level/Zero/Readings • Waveform Recognition • Troubleshooting	VE	
	Cervical Immobilization • Cervical Collar Maintenance • Cervical Collar Change • Halo Vest		
	Stroke/ tPA		
21	Intra-Abdominal (Bladder) Pressure	VE	
	Rapid Volume Infuser		
10	Patient Controlled Analgesia	VE	
Stage 23	Pediatric Emergencies **(for nurses who care for pediatric patients only)**	VE	
Stage 24	Pediatric Age Specific Care **(for nurses who care for pediatric patients only)**	VE	
12	Therapeutic Hypothermia	VE	
7	CAUTI prevention	VE	
	Universal Protocol		
Stage 25	Breastfeeding Skills **(PICU only)**	RD	
6	Restraints-Code Gold/Violence Prevention (not needed if hired or had Code Gold after June 2018)	VE	
GH 4200	Restraints Return Demonstration (not needed, if hired or had Code Gold after June)	RD	
GH 4221	Skin Care/Pressure Injury Prevention	VE	
19	Safe Patient Handling	RD	
GH 1729	POCT/Lab/Phlebotomy Update	VE	
Auditorium ORCHID	Infusion Management Suite	RD	

Rev 2019

VE = Verbal Exam
RD = Return demonstration

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