Clinical Departments: Special Care/Intensive Care Units

Name of Hospital: _____

Date: _____ Hospital Contact: _____

Always/ Yes	Sometimes	Never/ No	N/A	
				DEPARTMENT MANAGEMENT
☐	☐	☐	☐	1. There is a designated medical director for the unit with a written job description. Name: _____ Specialty: _____
☐	☐	☐	☐	2. There is a qualified designee who is readily available for administrative and consultative decisions when the medical director is not available.
☐	☐	☐	☐	3. There are written admission and discharge criteria, including a priority determination.
☐	☐	☐	☐	a. There is an alternative means of providing specialized patient care to patients who require such care but are not eligible for admission according to unit policy.
☐	☐	☐	☐	b. When there is a conflict on patient admission or discharge, a designated physician is consulted to determine patient priority and to interact with the attending physician(s).
☐	☐	☐	☐	4. There are established protocols on how to deal with specific emergencies (accidental patient extubation, bleeding, allergic reactions, etc.).
☐	☐	☐	☐	5. There are policies addressing family interaction, visiting hours, and family conferences.
☐	☐	☐	☐	6. There are protocols in place that address when an RN should inform the responsible physician of changes in the patient's condition (consultants, referrals, surgeons, attending, specialist, etc.).
☐	☐	☐	☐	7. There is a written policy addressing physician/RN disagreements about care and treatment that defines specific reporting lines.
☐	☐	☐	☐	8. There is a written policy on the withdrawal of life sustaining equipment that specifies who may remove the equipment.

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☐	☐	☐	☐	9. Physician intensivists are available to manage medical care on a full-time basis.
☐	☐	☐	☐	a. Physicians who admit and treat patients have specifically delineated privileges for special care units, including high-risk procedures like central line insertion, endotracheal intubation, and ventilation.
☐	☐	☐	☐	b. Privilege delineation information for all providers with admitting privileges to special care units is available to special care unit staff.
☐	☐	☐	☐	10. The medical staff rules and regulations provide time parameters for attending physicians to see patients following admission.
☐	☐	☐	☐	11. There is a policy requiring RNs to accompany critically ill patients from the ER to the ICU and to ancillary departments for treatments or diagnostic studies.

HUMAN RESOURCES

☐	☐	☐	☐	12. Staff members are given an initial orientation and an annually documented evaluation of their competency with equipment, assistance with special procedures, and other critical care skills.
☐	☐	☐	☐	13. Nursing staff are ACLS and/or PALS-certified.
☐	☐	☐	☐	14. There is ongoing unit-specific staff in-service training.
☐	☐	☐	☐	a. Training includes simulations of emergency situations (accidental extubation, hemorrhage, allergic reactions) and high-risk/low-frequency events to maintain skills and to enhance teamwork.
☐	☐	☐	☐	b. A debriefing of simulation exercises is conducted to help staff identify areas for improvement.
☐	☐	☐	☐	15. If agency or float staff are utilized, they are required to have critical care training.
☐	☐	☐	☐	a. They receive an orientation to the unit, and that orientation is documented.
☐	☐	☐	☐	b. Agency nurses or float staff have an identified resource person available to answer questions.

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☐	☐	☐	☐	16. If nurses perform special procedures such as arterial punctures and intubation, documentation of their training/competency and medical authorization is available.
☐	☐	☐	☐	17. There is adequate staffing if special care unit staff members need to respond to codes off the unit.

MEDICATION MANAGEMENT

☐	☐	☐	☐	18. All continuous IV medications are on infusion pumps.
☐	☐	☐	☐	19. All IV lines, arterial lines, pulmonary artery catheters, and other vascular access devices are clearly labeled.
☐	☐	☐	☐	20. An emergency cart with drugs and equipment is available and properly secured.
☐	☐	☐	☐	a. The cart is checked and resupplied after each use.
☐	☐	☐	☐	b. Drugs are checked periodically for expiration dates.
☐	☐	☐	☐	21. Stock medications are limited and dispensed via a controlled unit, such as Pyxis.
☐	☐	☐	☐	a. Pharmacy reviews all "overrides" on a daily basis.
☐	☐	☐	☐	b. All medications should be reviewed by a pharmacist prior to administering. In an emergency situation, when a medication is given to a patient prior to a pharmacy review (as in the instance of stock medication in the Pyxis system), the order is reviewed by the pharmacy as soon as possible.
☐	☐	☐	☐	22. Dosage and compatibility charts are readily available for emergency and other critical care medications.
☐	☐	☐	☐	23. Medication orders are clear:
☐	☐	☐	☐	a. Drug dosages are specific and appropriate.
☐	☐	☐	☐	b. If range orders are allowed, the policy sets out specific criteria for each range order.
☐	☐	☐	☐	c. Blanket orders (e.g., "resume preoperative meds") are prohibited.
☐	☐	☐	☐	24. Medications are not left unsecured in a patient room.

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				PATIENT CARE
☐	☐	☐	☐	25. The layout of the unit provides for visual monitoring of all patients from the nursing station.
☐	☐	☐	☐	26. If not, other mechanisms of monitoring are utilized to allow for patient visualization and remote monitoring.
☐	☐	☐	☐	27. Continual use of audible alarms is required on all cardiac monitoring systems and other equipment.
☐	☐	☐	☐	a. High-low parameters are set for each patient.
☐	☐	☐	☐	b. Monitors are continuously assessed by a nurse or trained technician.
☐	☐	☐	☐	28. The charting system provides for evidence of ongoing assessment and monitoring for all body systems and equipment.
☐	☐	☐	☐	29. Standing orders are used per ISMP Guidelines for Standard Order Sets (www.ISMP.org).
☐	☐	☐	☐	30. Copies of the standing orders are on the patient record and signed and dated by the ordering physician.
☐	☐	☐	☐	31. Critical events or complications are documented thoroughly, including physician phone calls, actions, patient responses, etc.
☐	☐	☐	☐	32. All entries in the record are dated and timed.
☐	☐	☐	☐	33. EKG strips or other monitoring records, identified with date, time, and patient name, are kept with the patient's medical record.
				ENVIRONMENT OF CARE
☐	☐	☐	☐	34. There is regular preventive maintenance and testing of all alarm systems.
☐	☐	☐	☐	35. There are code buttons or other emergency signaling devices in each patient room.
☐	☐	☐	☐	36. The physical environment is safe for visitors and for staff in their performance of everyday tasks.
☐	☐	☐	☐	a. Safety risks are identified and addressed. Equipment, cords, carts, and furniture are placed to avoid creating hazards for staff or visitors.
☐	☐	☐	☐	b. Security risks are identified and addressed (for example, unauthorized access to the special care unit and theft of patients' valuables).
☐	☐	☐	☐	c. The floor is free of clutter.

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☐	☐	☐	☐	37. Noise levels and light are reduced at night to facilitate patients' rest.

PROCESS IMPROVEMENT/PATIENT SAFETY

☐	☐	☐	☐	38. Adverse events and near misses are reported according to policy.
☐	☐	☐	☐	a. The unit provides constructive and timely feedback on each reported adverse event and near miss.
☐	☐	☐	☐	b. Staff members are able to describe how information on adverse events and near misses is used to improve patient safety.
☐	☐	☐	☐	39. The unit has a patient safety plan with specific goals and objectives.
☐	☐	☐	☐	40. The unit collects data needed to track progress toward the department patient safety goals.
☐	☐	☐	☐	a. Staff members are able to describe how they use data to determine which safety projects to adopt.
☐	☐	☐	☐	b. Staff members are able to describe how they use data to improve patient safety.
☐	☐	☐	☐	41. The special care unit has adopted one or more patient safety bundles (central line, sepsis, ventilator, etc.).
☐	☐	☐	☐	42. The special care unit has adopted one or more standardized emergency processes (cardiac arrest protocols, order sets, equipment setups, etc.).