High-Acuity Nursing

CHAPTER

1

Objectives:

1. Discuss the various healthcare environments in which high-acuity patients receive care.

2. Identify the need for resource allocation and staffing strategies for high-acuity patients.

3. Examine the use of technology in high-acuity environments.

4. Identify the components of a healthy work environment.

5. Discuss the importance of patient safety in the high-acuity environment.

1. **High-Acuity Environment**
   1. Historical perspective
      1. Intensive care units (ICUs) were developed in the 1960s. Medical advances resulted in the initiation of these units.
         1. The implementation of CPR
         2. Improved management of patients experiencing hypovolemia and shock
         3. The implementation of emergency medical services
         4. Technological advances that required close observation for effective use
         5. The advancement of renal transplant services
         6. The first ICUs were recovery rooms created for those postoperative patients who required extra equipment and prolonged observation.
   2. Determining the level of care needed
      1. Systematic triage approach for high-acuity patients aids in giving the most efficient and cost-effective care.
         1. ICU
         2. Intermediate care unit (IMC) or progressive care unit (PCU)
            1. Developed to manage those patients whose acute illness requires less monitoring equipment and staffing than is provided in an ICU
            2. Ability to manage patients with moderate or potentially severe physiological instability but who do not require artificial life support
         3. Medical–surgical acute care unit
      2. Nurses should use a prioritization model to triage and determine the level of care needed by acutely ill patients. The model divides patient needs into four categories:
         1. Priority 1: The patient is acutely ill, requiring intensive treatments not available outside of the intensive care unit.
         2. Priority 2: The patient is seriously ill and has the potential to require immediate medical interventions to prevent complications.
         3. Priority 3: The patient is critically ill but has a limited chance for recovery. There might be limits placed on the amount of life-saving interventions that may be implemented.
         4. Priority 4: This is a large category of patients. Their inclusion into the ICU will depend on an individualized decision based on the appropriate use of resources and current patient status.
   3. Levels of intensive care units
      1. The American College of Critical Care Medicine has identified three levels of ICUs as determined by resources available to the hospital:
         1. Level I: Hospitals with ICUs that provide comprehensive care for patients with a wide range of disorders. Sophisticated equipment, specialized nurses and healthcare providers, and comprehensive support services.
         2. Level II: Hospitals with ICUs that provide comprehensive care to most critically ill patients.
         3. Level III: Hospitals with ICUs that provide initial stabilization of critically ill patients but are limited in their ability to provide comprehensive care for all patients.
   4. Profile of the high-acuity nurse
      1. Able to analyze clinical situations
      2. Makes decisions based on analysis
      3. Rapidly intervenes to ensure optimal patient outcomes
      4. Competent in detecting early signs of an impending complication
      5. Role of the nurse in the management of the high-acuity environment:
         1. Constant surveillance and monitoring to identify possible impending and life-threatening complications
            1. Studies show that constant surveillance of patients by nurses reduces mortality and complications.
2. **Resource Allocation**
   1. Nurse staffing
      1. Nurse–patient ratios
         1. Many interrelated factors have led to a shortage of nurses able and willing to work with acutely ill patients. Factors linked to the nursing shortage include:
            1. Hospital restructuring of nursing personnel reduced job satisfaction, which resulted in nurses leaving the workforce.
            2. Aging of the registered nurse workforce
            3. Limited number of young adults choosing nursing as a career
            4. Increasing number of aging persons, resulting in an increase in persons requiring acute care health services
            5. Increase in access to health care as a result of the Affordable Care Act
            6. Legislation to support registered nurse-to-patient ratios and other nurse–patient issues have been raised to the national level.
         2. The reduction in the number of professional nurses has resulted in an increase in the nurse–patient ratio.
         3. The Academy of Medical Surgical Nurses (AMSN) does not support the development of exact patient–nurse ratios.
         4. The needs of the patient and the skill mix of the nursing staff must be considered when making decisions about staffing patterns.
         5. The first principle of staffing is to provide safe and effective patient care.
         6. Unlicensed assistive personnel (UAP) can be used to provide direct care under direct supervision of the professional nurse.
         7. The professional nurse uses leadership skills to safely and legally delegate tasks to the UAP.
      2. Magnet status: recruiting and retaining nurses
         1. Magnet designation is a status awarded to hospitals that demonstrate successful recruitment and retention of professional nurses.
         2. Magnet hospitals promote environments meant to attract and retain professional nurses.
         3. Nurses who work at Magnet hospitals are more involved in decision making, report better relations with physicians, and have higher nurse-to-patient ratios.
   2. Decreasing resources, increasing care needs
      1. Who Belongs in an ICU?
         1. Deciding factors for ICU care are multifactorial and may include severity of injury, futility of treatment and informed refusal, the need to provide the quality of the dying and death experience, and family involvement.
         2. The assignment of patients to units requires a close review of available resources.
         3. Age and seriousness of illness can be controversial variables in the assignment of intensive care beds. Severity scales are models used to determine which patients will benefit most from intensive care services.
         4. Ethical, economic, and legal considerations must be addressed with regard to ICU care.
         5. Patient death in a high-acuity area consumes significant resources.
         6. Each patient’s end-of-life care is subjective and different; therefore, cost alone cannot be used to justify the use of healthcare resources.
3. **Use of Technology in High-Acuity Environments**
   1. Benefits
      1. The use of technology in the intensive care unit allows for close monitoring of the unstable patient and can limit complications.
      2. The technology is a primary incentive for placement in the intensive care unit.
      3. The use of computers can provide a programmed approach to guide decision making by providing decision-making trees.
      4. Programs are available to diagnose patient conditions. Handheld devices can be used to provide bedside reference guides.
      5. Nurses must be able to use technology but also recognize its limitations.
   2. Patient depersonalization
      1. Difficulties arise when machines become the focus of care of the high-acuity patient.
      2. Technology must be used to enhance care, not take the place of a nurse’s personal knowledge, observation skills, and senses.
      3. Technology may evoke fear in patients and contribute to their anxiety about their recovery process.
   3. Overload and overreliance issues
      1. The potential for increased stress on the nurse as a result of information overload.
      2. Alarm fatigue is one result of overload and overreliance on technology.
      3. Support of patient well-being can be lost to the lure of technology.
   4. Finding a balance
      1. The skilled nurse who practices in a high-acuity setting must be able to bridge the gap between complex technology and the art of caring.
      2. Appropriate training in the use of technology prevents technology from becoming the focus of care.
      3. Nurses are at risk for becoming overly dependent on technology.
4. **Healthy Work Environment**
   1. Healthy work environment
      1. The American Association of Critical-Care Nurses (AACN) has identified six standards needed to sustain a healthy work environment. These standards are:
         1. Skilled communication
         2. True collaboration
         3. Effective decision making
         4. Appropriate staffing
         5. Meaningful recognition
         6. Authentic leadership
   2. Stress, burnout, and compassion fatigue
      1. Burnout is a term used to describe feelings of personal and professional frustration, dissatisfaction, job insecurities, and emotional and physical exertion.
      2. Causes for burnout:
         1. Nursing shortages, long work hours, and a loss of concentration, managerial unresponsiveness, lack of team support
         2. Stress caused by exposure to patients experiencing pain and suffering
         3. Feelings of powerlessness
         4. Repeated exposure to pain and traumatic loss
      3. Compassion fatigue describes the inability to reenergize because of the loss of compassion energy expended on others.
         1. Compassion fatigue results from stress nurses experience from daily relationships with patients and families.
   3. Coping with stress, burnout, and compassion fatigue
      1. Factors that improve a nurse’s ability to cope with stress are a positive social climate, managerial support, and staff cohesiveness.
      2. Critical incident stress debriefings (CISD) help to promote coping with special situations.
      3. A sense of community allows the nurse the ability to share both stresses and joys.
5. **Ensuring Patient Safety in High-Acuity Environments**
   1. The culture
      1. Studies have linked a relationship among work conditions, teamwork, and patient outcomes:
         1. High levels of teamwork have been associated with a decreased length of stay and decreased mortality.
   2. Patient safety
      1. The Joint Commission (TJC) is an accrediting organization that seeks to improve patient safety through an accreditation process.
         1. TJC developed National Patient Safety Goals for acute care hospitals.
         2. To receive accreditation, the applying organization must develop and provide evidence that it is meeting the outlined safety goals.
   3. Technology and patient safety
      1. Computerized systems are used to prevent errors.
         1. The computerized provider order entry (CPOE) systems
            1. Used to block incorrect medication orders; warn of drug interactions, allergies, and overdoses; provide current drug information; and alert one to similar drug names
         2. The barcode medication administration (BCMA)
            1. Allows nurses to scan their badges and then the patient wristbands to access medications profiled for that specific patient
         3. Smartphones allow for text messaging, email retrieval, and the use of clinical apps
   4. Other factors contributing to patient safety
      1. Patient safety can be promoted with factors other than technology.
      2. A strong educational foundation and solid orientation will help the high-acuity nurse provide a safe environment.
      3. Performance standards, specialty certification, culture of respect and professionalism, and strong physician–nurse relationships are among the factors that contribute to patient safety.
6. **Clinical Reasoning Checkpoint**

**Case 1:** RM is a 64-year-old with stage 4 metastatic colon cancer. She presents to the emergency department with shortness of breath. A chest x-ray reveals right lower lobe pneumonia. She is admitted to the hospital. She has advance directives that include no intubation or CPR.

1. Is RM a candidate for admission to the ICU? Why or why not?
2. Using the Society of Critical Care Medicine (SCCM) prioritization model, identify the patient’s priority level for ICU placement.

**Case 2:** A patient with a history of new-onset seizures is admitted to a level III ICU. A diagnosis of brain tumor is made, and surgery will be required. The healthcare provider (HCP) informs the patient that he needs to be transferred to another hospital that has a level I ICU.

1. After the HCP leaves the room, the patient says he doesn’t understand why he needs to be transferred. As his nurse, explain the reason for the need for transfer.

**Case 3:** You would like to work in a high-acuity unit that has a healthy practice environment that supports quality patient care and high levels of nurse satisfaction. You are aware of the six standards identified by AACN that are critical to creating and sustaining a healthy work environment.

1. Provide at least one example of how you might see each of the six standards operationalized in the high-acuity unit.
2. **Post-Test / Chapter 1 Review**

**Chapter 1 Question:** ch01\_01

**Question**: The ICU nurse receives a call from the medical–surgical unit requesting transfer of a patient to the ICU. The patient is in acute respiratory failure and requires mechanical ventilation. He will require vasoactive drugs to help manage his profound hypotension. Based on the SCCM prioritization model, what is this patient’s priority for ICU placement?

**Answer**:

1. Priority 1

**Rationale**:

1. This patient is unstable and requires treatment and monitoring that cannot be provided outside the ICU (new mechanical ventilation and vasoactive infusions). This condition meets the criteria for Priority 1 admission.

**Chapter 1 Question:** ch01\_02

**Question**: A nurse is interviewing for a position in a community hospital. Hospital brochures describe a Level III ICU. Which statement describes the resources that the nurse would expect in this hospital?

**Answer**:

3. Staff in the unit can provide initial stabilization of patients for transfer to more advanced care.

**Rationale:**

3. A Level III ICU provides initial stabilization of patients.

**Chapter 1 Question:** ch01\_03

**Question**: A hospital has been working to achieve Magnet status. Which statements by an ICU nurse reflect the benefits of Magnet status? (Select all that apply.)

**Answer**:

1. “I feel more ownership in the decisions being made to run the unit.”

4. “Taking care of one less patient each shift makes such a difference.”

**Rationale**:

1. Nurses who work in Magnet hospitals are more involved in decision making, which increases their ownership of the decisions.

4. Improved nurse–patient ratios are a benefit of work toward Magnet status.

**Chapter 1 Question:** ch01\_04

**Question**: In the middle of a shift a nurse comes to the manager to discuss the acuity level and number of patients he has been assigned. Which statement would the manager interpret as indicating the nurse needs further education about nurse–patient ratios?

**Answer**:

2. “Our professional organizations would not approve of exceeding their recommended ratios.”

**Rationale**:

2. AACN and AMSN do not set recommended ratios.

**Chapter 1 Question:** ch01\_05

**Question**: New, fairly complex monitoring devices have been purchased to replace current monitors in the ICU. How should the nurse manager plan to introduce this equipment to the unit?

**Answer**:

2. Require that all nurses caring for patients on this monitor have extensive training on its use.

**Rationale**:

2. All nurses who will use this equipment must be trained in its use before caring for a patient on the monitor.

**Chapter 1 Question:** ch01\_06

**Question**: What is the best advice that an experienced ICU nurse can offer to new nurses on how to remain focused on the patient?

**Answer**:

3. “Try to arrange equipment so that you have ample opportunity to use the power of your touch with the patient.”

**Rationale**:

3. Touch helps to personalize the patient for the nurse. Touch also helps to reduce anxiety in the patient.

**Chapter 1 Question:** ch01\_07

**Question**: A coworker has become increasingly withdrawn from social activities on the unit. She is often late for work and is ambivalent about warnings from the nurse manager. She has become hostile and negative about proposed changes in the unit. The nurse should recognize that the coworker is exhibiting symptoms of which condition?

**Answer**:

1. Burnout

**Rationale**:

1. Ambivalence, withdrawal, hostility, and negativity are all symptoms of burnout.

**Chapter 1 Question:** ch01\_08

**Question**: The nurse manager has made a commitment to improve the health of the ICU work environment. Which activities will help meet that goal? (Select all that apply.)

**Answer**:

1. Make every effort to assign patients so that their needs match the nurse’s strengths.

3. Engage the hospital nurse executive in efforts to improve the health of the entire environment.

5. Communicate in a clear and effective manner.

**Rationale**:

1. Matching patient need to nurse strength reflects appropriate staffing, which is one of the AACN standards for a healthy work environment.

3. The manager should demonstrate and encourage authentic leadership, embracing healthy living and environmental strategies.

5. Skilled communication is one of the AACN standards for a healthy work environment.

**Chapter 1 Question:** ch01\_09

**Question**: The hospital is planning to implement a CPOE system. One of the nurses says, “I don’t see how that is going to help.” Which statement by another nurse is a good response to this concern?

**Answer**:

3. “Actually, hospitals that have used these systems generally see error reduction.”

**Rationale**:

3. CPOE systems have been found to reduce error.

**Chapter 1 Question:** ch01\_10

**Question**: The high-acuity unit’s operations council is seeking suggestions concerning the use of technology to prevent errors on the unit. What statements by nurses are good responses to this request? (Select all that apply.)

**Answer**:

1. “Barcode medication administration (BCMA) has been shown to reduce medication errors.”

5. “If we had smartphones, we could look up so much information.”

**Rationale**:

1. BCMA systems do reduce medication errors.

5. Smartphones do allow for quick and convenient access to data.

1. **References**

Academy of Medical-Surgical Nurses (AMSN). (2011). Position statement: Staffing standards for patient care. Retrieved August 20, 2015, from http://www.amsn.org

Aiken, L. (2014). Baccalaureate nurses and hospital outcomes: More evidence. *Medical Care*, *52*(10), 861–863. doi: 10.1097/MLR.0000000000000222

American Association of Critical-Care Nurses (AACN). (2005). AACN standards for establishing and sustaining healthy work environments: A journey to excellence. *American Journal of Critical Care*, 14, 187–197.

American College of Critical Care Medicine (ACCM). (1993). Guidelines for the transfer of critically ill patients. *Critical Care Medicine*, *21*, 931–937.

American College of Critical Care Medicine (ACCM). (1998). Guidelines on admission and discharge for adult intermediate care units. *Critical Care Medicine*, *26*(3), 608.

American College of Critical Care Medicine (ACCM). (1999). Guidelines for intensive care unit admission, discharge, and triage. *Critical Care Medicine*, *27*(3), 633–638.

American Nurses Association (ANA). (2005). Delegation: Joint ANA and National Council of State Boards of Nursing Position Statement. Retrieved August 20, 2015, from http://nursingworld.org

Auerbach, D., Buerhaus, P., & Staiger, D. (2014). Registered nurses are delaying retirement, a shift that has contributed to recent growth in the nurse workforce. *Health Affairs*, *33*(8), 1474–1480. doi: 10.1377/hlthaff.2014.0128

Baker, M., Luce, J., & Bosslet, G. (2015). Integration of palliative care services in the intensive care unit. *Clinics in Chest Medicine*, *36*(3), 441–448. doi: 10.1016/ j.ccm.2015.05.010

Baldwin, M. R. (2015). Measuring and predicting long-term outcomes in older survivors of critical illness. *Minerva Anestesiologica*, *81*(6), 650–661.

Bonafide, C., Lin, R., Zander, M., Graham, C., Paine, C., Rock, W., ... Keren, R. (2015). Association between exposure to nonactionable physiologic monitor alarms and response time in a children’s hospital. *Journal of Hospital Medicine*, *10*(6), 345–351. doi: 10.1002/jhm.2331

Boyle, D. (2015). Compassion fatigue: The cost of caring. *Nursing*, *45*(7), 48–51. doi: 10.1097/01. NURSE.000061857.48809.a1

Centers for Disease Control and Prevention. (2012). 2011 Guidelines for Field Triage of Injured Patients. Retrieved September 15, 2017, from https://stacks.cdc.gov/view/cdc/23038/Share

Charles, K., Cannon, M., Hall, R., & Coustasse, A. (2014, Fall). Can utilizing a computerized provider order entry (CPOE) system prevent hospital medical errors and adverse drug events? *Perspectives in Health Information Management*, 1–16.

Dabney, B., & Kalisch, B. (2015). Nurse staffing levels and patient-reported missed nursing care. *Journal of Nursing Care Quality*, *30*(4), 306–312. doi: 10.1097/ NCQ.0000000000000123

Droogh, J., Smit, M., Absalom, A., Ligtenberg, J., & Zijlstra, J. (2015). Transferring the critically ill patient: Are we there yet? *Critical Care*, *19*(62). doi: 10.1186/ s13054-015-0749-4

Furness, N., Bradford, O., & Paterson, M. (2013). Tablets in trauma: Using mobile computing platforms to improve patient understanding and experience. *Orthopedics*, *36*(3), 205–208. doi: 10.3928/01477447-20130222-06

Haupt, M. T., Bekes, C. E., Carl, L. C., Gray, A. W., Jastremski, M. S., Naylor, D. F., ... Society of Critical Care Medicine. (2003). Guidelines on critical care services and personnel: Recommendations based on a system of categorization of three levels of care. *Critical Care Medicine*, *31*(11), 2677–2683.

Healy, S., & Tyrrell, M. (2013). Importance of debriefing following critical incidents. *Emergency Nurse*, *20*(10), 32–37.

Henderson, J. (2015). The effect of hardiness education on hardiness and burnout on registered nurses. *Nursing Economics*, *33*(4), 204–209.

Hinderer, K., VonRueden, K., Friedmann, E., McQuillan, K., Gilmore, R., Kramer, B., & Murray, M. (2014). Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses. *Journal of Trauma Nursing*, *21*(4), 160–169. doi: 10.1097/ JTN.0000000000000055

Institute of Medicine (IOM), Committee on Quality of Health Care in America. (2001). Crossing the quality chasm: A new health system for the 21st century. Retrieved November 24, 2016, from https://www.nap. edu/read/10027/chapter/1

Kelly, L., Runge, J., & Spencer, C. (2015). Predictors of compassion fatigue and compassion satisfaction in acute care nurses. *Journal of Nursing Scholarship*, *47*(6), 522–528. doi: 10.1111/jnu.12162

Kostakou, E., Rovina, N., Kyriakopoulou, M., Koulouris, N. G., & Koutsoukou, A. (2014). Critically ill cancer patient in intensive care unit: Issues that arise. *Journal of Critical Care*, *29*, 817–822.

Kramer, M., Brewer, B., Halfer, D., Hnatiuk, C., MacPhee, M., & Schmalenberg, C. (2014). The evolution and development of an instrument to measure essential professional nursing practices. *Journal of Nursing Administration*, *44*(11), 569–576. doi: 10.1097/ NNA.0000000000000128

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly*, *34*(1), 4–17.

Kutney-Lee, A., Stimpfel, A., Sloane, D., Cimiotti J., Quinn, L., & Aiken, L. (2015). Changes in patient and nurse outcomes associated with magnet hospital recognition. *Medical Care*, *53*(6), 550–557. doi: 10.1097/ MLR.0000000000000355

Maresca, R., Eggenberger, T., Moffa, C., & Newman, D. (2015). Lessons learned: Accessing the voice of nurses to improve a novice nurse program. *Journal for Nurses in Professional Development*, *31*(4), 218–224. doi: 10.1097/ NND.0000000000000169

McHugh, N., Baker, R., Mason, H., Williamson, L., Van Exel, J., Deogaonkar, R., ... Donaldson, C. (2015). Extending life for people with a terminal illness: A moral right and an expensive death? Exploring societal perspectives. *BMC Medical Ethics*, *16*(14). doi: 10.1186/ s12910-015-0008-x

Meyer, M. (2003). Avoid PCU bottlenecks with proper admission and discharge criteria. *Critical Care Nurse*, *23*(3), 59–63.

Mick, D. J., & Ackerman, M. H. (2004). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, *39*(3), 473–493.

Ñamendys-Silva, S., Plata-Menchaca, E., Rivero-Sigarroa, E., & Herrera-Gómez, A. (2015). Opening the doors of the intensive care unit to cancer patients: A current perspective. *World Journal of Critical Care Medicine*, *4*(3), 159–162. doi: 10.5492/wjccm.v4.i3.159

Oerlemans, A., Van Sluisveld, N., Van Leeuwen, E., Wollersheim H., Dekkers, W., & Zegers, M. (2015). Ethical problems in intensive care unit admission and discharge decisions: A qualitative study among physicians and nurses in the Netherlands. *BMC Medical Ethics*, *16*(9), 1–10. doi: 10.1186/s12910-015-0001-4

Pattison, J., & Kline, T. (2015). Facilitating a just and trusting culture. *International Journal of Health Care Quality Assurance*, *28*(1), 11–26. doi: 10.1108/ IJHCQA-05-2013-0055

Peigne, V., Somme, D., Guerot, E., Lenain, E., Chatellier, G., Fagon, J.-Y., & Saint-Jean, O. (2016). Treatment intensity, age and outcome in medical ICU patients: Results of a French administrative database. *Annals of Intensive Care*, *6*(7), 1–8. doi: 10.1186/s13613-016-0107-y

Riemer, H., Mates, J., Ryan, L., & Schleder, B. (2015). Decreased stress levels in nurses: A benefit of quiet oi: 10.4037/ajcc2015706 Rubin R. (2015). Bill takes aim at nationwide shortage of nurses. *Journal of the American Medical Association*, *313*(18), 1787. doi:10.1001/jama.2015.3747

Rubin, R. (2015). Bill takes aim at nationwide shortage of nurses. *Journal of the American Medical Association, 313*(18), 1787. doi:10.1001/jama.2015.3747

Sabzevari, S., Mirzaei, T., Bagherian, B., & Iranpour, M. (2015). Critical care nurses’ attitudes about influences of technology on nursing care. *British Journal of Medicine & Medical Research*, *9*(8), 1–10. doi: 10.9734/ BJMMR/2015/18400

Seibert, H., Maddox, R., Flynn, E., & Williams, C. (2014). Effect of barcode technology with electronic medication administration record on medication accuracy rates. *American Journal of Health-System Pharmacy*, *71*, 209–218.

Sendelbach, S., Wahl, S., Anthony, A., & Shotts, P. (2015). Stop the noise: A quality improvement project to decrease electrocardiographic nuisance alarms. *Critical Care Nurse*, *35*(4), 15–23. doi: 10.4037/ccn2015858

Sim, Y., Jung, H., Shin, T., Kim, D., & Park, S. (2015). Mortality and outcomes in very elderly patients 90 years of age or older admitted to the ICU. *Respiratory Care*, *60*(3), 347–355. doi: 10.4187/respcare.03155

The Joint Commission. (2015). National Patient Safety Goals Effective January 1, 2015. Retrieved November 21, 2016, from http://www.jointcommission.org/ assets/1/6/2015\_NPSG\_HAP.pdf

Ulrich, B., & Kear, T. (2014). Patient safety and patient safety culture: Foundations of excellent health care delivery. *Nephrology Nursing Journal*, *41*(5), 447–456, 505.

U.S. Department of Health & Human Services. (2014). Key features of the Affordable Care Act by year. Retrieved November 19, 2016, from http://www.hhs.gov/ healthcare/facts/timeline/timeline-text.html

Van Sluisveld, N., Zegers, M., Westert, G., Van der Hoeven, J., & Wollersheim, H. (2013). A strategy to enhance the safety and efficiency of handovers of ICU patients: Study protocol of the pICUp study. *Implementation Science 2013*, *8*(67). doi:10.1186/1748-5908-8-67

West, E., Barron, D., Harrison, D., Rafferty, A., Rowan, K., & Sanderson, C. (2014). Nurse staffing, medical staffing and mortality in intensive care: An observational study. *International Journal of Nursing Studies*, *51*, 781–794. doi: 10.1016/j.ijnurstu.2014.02.007

White, K., Scott, I. A., Vaux, A., & Sullivan, C. M. (2015). Rapid response teams in adult hospitals: Time for another look? *Internal Medicine Journal*. doi: 10.1111/imj.12845

Whittingham, K., & Oldroyd, L. (2014). Using an SBAR— Keeping it real! Demonstrating how improving safe care delivery has been incorporated into a top-up degree programme. *Nurse Education Today*, *34*(6), e47–e52.

Wong, T. H., Krishnaswamy, G., Nadkarni, N. V., Nguyen, H. V., Lim, G. H., Bautista, D. C. T., . . . Ong, M. E. H. (2016). Combining the New Injury Severity Score with an anatomical polytrauma injury variable predicts mortality better than the New Injury Severity Score and the Injury Severity Score: A retrospective cohort study. *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine*, *24*(25), 1–11. doi: 10.1186/ s13049-016-0215-6

1. **Suggestions for Classroom Activities**

* Develop three to four patient scenarios. Lead a class discussion as to whether the patients being   
  referenced are suitable for the ICU, IMC, or general medical–surgical unit.
* Determine the students’ interest level. Ask the students if they are considering a nursing career in an ICU, an IMC, or a generalized medical–surgical care unit. What factors do the students cite as the reasons behind their choices?
* Contact a local clinical facility. Ask to have a copy of its policies concerning the steps taken when the intensive care units are filled to capacity.
* Ask students to identify behaviors associated with professional burnout. Lead the discussion on recognizing burnout and coping with the high-acuity nursing environment.

1. **Suggestions for Clinical Activities**

* During the clinical postconference, ask the students to evaluate whether their assigned patients were appropriate for the ICU, IMC, or general medical–surgical care unit.
* Lead a class discussion to determine potential factors that would lead to a patient’s being considered a Priority 4 patient.
* Provide the clinical group rotation opportunities to the ICU and the IMC. Ask the students to develop a listing of the noted differences between the units.