NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Training in Adult Intensive Care Nursing

The Emirati Board in Adult Intensive Care Nursing Program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Issue Date: 22/04/2024

Draft Version 1

Table of Contents

Introduction

Int. A. Preamble

The UAE National Strategy for Nursing/Midwifery: A Roadmap 2026 focuses on human capital development highlighting the need to drive excellence in nursing/midwifery practice. One of the initiatives to achieve this is developing and implementing nursing/midwifery specialist programs.

Adult Intensive care nursing has been identified as one of the priorities for specialization in nursing in the Nursing Strategy and Model for specialization.

Residency is defined as the stage of postgraduate training and education leading to a qualification of independent practice in a core specialty (NHIS 2020:4). Essentially the purpose of the residency program is to equip nurses and midwives with the knowledge, attitude, and skills essential for specialist practice (Raman et al., 2019).

The clinical competence of nurses plays a significant role in the quality of nursing care provision and patient outcomes and the clinical competence of nurses and midwives is inextricably linked to the foundational knowledge of the specialist area which is continuously strengthened through lifelong learning by practitioners.

The need for the adult intensive care nursing specialist program is confirmed by the following information:

- Increasing need for ICU beds and the staff to manage the care of patients with increasingly complex conditions DHA 2019; Staff Writer, 2017)
- Increasing need to produce specialists in adult intensive care or critical care nursing (Ahmed et al., 2022; Al- Yateem, et al., 2021)

Int. B. Goals

The Goal of this program is to raise the quality of care through expanded knowledge and clinical expertise of registered nurses in intensive care.

The program objectives are to develop and strengthen:

- Knowledge, desirable attitude & application of skill in the systematic and comprehensive assessment, care provision and record keeping for adult patients in intensive care units as autonomous and responsible practitioners.
- Critical thinking skills using a health systems approach to problem-solve and make complex decisions in intensive care contexts.
- Lead in the design, implementation, and evaluation of quality improvement processes in intensive care units.
- Leadership of registered nurses as best practice and management role models in the delivery of care to patients in intensive care units.

- Influencing the delivery of intensive care nursing through engagement in policy development at an institutional, national, or international level.
- Development and implementation of teaching and learning strategies for own and staff development that can be implemented to support and enhance in the field of intensive care.

Int. C. Definition of Specialty

Intensive care nursing science is a well-defined base of knowledge within the overall discipline of nursing. This program prepares nurses with specialist knowledge and skills to address the intensive care nursing needs of adults and support of their families.

Int. D. Length of educational program

The training of **Intensive Care Nursing Residency program** must be at least continuous 12 months in total. (Core)

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate nursing education, consistent with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.A.2. At least one site must be assigned for training to assume responsibility for the intensive care residency program. (Core)

I.A.3. A letter of commitment, the need for the program and pledged support must be available. (Core)

I.A.4. Timely and effective internal relationships with all program teams and stakeholders must be evidenced by documentation of meetings and protocols for communication. (Core)

I.B. Participating Sites:

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

I.B.4. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

I.C. Resources

I.C.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. including lecture rooms, skills labs, recreation, and gender-sensitive amenities. (Core)

I.C.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for (Core):

I.C.2.a) access to food while on duty; (Core)

I.C.2.b) security and safety measures appropriate to the participating site. (Core)

I.C.3. Residents must have ready access to intensive care nursing and other appropriate reference material in print or electronic format. This must include: (Core)

I.C.3.a) access to electronic medical literature databases with full text capabilities. (Core)

I.C.3.b) access to institutional intensive care health resources and other relevant electronic databases. (Core)

I.C.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

I.C.4.a) A sufficient population of patients with a variety of demographic, socioeconomic backgrounds, and disease patterns to allow for effective and comprehensive training experiences. (Core)

I.C.4.b) Residents must be provided with software resources, training and technical support for research, scholarly activities and presentations or manuscripts and other written assignments. (Core)

I.C.5. The program must provide a positive learning environment in a flexible, compassionate culture promoting teamwork and interdisciplinary and interprofessional learning environment. (Core)

I.D. Other Learners and Other Care Providers

The presence of other learners and other care providers, including, but not limited to, interns, residents from other programs (including medical) must enrich the appointed residents' education. (Core)

I.D.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). (Core)

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director for the intensive care program with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

II.A.1.c) The Program Director position shall be assumed for a minimum of 3 years to ensure continuity. (Core)

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core)

II.A.2.a) Additionally, the program director must be provided with:

II.A.2.a)(1) Workspace, equipment and technology, administration support, resources. (Core)

II.A.2.a)(2) A stated clear job description defining expectations and accountability and reporting structure. (Core)

II.A.2.a)(3) An associate program director to support the management of the residency program. (Core)

II.A.3. Qualifications of the program director:

II.A.3.a) must include knowledge and/or experience in adult learning principles and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

II.A.3.b) must be licensed as Critical Care specialist; (Core)

II.A.3.c) must include appropriate staff appointment; (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; (Core)

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Competency domains; (Core)

II.A.4.a)(4) develop and oversee a process to evaluate preceptors prior to approval as program faculty members for participation in the residency program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend, dismiss, not to promote, or not to renew the appointment of a resident; (Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(12) document verification of program completion for all graduating residents; within 30 days; (Core)

II.A.4.a)(13) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as

required in the Institutional Requirements and outlined in the NIHS guidelines to the Program Requirements. (Core)

II.A.4.a)(14) ensure implementation of procedures for training of faculty and administrative staff and address concerns timely and fairly. (Core)

II.A.5. Associate Program Director (APD):

II.A.5.a) The sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration. (Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.A.5.d) APD must be a registered nurse (RN); • holds a graduate degree in nursing and a doctoral degree; and • provides effective leadership and/or professional consultation to the program in achieving its mission, goals, and expected outcomes.

II.B. Faculty/ Resident facilitators

Faculty or Resident facilitators members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. By employing a scholarly approach to patient care, faculty members, through the education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

II.B.1. At each participating site, there must be enough faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.1.b) The ratio of all faculty to residents must be a minimum of 1:4. (Core).

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

II.B.2.g) At least one member of the faculty should support resident scholarly activities. (Core)

II.B.3. Faculty Qualifications

II.B.3.a) Faculty must be intensive care or critical care specialist nurses that are licensed to practice and hold appropriate institutional appointments. (Core)

II.B.3.b) Administrative staff must have qualifications and experience suitable for their roles. (Core) An experienced registered nurse with a baccalaureate or graduate degree in nursing who guides and supports nurse residents in classroom and clinical settings to achieve the goals of the residency program. This individual's primary role is to facilitate learning sessions

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. (Core)

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS -accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.b) Registered nurses who have completed their undergraduate program, transition to practice residency program and at least one year of service in intensive care services. (Core)

III.A.1.c) Registered nurses with three or more years' experience in intensive care nursing, can access the program through Recognition of Prior Learning (RPL) by completing a Portfolio of Evidence and/or challenging the examination for the program as determined by the policy of the sponsoring institution to get access to the postgraduate diploma in intensive care nursing. (Core)

III.B. Number of Residents

III.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in nursing education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful nurses who provide compassionate care.

IV.A. Curriculum Components

The core curriculum must include didactic sessions including ward rounds, clinical meetings, case presentations, morbidity and mortality reviews, lectures, journal clubs and evidence reviews, multidisciplinary meetings, seminars, workshops, videos, demonstrations, simulation, standardized patient activities, reflective and interactive activities. (Core)

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.2. There must be structured clinical experience (with the curriculum contributing to the overall goal of the program) incorporating exposure to acute emergency and acute in-patient care, chronic care, community, and primary healthcare services, psychogeriatric, clinical psychology and counseling services, substance use services, working with families and children. (Core)

IV.A.3. Overall educational goals for the program must exist and communicated to residents and faculty. (Core)

IV.A.4. Competency-based goals and objectives for each educational experience are designed to promote progress on a trajectory to autonomous practice and must be available for assignments at each level. (Core)

IV.A.5. Residents must be provided with increasing responsibility in patient care and management, supervision, and administration according to the training stage. (Core)

IV.A.6. Residents must be equipped with essential research principles and competencies and residents and faculty must participate in research and scholarly activities. (Core)

IV.A.7. The implementation of guidelines on residents' education-service balance must be available consisting of at least 600 hours for knowledge development, 600 hours skills development, and placement in clinical practice for a minimum of 250 hours. (Core)

IV.A.7.a) There must be structured clinical experience with the curriculum contributing to the overall goal of the program

providing learning opportunities in medical, surgical, and sub-specialty intensive care units. (Core)

IV.A.8. Diversity of training experiences for residents must be made available through rotations through different services providing intensive care nursing services. (Core)

IV.A.9. Residents must be provided with protected time to participate in structured didactic activities. (Core)

IV.A.9.a) Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. (Core)

IV.B. Competency for Critical care /intensive care Nurse Specialist

IV.B.1. Entry-to-Practice competencies for Nurse Specialist

Specialty background: This document outlines the expected entry level competencies for Nurses Specialist**.**

This should guide the academic institutions on the outcomes that should be achieved for any Post graduate Nursing specialization.

These competencies are the benchmark for the knowledge, skills, and judgements individuals must demonstrate for safe, ethical, and effective Nurses specialist practice.

IV.B.1.a) Client Care

IV.B.1.a)(1) Client Relationship Building and Communication

The competent, entry-level nurse Specialist uses appropriate communication strategies to create a safe and therapeutic environment for client care.

IV.B.1.a)(1)(a) Clearly articulate the role of the Nurse Specialist when interacting with the client. (Core)

IV.B.1.a)(1)(b) Use developmentally and culturally appropriate communication techniques and tools. (Core)

IV.B.1.a)(1)(c) Create a safe environment for effective and trusting client interaction where privacy and confidentiality are maintained. (Core)

IV.B.1.a)(1)(d) Use relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships. (Core)

IV.B.1.a)(1)(e) Provide culturally safe care, integrating clients' cultural beliefs and values in all client interactions. (Core)

IV.B.1.a)(1)(f) Identify personal beliefs and values and provide unbiased care. (Core)

IV.B.1.a)(1)(g) Recognize moral or ethical dilemmas, and take appropriate action if necessary (e.g., consult with others, involve legal system). (Core)

IV.B.1.a)(1)(h) Document relevant aspects of client care in client record. (Core)

IV.B.1.a)(2) Assessment

The competent, entry-level Nurse Specialist integrates an evidence-informed knowledge base with advanced assessment skills to obtain the necessary information to identify client diagnoses, strengths, and needs.

IV.B.1.a)(2)(a) Establish the reason for the client encounter: (Core)

- review information relevant to the client encounter (e.g., referral information, information from other healthcare providers, triage notes) if available.
- perform initial observational assessment of the client's condition.
- ask pertinent questions to establish the context for client encounter and chief presenting issue.
- identify urgent, emergent, and life- threatening situations.
- establish priorities of client encounters.

IV.B.1.a)(2)(b) Complete relevant health history appropriate to the client's presentation: (Core)

- collect health history such as symptoms, history of presenting issue, past medical and mental health history, family health history, pre-natal history, growth and development history,

allergies, prescription and OTC medications, and complementary therapies.
- collect relevant information specific to the client's psychosocial, behavioral, cultural, ethnic, spiritual, developmental life stage, and social determinants of health.
- determine the client's potential risk profile or actual risk behaviors (e.g., alcohol, illicit drugs and/or controlled substances, suicide or self-harm, abuse, or neglect, falls, infections).
- assess client's strengths and health promotion, illness prevention, or risk reduction needs.

IV.B.1.a)(2)(c) Perform assessment: (Core)

- based on the client's presenting condition and health history, identify level of assessment (focused or comprehensive) required, and perform review of relevant systems.
- select relevant assessment tools and techniques to examine the client.
- perform a relevant physical examination based on assessment findings and specific client characteristics (e.g., age, culture, developmental level, functional ability).
- assess mental health, cognitive status, and vulnerability using relevant assessment tools.
- integrate laboratory and diagnostic results with history and physical assessment findings.

IV.B.1.a)(3) Diagnosis

The competent, entry-level Nurse Specialist is engaged in the diagnostic process and develops differential diagnoses through identification, analysis, and interpretation of findings from a variety of sources.

IV.B.1.a)(3)(a) Determine differential diagnoses for acute, chronic, and life-threatening conditions: (Core)

- analyze and interpret multiple sources of data, including results of diagnostic and screening tests, health history, and physical examination.
- synthesize assessment findings with scientific knowledge, determinants of health, knowledge of normal and abnormal states of health/illness,

patient and population level characteristics, epidemiology, health risks.
- inform the client of the rationale for ordering diagnostic tests.
- determine most likely diagnoses based on clinical reasoning and available evidence.
- assume responsibility for follow-up of test results.
- confirm most likely diagnoses.

IV.B.1.a)(3)(b) Explain assessment findings and communicate diagnosis to client: (Core)

- explain results of clinical investigations to client.
- communicate diagnosis to client, including implications for short- and long-term outcomes and prognosis.
- ascertain client understanding of information related to findings and diagnoses.

IV.B.1.a)(4) Management

The competent, entry-level Nurse Specialist, based on assessment and diagnosis, formulates the most appropriate plan of care for the client, implementing evidence-informed therapeutic interventions in partnership with the client to optimize health.

IV.B.1.a)(4)(a) Initiate interventions for the purpose of stabilizing the client in urgent, emergent, and life-threatening situations (e.g., establish and maintain airway, breathing and circulation, suicidal ideation). (Core)

IV.B.1.a)(4)(b) Formulate plan of care based on diagnosis and evidence-informed practice: (Core)

- determine and discuss options for managing the client's diagnosis, incorporating client considerations (e.g., socioeconomic factors, geography, developmental stage).
- select appropriate interventions, synthesizing information including determinants of health, evidence-informed practice, and client preferences.

- initiate appropriate plan of care (e.g. non-pharmacological, pharmacological, diagnostic tests, referral).
- consider resource implications of therapeutic choices (e.g. cost, availability).

IV.B.1.a)(4)(c) Provide pharmacological interventions, treatment, or therapy: (Core)

- counsel client on pharmacotherapeutics, including rationale, cost, potential adverse effects, interactions, contraindications, and precautions as well as reasons to adhere to the prescribed regimen and required monitoring and follow up.
- establish a plan to monitor client's responses to medication therapy.
- apply strategies to reduce risk of harm involving controlled substances, including medication abuse, addiction, and diversion.

IV.B.1.a)(4)(d) Provide non-pharmacological interventions, treatments, or therapies: (Core)

- select therapeutic options (including complementary and alternative approaches) as indicated by diagnosis based on determinants of health, evidence-informed practice, and client preference.
- counsel client on therapeutic option(s), including rationale, potential risks and benefits, adverse effects, required after care, and follow-up.
- order required treatments (e.g., wound care, phlebotomy).
- discuss and arrange follow-up.

IV.B.1.a)(4)(e) Perform invasive and non-invasive procedures: (Core)

- inform client about the procedure, including rationale, potential risks and benefits, adverse effects, and anticipated aftercare and follow-up.
- obtain and document informed consent from the client.

- perform procedures using evidence- informed techniques as per regulations and scope of practice.
- review clinical findings, aftercare, and follow-up.

IV.B.1.a)(4)(f) Provide oversight of care across the continuum for clients with complex and/or chronic conditions. (Core)

IV.B.1.a)(4)(g) Follow up and provide ongoing management: (Core)

- develop a systematic and timely process for monitoring client progress.
- evaluate response to plan of care in collaboration with the client.
- revise plan of care based on client's response and preferences.

IV.B.1.a)(5) Collaboration, Consultation, and Referral

The competent, entry-level Nurse Specialist identifies when collaboration, consultation, and referral are necessary for safe, competent, and comprehensive client care.

IV.B.1.a)(5)(a) Establish collaborative relationships with healthcare providers and community-based services (e.g., school, police, child protection services, rehabilitation, home care). (Core)

IV.B.1.a)(5)(b) Provide recommendations or relevant treatment in response to consultation requests or incoming referrals. (Core)

IV.B.1.a)(5)(c) Identify need for consultation and/or referral (e.g., to confirm a diagnosis, to augment a plan of care, to assume care when a client's health condition is beyond the nurse Specialist's individual competence or legal scope of practice). (Core)

IV.B.1.a)(5)(d) Initiate a consultation and/or referral, specifying relevant information (e.g., client history, assessment findings, diagnosis) and expectations. (Core)

IV.B.1.a)(5)(e) Review consultation and/or referral recommendations with the client and integrate into plan of care as appropriate. (Core)

IV.B.1.a)(6) Health Promotion

The competent, entry-level Nurse Specialist uses evidence and collaborates with community partners and other healthcare providers to optimize the health of individuals, families, communities, and populations.

IV.B.1.a)(6)(a) Identify individual, family, community and/or population strengths and health needs to collaboratively develop strategies to address issues. (Core)

IV.B.1.a)(6)(b) Analyze information from a variety of sources to determine population trends that have health implications. (Core)

IV.B.1.a)(6)(c) Select and implement evidence-informed strategies for health promotion and primary, secondary, and tertiary prevention. (Core)

IV.B.1.a)(6)(d) Evaluate outcomes of selected health promotion strategies and revise the plan accordingly. (Core)

IV.B.1.b) Quality Improvement and Research

The competent, entry-level Nurse Specialist uses evidence-informed practice, seeks to optimize client care and health service delivery, and participates in research.

IV.B.1.b)(1) Identify, appraise, and apply research, practice guidelines, and current best practice. (Core)

IV.B.1.b)(2) Identify the need for improvements in health service delivery. (Core)

IV.B.1.b)(3) Analyze the implications (e.g., opportunity costs, unintended consequences) for the client and/or the system of implementing changes in practice. (Core)

IV.B.1.b)(4) Implement planned improvements in healthcare and delivery structures and processes. (Core)

IV.B.1.b)(5) Participate in quality improvement and evaluation of client care outcomes and health service delivery. (Core)

IV.B.1.b)(6) Identify and manage risks to individuals, families, populations, and the healthcare system to support quality improvement. (Core)

IV.B.1.b)(7) Report adverse events to clients and/or appropriate authorities, in keeping with relevant legislation and organizational policies. (Core)

IV.B.1.b)(8) Analyze factors that contribute to the occurrence of adverse events and near misses and develop strategies to mitigate risks. (Core)

IV.B.1.b)(9) Participate in research. (Core)

IV.B.1.b)(10) Contribute to the evaluation of the impact of nurse Specialist practice on client outcomes and healthcare delivery. (Core)

IV.B.1.c) Leadership

The competent entry-level nurse specialist demonstrates leadership by using the nurse specialist role to improve client care and facilitate system change.

IV.B.1.c)(1) Promote the benefits of the nurse specialist role in client care to other healthcare providers and stakeholders (e.g., employers, social and public service sectors, the public, legislators, policymakers). (Core)

IV.B.1.c)(2) Implement strategies to integrate and optimize the nurse specialist role within healthcare teams and systems to improve client care. (Core)

IV.B.1.c)(3) Coordinate interprofessional teams in the provision of client care. (Core)

IV.B.1.c)(4) Create opportunities to learn with, from, and about other healthcare providers to optimize client care. (Core)

IV.B.1.c)(5) Contribute to team members' and other healthcare providers' knowledge, clinical skills, and client care (e.g., by responding to clinical questions, sharing evidence). (Core)

IV.B.1.c)(6) Identify gaps and/or opportunities to improve processes and practices, and provide evidence informed recommendations for change. (Core)

IV.B.1.c)(7) Utilize theories of and skill in communication, negotiation, conflict resolution, coalition building, and change management. (Core)

IV.B.1.c)(8) Identify the need and advocate for policy development to enhance client care. (Core)

IV.B.1.c)(9) Participate in program planning and development to optimize client care. (Core)

IV.B.1.d) Education

The competent, entry-level nurse specialist integrates formal and informal education into practice. This includes but is not limited to educating self, clients, the community, and members of the healthcare team.

IV.B.1.d)(1) Client, community, and healthcare team education

IV.B.1.d)(1)(a) Assess and prioritize learning needs of intended recipients. (Core)

IV.B.1.d)(1)(b) Apply relevant, theory-based, and evidence informed content when providing education. (Core)

IV.B.1.d)(1)(c) Utilize applicable learning theories, develop education plans, and select appropriate delivery methods, considering available resources (e.g., human, material, financial). (Core)

IV.B.1.d)(1)(d) Disseminate knowledge using appropriate delivery methods (e.g., pamphlets, visual aids, presentations, publications). (Core)

IV.B.1.d)(1)(e) Recognize the need for and plan outcome measurements (e.g., obtaining client feedback, conducting pre- and post-surveys). (Core)

IV.B.1.d)(2) Continuing competence

IV.B.1.d)(2)(a) Engage in self-reflection to determine continuing education competence needs. (Core)

IV.B.1.d)(2)(b) Engage in ongoing professional development. (Core)

IV.B.1.d)(2)(c) Seek mentorship opportunities to support one’s professional development. (Core)

IV.B.2. Critical care /Intensive Care Nurse Specialist Competencies

IV.B.2.a) PROFESSIONAL, ETHICAL and LEGAL PRACTICE

IV.B.2.a)(1) Professional Practice

IV.B.2.a)(1)(a) Accepts accountability for increased responsibility for own professional and clinical judgment, actions, health care outcomes and continued competence in accordance with the prescribed scope of practice, relevant health and nursing acts and regulations. (Core)

IV.B.2.a)(1)(b) Practices within the realm of critical care nurse specialist scope of practice and knowledge based in accordance with the advances, current evidence, and trends in critical care nursing. (Core)

IV.B.2.a)(1)(c) Engages in self-evaluation of own practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial. (Core)

IV.B.2.a)(1)(d) Obtains formal and informal feedback regarding one's own practice from health care users, peers, professional colleagues, and others. (Core)

IV.B.2.a)(1)(e) Actively engages with intra and inter-professional peers and colleagues contributing one's professional perspective to enhance one's own professional practice or role performance. (Core)

IV.B.2.a)(1)(f) Provides peers with formal and informal constructive feedback regarding their practice or role performance to enhance professional development/advancement. (Core)

IV.B.2.a)(1)(g) Demonstrates commitment to personal growth through self-reflection, and inquiry as well as engagement in and keeping of a record of lifelong learning. (Core)

IV.B.2.a)(1)(h) Fosters professional autonomy and accountability in self and others. (Core)

IV.B.2.a)(1)(i) Participates and advocates for the profession in policy development on health care in

particular critical care cursing and professional affairs. (Core)

IV.B.2.a)(1)(j) Participates actively and expertly in consultative activities or affairs of the professional associations and regulatory bodies especially in relation to critical care practice to enhance personal and professional development. (Core)

IV.B.2.a)(1)(k) Contributes to nursing knowledge by conducting or synthesizing research and other evidence that reveals, examines and evaluates current practice, knowledge, theories, criteria and creative approaches to improve critical care practice and professional development. (Core)

IV.B.2.a)(1)(l) Shares best practice with colleagues, peers and professional counterparts through dissemination by way of presentations in conferences, publication in reputable but accessible journals to local health care professionals and journal clubs. (Core)

IV.B.2.a)(2) Ethical Practice

IV.B.2.a)(2)(a) Delivers care in a manner that preserves and protects the autonomy, dignity, rights, values, beliefs and preferences of the health care user and family during dehumanizing environment such as high technology, buzzing alarms, complex decision making like termination of life support considering applicable the code of conduct, pledge of service, patient's rights charter. (Core)

IV.B.2.a)(2)(b) Engages in ethical and legal debates concerning some complex decisions and orders in ICU for example: The do not resuscitate (DNR) orders, and research of vulnerable patients who are unconscious, heavily sedated and with communication barriers within the relevant multidisciplinary team. (Core)

IV.B.2.a)(2)(c) Recognizes the significance of the critically ill patient and family in ethical decision making within the multidisciplinary team ensuring that they take informed decisions. (Core)

IV.B.2.a)(2)(d) Upholds and advocates for critically ill patient confidentiality within the legal and ethical framework because the critically ill patient is not in control of his/her situation. (Core)

IV.B.2.a)(2)(e) Takes appropriate action in case of illegal, unethical or inappropriate behavior that exposes the critically ill patient to risk and jeopardize the best interest of the patient, for example, reports and documents adverse events to relevant structures including the regulatory body. (Core)

IV.B.2.a)(2)(f) Speaks up when appropriate to question critical care practice when necessary for safety and quality improvement. (Core)

IV.B.2.a)(2)(g) Participates and advocates for the patient and profession in decision making about ethical dilemmas. (Core)

IV.B.2.a)(2)(h) Provides information on the risks, benefits, and outcomes of health care regimens to allow informed decision making by health care users, including informed consent and refusal of treatment. (Core)

IV.B.2.a)(2)(i) Advocates for staff in addressing risks in the critical care environment, promoting advancement and positive practice environments. (Core)

IV.B.2.a)(2)(j) Demonstrates sensitivity to medico-legal risks related to monitoring and therapeutic interventions in ICU and consciously avoids them or reports them accordingly. (Core)

IV.B.2.a)(2)(k) Demonstrates sensitivity to cultural, professional, and technological diversity within the multidisciplinary team and critical health care continuum. (Core)

IV.B.2.a)(3) Legal Practice

IV.B.2.a)(3)(a) Participates directly and/or indirectly in the development of health care legislation, regulations, policies and care management tools,

such as, clinical guidelines, protocols, early warning signs and algorithms. (Core)

IV.B.2.a)(3)(b) Practices in accordance with the relevant International and National Legislative Framework, local policies, and care management tools such as clinical guidelines, protocols, algorithms, including but not limited to: (Core)

- World Health Organization (WHO) Guidelines
- National Health Act
- Nursing Act
- Medicines and Related Substances Act
- ACLS Guidelines.

IV.B.2.a)(3)(c) Constantly analyses policies and care management tools for relevance against the current developments and trends and feeds back to line management, colleagues, and the multidisciplinary team to collaboratively initiate change. (Core)

IV.B.2.b) CARE PROVISION AND MANAGEMENT

IV.B.2.b)(1) Health promotion

IV.B.2.b)(1)(a) Applies insight into the position of critical care in the health care system to provide care. (Core)

IV.B.2.b)(1)(b) Orientates critically ill patients, their families and community in the critical care environment in collaboration with other health care teams. (Core)

IV.B.2.b)(1)(c) Develops appropriate discharge plans concurrently with other interventions of the critically ill patient. (Core)

IV.B.2.b)(1)(d) Ensures continuity of care through an accurate, comprehensive handover to Step Down Units/Facilities and related units like operating theatre and diagnostics. (Core)

IV.B.2.b)(1)(e) Utilizes epidemiological data of the critically ill patient to plan and advocate for the patient in the community in terms of provision of infrastructure, equipment, etc. for the continuity of care. (Core)

IV.B.2.b)(1)(f) Empower nursing professionals outside the critical care setting (Units and HDU) to: (Core)

- Avert or reduce episodes of critical illness.
- Ensure early detection of critical illness if it develops.
- Initiate action with urgency (comprehensive critical care).

IV.B.2.b)(1)(g) Collaboratively develop early warning systems to enable nurses outside ICU to implement preventive critical care (prevention, early detection, and immediate action). (Core)

IV.B.2.b)(1)(h) Always fears and dispel myths and misconceptions about intensive care or extraordinary care in the community by orientating the community on the role of ICU through collaboration with community health and primary care nurses. (Core)

IV.B.2.b)(2) Assessment

IV.B.2.b)(2)(a) Develops an epidemiological profile concerning the incidence, prevalence, morbidity, and mortality of life-threatening conditions to practice evidence-based assessment. (Core)

IV.B.2.b)(2)(b) Applies biomedical and social sciences such as anatomy, physiology, pathophysiology, clinical pharmacology, educational, psycho-socio-cultural, ethical, legal, and economical context of disease to assess a critically ill patient. (Core)

IV.B.2.b)(2)(c) Organizes, synthesizes, analyses, and interprets the assessment data of the critically ill patient from the various data sources to derive the nursing diagnoses. (Core)

IV.B.2.b)(2)(d) Formulate nursing diagnoses based on accurate analysis and interpretation of the assessment data obtained from a critical evaluation of the critically ill patient or patient with life threatening problems. (Core)

IV.B.2.b)(2)(e) Establishes priorities in relation to the critically ill patients' problems according to severity as determined by the complexity and multiplicity of problems including the life threat and impingement on the patient's quality of life. (Core)

IV.B.2.b)(2)(f) Continuously monitors, interprets and reacts to the respiratory and hemodynamic status of the critically ill patient including acid base and electrolyte status as frequently as hourly to 4 hourly according to care management tools (protocols, guidelines, algorithms, etc.) using both non-invasive (pulse oximeter, cardiac monitor, NIBP, capnograph, cardiac output) and invasive technology (invasive arterial pressure monitor, ventricular assist mechanisms like IABP). (Core)

IV.B.2.b)(2)(g) Safely and confidently operates various types of technology used in the critical care setting, e.g. mechanical ventilators, cardiac monitors, infusion pumps, both volume, pressure and patient-controlled pumps, IABP, and CVVH. (Core)

IV.B.2.b)(3) Planning

IV.B.2.b)(3)(a) Applies critical thinking and clinical judgment underpinned by scientific, biomedical, and technological knowledge in the critical care field to deduce a plan of care for the critically ill patient. (Core)

IV.B.2.b)(3)(b) Develops a complex, comprehensive, individualized and evidence-based plan of care according to determined health care priorities and care management tools in collaboration with the relevant multidisciplinary team. (Core)

IV.B.2.b)(3)(c) Collaboratively and frequently makes a critical analysis of the plan of care based on the critically ill patient progress and as directed by the care management tools (protocols, algorithms, guidelines) and laboratory findings. (Core)

IV.B.2.b)(3)(d) Collaboratively reviews and revises the plan of care of the critically ill patient according to the compromise/ deterioration or progress of the critically ill patient as illustrated/confirmed in the

patient status, advanced technological parameters, and laboratory findings. (Core)

IV.B.2.b)(4) Implementation

IV.B.2.b)(4)(a) Implements individualized, comprehensive, evidence- based care, based on the findings of the scientific, biomedical, and technological assessment of the critically ill patient within the relevant contextual variables/factors and multidisciplinary collaboration. (Core)

IV.B.2.b)(4)(b) Appropriately prepares for, initiate under supervision, monitors, and administers appropriate care to critically ill patients on technological support, e.g. mechanical ventilator, ventricular assist devices like IABP, pacemaker, CVVH, etc. (Core)

IV.B.2.b)(4)(c) Executes airway management in accordance with the patients' needs or state of respiratory failure, e.g. position, anatomical alignment, meticulous suction of a mechanically ventilated patient with special consideration of detrimental consequences to the hemodynamic status including intubation (oropharyngeal, nasopharyngeal, endotracheal). (Core)

IV.B.2.b)(4)(d) Performs effective oxygenation of a critically ill patient using various types of oxygenation devices in accordance with patient needs/status and vital parameters or criteria, for example: nasal prongs, various O_2 masks, AMBU bags, CPAP, mechanical ventilation, etc. (Core)

IV.B.2.b)(4)(e) Determines readiness, prepares for, and performs weaning of critically ill patients from assistive technological devices in accordance with current evidence and protocols, for example, mechanical ventilation, intra-aortic balloon pump (IABP). (Core)

IV.B.2.b)(4)(f) Determines readiness, prepares the patient for and performs extubation of an intubated patient based on good understanding of current evidence and protocols. (Core)

IV.B.2.b)(4)(g) Initiates/performs advanced resuscitative procedures informed by the patient's cardiopulmonary status and technological parameters, using advanced airway management techniques, cardioversion, defibrillation, external cardiac pacing, and emergency drugs, among others, as spelt out in the care management tools such as protocols or advanced cardiac life support (ACLS) algorithm. (Core)

IV.B.2.b)(4)(h) Accurately records, analyses, interprets and reacts appropriately to advanced biomedical and technological findings/ information/parameters such as ventilator parameters, arterial and venous blood gases (where required), capnograph, sputum status; arterial and venous pressure, pulse; electrocardiogram (ECG) both cardiac monitored and 12 to 18 lead ECG, electrolytes, renal output, intracranial pressure (where applicable), Glasgow coma scale (GCS), peripheral pulses, skin color, temperature (core and peripheral) including capillary refill, etc. (Core)

IV.B.2.b)(4)(i) Utilizes evidence-based formulae to accurately calculate drug dosages for continuous infusions and boluses of treatment to a critically ill patient, especially inotropic support or vasoactive drugs, glycemic control, etc. (Core)

IV.B.2.b)(4)(j) Utilizes evidence-based formulae to accurately calculate replacement and maintenance fluids for hemodynamically compromised patients. (Core)

IV.B.2.b)(4)(k) Safely and confidently operates various types of technology used in the critical care setting for the care and maintenance of the homeostatically and clinically compromised patient, including calibration where necessary, such as cardiac monitors, mechanical ventilators, pulse oximeter, infusion pumps, both volume, pressure and patient-controlled pumps, intracranial pressure monitor, etc. (Core)

IV.B.2.b)(4)(l) Prepares for and assists with diagnostic procedures performed to critical care

patients including execution of insightful post procedure observations, e.g.: (Core)

- cardiac catheterization
- coronary angiogram and insertion of stent
- percutaneous transluminal coronary angioplasty
- insertion of artificial pacemaker insertion of intra-aortic balloon pump (IABP)

IV.B.2.b)(4)(m) Appropriately prepares for reception, initiates and maintains care of patients post major surgery and/or multiple trauma in the ICU, for example, cardiac surgery, neurosurgery, thoracic surgery, transplant, chest trauma, head injuries and abdominal injuries. (Core)

IV.B.2.b)(4)(n) Executes appropriate interventions, both emergency and maintenance, for critical care conditions such as coronary artery syndromes, valvular diseases, cardiomyopathies, neurological conditions, like status epilepticus, vascular and abdominal emergencies, poisoning etc. (Core)

IV.B.2.b)(4)(o) Executes appropriate critical care nursing to special patient populations when confronted with such in the critical care practice/setting, for example: (Core)

- patients in the immediate post –operative period
- critically ill pregnant patient
- pediatric patient in an adult critical care unit
- critically ill elderly patient (SA cannot accommodate them in the interest of distributive justice)
- critically ill patient with a neuropsychiatric disorder
- caring for the bariatric (obese) patient
- oncologic emergencies
- chemical dependency
- end-of-life care

IV.B.2.b)(4)(p) Safely administers massive blood transfusion and other blood components including fluid challenges while accurately anticipating

homeostatic and hemodynamic reaction of the critically ill patient to such treatment. (Core)

IV.B.2.b)(4)(q) Safely monitors and executes appropriate care of venous and arterial. (Core)

IV.B.2.b)(4)(r) Safely monitors the hemodynamic, biomedical, and clinical effects of the multiple pharmacological agents used in the critical care settings, namely, vasoactive (inotropic) drugs, antidysrhythmic, thrombolytics, anticoagulants, antidiuretic, analgesics and antibiotics. (Core)

IV.B.2.b)(4)(s) Monitors, analyzes, and critically evaluates interventions and progress of the patient with a life-threatening condition in the frequency determined by the compromise, care management tools and in collaboration with the multidisciplinary team. (Core)

IV.B.2.b)(4)(t) Revises the care of the critically ill patient according to the revised plan, patient status and progress in collaboration with the multidisciplinary team. (Core)

IV.B.2.b)(4)(u) Engages in decision making and clinical judgment in safe weaning of the patient from assistive or therapeutic technological devices, such as the mechanical ventilator, pacemaker, intra-aortic balloon pump, continuous veno-venous haemo-filtration (CVVH), etc. (Core)

IV.B.2.b)(4)(v) Articulates the critical care nursing with psychosocial aspects in the care of the critically ill patient, for example, communication, family support and involvement in addition to judicious administration of analgesics and sedation for pain/comfort and sleep management. (Core)

IV.B.2.b)(4)(w) Correlates or articulates the basic nursing care with critical care nursing of the patient with a life-threatening condition/problem, considering hygiene of the patient (mouthwash, bed bath, catheter care, perineal care, and eye care especially for patients with loss of corneal reflex. (Core)

IV.B.2.b)(4)(x) Prevents, identifies early, and manages complications of inactivity of critically ill patients using conventional and/or assistive devices, for example, ripple beds for decubitus ulcers, elastic stockings or sequential compression devices (SCDs) for venous thromboembolism, or low dose heparin as prescribed, with early mobilization taking priority. (Core)

IV.B.2.b)(4)(y) Ensures the comfort of the patient through appropriate basic strategies, such as: (Core)

- comfortable rotated positioning
- comfortable bandage/dressing tension
- catheter patency to ensure empty bladder
- aggressive critical care measures such as:
    - administration and titration of analgesia as prescribed and in accordance with protocols
    - sedation as prescribed and in accordance with protocols
    - neuromuscular blockade in extreme cases as prescribed and in accordance with the organizational or interprofessional guidelines

IV.B.2.b)(4)(z) Actively participates in decision making on transfer out of patients including termination of life support. (Core)

IV.B.2.b)(4)(aa) Initiates a timely discharge plan directly or indirectly through the family or relatives in consultation with the relevant health care team members, for example, medical counterparts, dietician, microbiologist including nursing colleagues at the step-down units and/or discharge coordinator if available. (Core)

IV.B.2.b)(4)(bb) Provides adequate and early enteral or parenteral nutrition of a compromised critically ill patient in accordance with energy requirements, respiratory capability, status of the gut, current evidence including unit protocols. (Core)

IV.B.2.b)(4)(cc) Ensures continuity of care and adjustment of the critically ill patient by: (Core)

- preparing the patient and the family including staff at HDU for transfer and/or discharge.
- communicating a comprehensive discharge plan and handover report on the patient progress in ICU and further management to high dependency unit staff.

IV.B.2.b)(4)(dd) Ensures safe intra-hospital and inter-hospital transportation of critically ill patients especially in relation to the airway management, oxygenation and placement and patency of invasive line. (Core)

IV.B.2.b)(4)(ee) Accurately, comprehensively and regularly documents the interventions and progress of the patient as determined by the critical illness of the patient and applicable care management tools or protocols. (Core)

IV.B.2.b)(5) Evaluation

IV.B.2.b)(5)(a) Regularly monitors and critically evaluates the progress of the patient with a life-threatening condition against the collaboratively predetermined and revised outcomes of the critically ill patient. (Core)

IV.B.2.b)(5)(b)Validates the patient's progress with the relevant multidisciplinary team and significant others. (Core)

IV.B.2.b)(5)(c)Utilizes evaluation data to modify the plan of critical care of the patient with life threatening condition in accordance with protocols and algorithms and in collaboration with the multidisciplinary team. (Core)

IV.B.2.b)(6) Therapeutic Communication and Relationships

IV.B.2.b)(6)(a) Uses skilled communication to foster true inter and intraprofessional collaboration in the interest of continuity of patient care and professional development. (Core)

IV.B.2.b)(6)(b) Establishes and enforces channels of communication (written and verbal) within the nursing structures and multidisciplinary team involved in critical care nursing practice. (Core)

IV.B.2.b)(6)(c) Communicates effectively and timely within the multidisciplinary team in relation to consultation and referral of complex problems or deterioration in the patient's status. (Core)

IV.B.2.b)(6)(d) Role models for and encourages staff on therapeutic communication especially in relation to patients with compromised communication ability in a highly technological environment, for example, making time to communicate with patients and families (availability), active listening, therapeutic touch (high-touch versus high-tech), being sensitive to cultural diversity, ensuring privacy, assurance of confidentiality, paying attention to non-verbal cues, etc. (Core)

IV.B.2.b)(6)(e) Communicates effectively with critically ill patients whose communication skills are compromised from intubation, sedation, and loss of consciousness from the disease process employing verbal and non-verbal communication. (Core)

IV.B.2.b)(6)(f) Communicates with the critically ill patient irrespective of the level of consciousness to explain and orientate the patient on all interventions carried out based on the assumption that hearing is the last sense to die. (Core)

IV.B.2.b)(6)(g) Advocates for the patient in relation to all interventions and orders especially in relation to clinical trials, "do not resuscitate (DNR) orders" and termination of life support. (Core)

IV.B.2.b)(6)(h) Communicates with the family of the critically ill patient to orientate them about the ICU interventions, technology, and the patient status especially when there is a change in the patient status and to foster smooth transition of the patient across the critical care setting. (Core)

IV.B.2.b)(6)(i) Establishes trust in the critically ill patients and families through constant availability, listening, giving honest answers, non-judgmental attitude, etc. (Core)

IV.B.2.c) QUALITY OF PRACTICE

IV.B.2.c)(1) Quality improvement

IV.B.2.c)(1)(a) Regularly analyzes the whole health care system and its philosophy to align the critical care accordingly, for example, primary health care approach, the implication of national core standards for critical care nursing practice, other national health care program such as the strategy for nursing education, training and practice, infection control program, disaster programs, etc. (Core)

IV.B.2.c)(1)(b) Regularly reflects on the social, political, cultural, and economic developments within the context of the health care system of the country whilst conforming to national and international standards of critical care nursing (Core)

IV.B.2.c)(1)(c) Provides leadership in the design, implementation, and monitoring of quality improvement activities. (Core)

IV.B.2.c)(1)(d) Collaboratively develops indicators and checklists to monitor quality and effectiveness of critical care nursing practice based on contextual variables, for example, infection rates, length of stay, morbidity, mortality, adverse events, etc. (Core)

IV.B.2.c)(1)(e) Collaboratively implements, evaluates, and updates policies, procedures, and/or guidelines to improve the quality and effectiveness of nursing practice. (Core)

IV.B.2.c)(1)(f) Participates in the formulation and review of management tools e.g. protocols, algorithms used in the practice of critical care nursing. (Core)

IV.B.2.c)(1)(g) Manages and optimizes the critical care context (physical, psychological, and physiological) in a professional manner to the benefit of critically ill patients, families and other health care workers e.g.: (Core)

- observes aseptic technique with all procedures even the simplest.

- ensures adequate supply of antiseptics and disinfectants.
- provides meticulous care to venous or arterial accesses.
- performs meticulous respiratory/bronchial hygiene to avoid ventilator associated pneumonia (VAP).
- ensures that emergency/safety plugs are labelled and continuously available.
- orientates staff on safety including general assistants.
- coordinates infection surveillance at intervals to identify nosocomial infections and resistant organisms in collaboration with the health care team especially the microbiologist.
- traces infection with first signs of infection, for example, change in the consistency and color of sputum, urine, drainage, etc.
- ensures that alarms are kept on and within acceptable limits/ranges.
- applies the various patient restraints considering safety, prescriptive requirements, and legal implications.
- avoids/reduces noise in the ICU.
- consciously observes the dignity of the patient and their families through affording them privacy and explanation of all interventions and progress or deterioration.
- communicates effectively with the patient whose communication ability is compromised by intubation, sedation, and disease process.
- provides unrestricted family visitation.
- accurate and appropriately timed hemodynamic and biomedical monitoring.
- communicates effectively and timeously within the multidisciplinary team to ensure timeous consultation and referral of critically ill patients.

IV.B.2.c)(1)(h) Designs innovations to effect change in critical care nursing practice and improve outcomes based on current evidence. (Core)

IV.B.2.c)(1)(i) Evaluates the practice environment and quality of critical care nursing rendered in

relation to existing evidence, feedback from health care users and pre-set indicators. (Core)

IV.B.2.c)(1)(j) Uses the results of quality improvement activities to initiate changes in critical care nursing practice and in the health care delivery system, for example, change of equipment reported to be having problems. (Core)

IV.B.2.c)(1)(k) Participates in clinical inquiry such as infection surveillance for prevalent and resistant organisms to execute quality improvement activities. (Core)

IV.B.2.c)(1)(l) Collects data to monitor quality and effectiveness of critical care nursing practice. (Core)

IV.B.2.c)(1)(m) Analyses quality data to identify opportunities for improvement of nursing practice and care of the critically ill patient. (Core)

IV.B.2.c)(1)(n) Formulates evidence-based recommendations to improve critical care nursing practice and implements activities to enhance the quality of critical care nursing practice. (Core)

IV.B.2.c)(1)(o) Ensures that quality improvement activities incorporate the patient's and family's beliefs, values and preferences as appropriate. (Core)

IV.B.2.c)(1)(p) Establishes and maintains an environment conducive to adequate performance of staff, for example: (Core)

- coordinates the services to ensure harmony in the unit.
- ensures good functioning of equipment or technological devices.
- ensures adequate material resources, for example, cleaning, servicing, and replacement of defective equipment.
- ensures adequate human resources both in quantity (numbers for shifts) and quality (specialization) including skill-mix daily.
- ensures good interpersonal relationships among staff in the unit, for example, provides stress management, debriefing sessions, considers

individual requests, promotes communication, engages in team building, etc.

IV.B.2.c)(1)(q) Engages with the various committees of the health facility to keep up to date with developments in the health facility, for example, the Infection Control Committee, Hospital Planning Committee, Quality Improvement Committee, Resuscitation Committee, Cash Flow Committee or equivalents. (Core)

IV.B.2.c)(1)(r) Utilizes critical thinking and decision-making skills needed to improve care of high-risk clients and act as agents of change. (Core)

IV.B.2.c)(1)(s) Demonstrates adaptability to unexpected situations (situational leadership). (Core)

IV.B.2.c)(1)(t) Liaises effectively with other departments in relation to staff, students, patients, and equipment, for example, HEIs/NEIs, support departments, other units/wards, etc. (Core)

IV.B.2.c)(1)(u) Performs audits of records and all interventions carried out in ICU at regular intervals and utilizes the outcomes of the audits to put in place quality improvements. (Core)

IV.B.2.c)(1)(v) Participates in review meetings, grand rounds to learn of the general activities in the critical care unit and from omissions and commissions or adverse events to improve quality in the critical care environment. (Core)

IV.B.2.c)(1)(w) Documents incidents both adverse and commendable to allow quality assurance and recognition of staff involved in commendable incidents. (Core)

IV.B.2.c)(2) Continuing Education

IV.B.2.c)(2)(a) Creates and utilizes learning opportunities for orientation and teaching of staff, patients, and families of critically ill patients in the very unfamiliar and stressful ICU environment. (Core)

IV.B.2.c)(2)(b) Continuously reflects on the self and staff competence and keeps her/himself and staff

up to date with current health issues and health care trends in the dynamic environment like critical care nursing. (Core)

IV.B.2.c)(2)(c) Consciously seek experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge as well as personal growth. (Core)

IV.B.2.c)(2)(d) Applies principles of teaching, learning and evaluation to design educational programs that enhance the knowledge and practice of staff in the critical care unit. (Core)

IV.B.2.c)(2)(e) Mentors staff and students in the critical care unit to develop expertise in critically ill patients. (Core)

IV.B.2.c)(2)(f) Participates in the formal and informal education of students, both specialist and general nursing students including new staff members. (Core)

IV.B.2.c)(2)(g) Acts as a resource person or expert in the health facility by: (Core)

- responding to calls for resuscitation in other units.
- responding to enquiries especially in relation to post ICU patients in step down facilities.
- support of staff in general wards to avert unnecessary admissions to ICU, promote early detection of critical illness and prompt action in case of emergency.

IV.B.2.c)(2)(h) Liaises with the trade representatives in relation to new equipment/technology on the market to empower staff in the critical care units on the use and maintenance of such equipment or technology. (Core)

IV.B.2.c)(2)(i) Educates recuperating patients and their families post major surgery or diagnostic procedures such as adult and pediatric cardiac and thoracic surgery, neurosurgery, angiogram, etc. (Core)

IV.B.2.c)(2)(j) Maintains professional records that provide evidence of competency and lifelong learning. (Core)

IV.B.2.d) MANAGEMENT AND LEADERSHIP

IV.B.2.d)(1) Creates a critical care practice environment that reduces environmental risks for workers and health care users including families, for example, reduced risk for transmission of infections. (Core)

IV.B.2.d)(2) Assesses the practice environment for risks such as air quality, noise, odor, obstacles like cords, temperature, and light that negatively affect the health care user and staff. (Core)

IV.B.2.d)(3) Takes action to prevent or report a hostile work environment. (Core)

IV.B.2.d)(4) Undertakes timeous and appropriate conflict resolution among staff and various disciplines. (Core)

IV.B.2.d)(5) Ensures constant availability of adequate, operational, cost effective, safe and efficient equipment and technology for the care of critically ill patients on a daily basis. (Core)

IV.B.2.d)(6) Ensures availability of back up airway, oxygenation and hemodynamic management equipment and technology for patient on life support and for transportation. (Core)

IV.B.2.d)(7) Designs evaluation strategies to demonstrate cost effectiveness, cost benefit and efficiency (fitness for purpose) factors associated with critical care nursing practice, for example: documents adverse events in relation to specific practice, technology, compares parameters from various technology, e.g. O_2 saturation from different sources, NIBP and IBP which should not project dramatic differences. (Core)

IV.B.2.d)(8) Considers fiscal and budgetary implications in decision making related to practice and practice modifications, for example: (Core)

- evaluates the use of products and services for appropriateness and cost/benefit in meeting critical care needs.
- conducts cost/benefit analysis of new clinical technology.
- evaluates the impact of introducing or withdrawal of products, services, and technologies.

IV.B.2.d)(9) Engages in commissioning of a critical care unit with confidence based on sound knowledge of the needs and resource requirements of an ICU setting. (Core)

IV.B.2.d)(10) Ensures adequate coverage of all shifts with appropriately qualified staff and skill-mix in accordance with the organizational policies, guidelines, and norms. (Core)

IV.B.2.d)(11) Assigns aspects of care based on a careful assessment of the needs and condition of the patient, the potential risks/harm, availability and competence of the health care providers and applicable policy, norms, and legal framework like the scope of practice. (Core)

IV.B.2.d)(12) Assists the health care user including the family to make informed choices in relation to treatment options, alternatives, risks, benefits and costs for treatment and care which will result in the same expected outcomes across the critical care continuum. (Core)

IV.B.2.d)(13) Shares, fosters, and translates the vision and mission of the organization into the practice of nursing in the critical care setting. (Core)

IV.B.2.d)(14) Coordinates the care of critically ill patients across critical care continuum to ensure smooth/seamless transition through the critical care continuum, enhance health care delivery and achieve optimal patient outcomes. (Core)

IV.B.2.d)(15) Oversees the care given by others while retaining accountability for the quality of care given to the critically ill patients and their families. (Core)

IV.B.2.d)(16) Mentor colleagues for the advancement of critical care nursing practice, the nursing profession and quality of care. (Core)

IV.B.2.d)(17) Mentor colleagues in acquisition of clinical knowledge, skills, abilities, and judgment. (Core)

IV.B.2.d)(18) Participates in efforts to influence health care policy on behalf of heath care users and the profession. (Core)

IV.B.2.d)(19) Develops and implements a succession plan to ensure continuity of care in critical care nursing practice. (Core)

IV.B.2.d)(20) Participates in key roles on committees, councils, and administrative teams in the interest of empowering own nursing practice, that of colleagues and the profession. (Core)

IV.B.2.d)(21) Influences decision making bodies to improve critical care nursing practice environment and patient outcomes. (Core)

IV.B.2.d)(22) Treats colleagues with respect, trust and dignity including recognition and utilization of their potential. (Core)

IV.B.2.d)(23) Promotes the specialist nursing practice in critical care nursing and role development by interpreting its role for the health care users, families, and the profession as a whole. (Core)

IV.B.2.d)(24) Models expert practice to critical care nurses, other interdisciplinary team members and health care users. (Core)

IV.B.2.d)(25) Participates in designing systems that support effective teamwork and positive outcomes. (Core)

IV.B.2.d)(26) Introduces, evaluates and manages innovation and change in the critical care setting through encouraging creativity. (Core)

IV.B.2.e) RESEARCH

IV.B.2.e)(1) Contributes to nursing knowledge by conducting or synthesizing group research and other evidence that discovers, examines, and evaluates current practice, knowledge, theories, criteria and creative approaches to improve critical care practice. (Core)

IV.B.2.e)(2) Promotes a climate of research and clinical inquiry in the critical care setting. (Core)

IV.B.2.e)(3) Critically analyzes and discusses the findings of nursing research studies within the health care team in the field of critical care nursing to negotiate for applicable findings in own work environment. (Core)

IV.B.2.e)(4) Disseminates research findings through activities, such as, presentations, publications, consultations, and journal clubs for a variety of audiences but more especially coworkers to improve the critical care nursing practice. (Core)

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Assignment of rotations must be structured with sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. (Core)

IV.D. Scholarship

Scholarly activities must include discovery, integration, application, and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities in a group peers and faculty consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in education, patient care, or population health

- case-presentations
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, or case reports
- Creation of curricula, didactic educational activities, or electronic educational materials
- Contribution to professional committees, or educational organizations
- Innovations in education

IV.D.3. Resident Scholarly Activity

IV.D.3.a) While in the program, residents must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, webinars, or service on professional committees. (Core)

IV.D.3.b) Residents must participate in scholarly projects. (Core)

IV.D.3.b)(1) Residents must complete a scholarly project relevant to the specialty which was conducted under supervision of a faculty member. (Core)

IV.D.3.b)(2) The project shall be presented in a local, national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of project presentation in a nursing/medical conference, will be part of the resident's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines. (Core)

V. Evaluation

V.A. Resident Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work.

- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

A planned, defined and implemented system of resident assessment must be in place with clearly defined methods and identified level of the expected outcomes. (Core)

V.A.1. Formative evaluation

There must be a system of formative documented evaluation of resident's performance at the completion of the rotation and assignments. (Core)

V.A.1.a) The formative evaluator must:

V.A.1.a)(1) Assess residents' performance based on the seven professional practice standards namely person-centered care, ethical and legal practice, communication and collaboration, research and evidence-based practice, community and public health, leadership and management, and informatics and technology. (Core)

V.A.1.a)(2) Include a review of case volume to ascertain comprehensive coverage. (Core)

V.A.1.a)(3) Use formal in-service cognitive exams to monitor knowledge when appropriate. (Core)

V.A.1.a)(4) Use multiplicity in resident evaluation (e.g. faculty, self, peer evaluation. online and simulation). (Core)

V.A.1.a)(5) Document progressive resident performance improvement. (Core)

V.A.1.a)(6) Provide residents with a documented semi-annual evaluation on performance with feedback to guide their learning plans. (Core)

V.A.2. Summative evaluation

There must be a system of documented summative evaluation of resident performance at the end of the rotation/year/program to verify that the resident demonstrated sufficient competence to enter practice without supervision. (Core)

V.A.2.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

V.A.2.a)(1) More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation. (Core)

V.A.2.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.2.c) The program must provide an objective performance evaluation based on the Competencies, and must: (Core)

V.A.2.c)(1) use multiple evaluators (e.g., faculty members, peers, self, and other professional staff members) (Core)

V.A.2.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.2.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.2.d)(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress (Core)

V.A.2.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. (Detail)

V.A.2.d)(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; (Core)

V.A.2.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

Residents who are experiencing difficulties with achieving progress may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program

director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.2.d)(4) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.3. Final Evaluation

V.A.3.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.3.a)(1) The specialty-specific Competencies, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)

V.A.3.a)(2) The final evaluation must:

V.A.3.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.3.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; (Core)

V.A.3.a)(2)(c) consider recommendations from the Clinical Competency Committee; (Core)

V.A.3.a)(2)(d) be shared with the resident upon completion of the program. (Core)

V.A.4. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.4.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.4.a)(1) Additional members must be faculty members from the same program or other programs, or other health

professionals who have extensive contact and experience with the program's residents. (Core)

V.A.4.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. (Core)

V.A.4.b) The Clinical Competency Committee must:

V.A.4.b)(1) review all residents evaluation at least semi-annually; (Core)

V.A.4.b)(2) determine each resident's progress on achievement of the specialty-specific Competencies; (Core)

V.A.4.b)(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress, promotion, remediation, or dismissal; (Core)

V.A.4.b)(4) meet at least quarterly, keep minutes of their meetings and report to the Program Director. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.B.4. The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. (Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of residents and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least two or more residents from different years. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(e) scholarly activity; (Core)

V.C.1.c)(5)(f) resident and faculty surveys; (Core)

V.C.1.c)(5)(g) written evaluations of the program. (Core)

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(c) board pass and certification rates; (Core)

V.C.1.c)(6)(d) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents; (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

V.C.1.d) A process must be in place to incorporate stakeholder perspectives and feedback, ensuring that confidentiality is maintained.

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. (Core)

V.C.3. The goal of NIHS-accredited education is to train nurses who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Core)

V.C.4. Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board to obtain the Board Certification. (Core)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care
- Excellence in the safety and quality of care
- Excellence in professionalism through faculty modeling of:
    - the effacement of self-interest in a humanistic environment;
    - the joy of curiosity, problem-solving, intellectual rigor, and discovery.
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

VI.A.1.a)(1)(a) The program, its faculty and residents, must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. (Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a)(3) Patient Safety Events

VI.A.1.a)(3)(a) Residents, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

VI.A.1.b)(1)(a) A system must be in place for internal quality improvements. (Core)

VI.A.1.b)(1)(b) Documentation and reporting systems must be in place, including the production of guidelines, manuals, and reports. (Core)

VI.A.1.b)(1)(c) Residents and faculty must be involved in quality improvement processes as part of interprofessional teams. The results must be used to improve the program. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Supervision in the setting of nursing education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice and establishes a foundation for continued professional growth. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. Care provided by the resident shall be adequately supervised by the appropriate availability of the supervising faculty member. (Core)

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when the physical presence of a supervising nurse is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervisor is physically present with the resident during the key portions of the patient interaction. (Core)

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervisor is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(3) Oversight: the supervisor is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.d)(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Fatigue Mitigation

VI.B.1. Programs must:

VI.B.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.B.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

VI.B.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.B.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.C. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.C.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on educational level, patient safety, resident ability, severity, and complexity of patient illness/condition. (Core)

VI.C.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.C.3. Transitions of Care

VI.C.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.C.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.C.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.C.3.d) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.D. Clinical Experience and Education

VI.D.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 48 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

VI.D.2. Mandatory Time Free of Clinical Work and Education

VI.D.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.D.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.D.2.b)(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 48-hour and the one-day-off-in-seven requirements. (Detail)

VI.D.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). (Core)

VI.D.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 12 hours of continuous scheduled clinical assignments. . (Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.5. Moonlight

Residents are not permitted to moonlight. (Core)

References

- Ahmed, F. R. Dias, J. M. Al Yateem, N. Subu, M. A., & Abu Ruz, M. 2022. Lessons learned and recommendations from the COVID-19 pandemic: Content analysis of semi-structured interviews with intensive care unit nurse managers in the United Arab Emirates. Journal of Nursing Management,30(7),2479– 2487. https://doi.org/10.1111/jonm.13677
- DHA Health Facility Guidelines 2019. Part B – Health Facility Briefing & Design 200 – Intensive Care Unit – General.
- Ghaljeh M, Rezaee N, & Arbabisarjou A. (2021). Comparison of self-, peer, and teachers' evaluation about the clinical skills of nursing students at the

department of psychiatry. J Educ Health Promot. 10:397. doi: 10.4103/jehp.jehp_1034_20. Retrieved from

- McCoy L, Lewis JH, & Dalton D. 2016. Gamification and multimedia for medical education: A Landscape review. J Am Osteopath Assoc; 116:22–34
- National Institution of Health Specialties (NIHS). 2020. General Requirements for Accreditation of Residency/Fellowship programs.
- Smith, A. L. (2021). Evidence-based practice training in nurse residency programs: Enhancing confidence for practice implementation. Teaching and Learning in Nursing, 16(4), 315–320.
- Staff Writer. 2017. UAE needs 1,000 ICU beds to meet patient demands. Arabian Business.
- UAE Government (2021). National Strategy for Nursing and Midwifery - Roadmap for 2025- The Official Portal of the UAE Government.
- UAE Government (2021). Vision 2021 - The Official Portal of the UAE Government. 7.10UAE Ministry of Education. 2012. National Qualifications Framework Handbook.
- UAE Nursing and Midwifery Council 2018. Model for Nursing and Midwifery Specialization in the United Arab Emirates.

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical/nursing educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical/nursing education.

Acknowledgement

A special gratitude to the Adult Intensive Care Nursing Program Committee for their contribution in preparing NIHS Nursing Transition to Practice Program Requirements.

Chairman:

Shaikhah Mohamed Al Zahmi

Members:

Dr. Rennie Joshua

Emily Alejandro

Heba Khalil

John Tote

Joven Santigo Bernadit

Malek Mechref

Mansour Jawdet Mohammed Mansour

Nazih Said Abu Tabar

Rana F. Obeidat

Raziya Hamaydeh

Sinat Mathew

Sinimol Thomas

Tijy Thomas


المعهد الوطني للتخصصات الصحية
NATIONAL INSTITUE FOR HEALTH SPECIALITIES